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Medicare SGR formula/physician payment reform

On April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015, which permanently repealed the Medicare SGR formula.

ACP commends Congress and President Obama for enactment of the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA), H.R. 2, which permanently repeals the Medicare Sustainable Growth Rate (SGR) formula, makes other improvements in Medicare payment policies, and reauthorizes the Children's Health Insurance Program (CHIP), the National Health Service Corps, community health centers, and teaching health centers for two more years.

What's it all about?

MACRA repealed the Medicare Sustainable Growth Rate (SGR) formula, which since 1998 had adjusted Medicare's payment updates to physicians based on overall spending on physician services compared to growth in the economy (as measured by per-capita GDP). When spending exceeded per-capita GDP, the SGR reduced the annual inflation update for the Medicare physician fee schedule by the difference. The result had been scheduled cuts to physicians each and every year since 2002. Except for one year, Congress overrode the SGR cut by passing a temporary "patch"—blocking the next scheduled cut but not repealing the SGR itself. This was done 17 times over the past 12 years. Over time, the amount of the schedule cut grew, mainly because the temporary patches did not fully cover the cost of *future* scheduled cuts from the SGR. Now that MACRA has been signed into law, physicians will never again have to face the uncertainty created by scheduled SGR payment cuts.

What's the current status?

MACRA was passed by the House of Representatives on March 26, 2015 by a vote of 392 to 37, approved by the Senate on April 14 by a vote of 92 to 8, and signed by the President on April 16.

Read an official congressional committee summary http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/Analysis/20150324-HR2-SectionbySection.pdf of the MACRA law.

How and why did the 114th Congress address it?

MACRA is the result of a decision by Speaker of the House John Boehner, and Minority Leader Nancy Pelosi, to reach a bipartisan agreement on budget offsets to partially pay for SGR repeal. They also agreed to other changes in federal health programs that would have bipartisan support, including entitlement reforms and reauthorization of CHIP and several other healthcare access programs. Their agreement built on the great progress made last year, when the chairs and ranking members of the House Energy and Commerce, Ways and Means, and Senate Finance Committees agreed on a bill that would have repealed the SGR and made other improvements in Medicare physician payments. Although last year's bipartisan and bicameral bill ultimately did not pass Congress because of differences over how to pay for it, the physician payment policies included in it became the basis for MACRA.

What's ACP's view?

ACP strongly supported MACRA and played a key leadership role in providing our ideas for policies to improve Medicare physician payments, many of which were incorporated into MACRA, and in organizing support for it. We

were one of 750-plus physician membership organizations, national and state, and spanning all specialties, which endorsed it. Below are 5 key reasons why MACRA represents an improvement for internists and their patients:

1. After 11 years, 17 patches, and more than $154 billion wasted—the failed SGR formula has been eliminated!

2. MACRA establishes stable positive updates during a transition period:

    - Annual updates of 0.5 percent starting on July 1, 2015 through the end of 2019. The rates in 2019 will be maintained through 2025 while providing professionals with the opportunity to receive additional payment adjustments through a new Merit-Based Incentive Payment System (MIPS). This is much better than a 21 percent SGR cut on April 1—which in all probability would have been followed by more patches with rates frozen indefinitely, year after year, as far as the eye could see.

3. Starting in 2019, the existing Medicare quality reporting/incentive programs—Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), and Meaningful Use) — which vary significantly in terms of measures, data submission options, and payment timelines — will be consolidated into one single quality improvement program, the Merit-Based Incentive Payment System (MIPS), reducing the significant confusion associated with the current three separate reporting programs. Existing 2019 penalties under the PQRS, VBM, and MU programs, which can total as much 11 percent or more, are cancelled, and put back into physician payments, significantly increasing the total funds available to pay physicians.

4. The new MIPS program will allow physicians to more clearly determine their eligibility for incentive payments. In essence, it empowers physicians to set their own individual conversion factor, rather than having it determined by a flawed formula or other external approach. Physicians will be able to proactively review their data in order to set their performance goals and will get credit for improvement.

    - Physicians will also get credit for their clinical quality improvement activities, as well for transitioning to the Patient-Centered Medical Home (PCMH) model or the PCMH specialty practice model.

    - High performing physicians can also receive additional payment. In aggregate, this additional payment would be up to $500 million per year from 2019 to 2024. This new money does not exist within the current Medicare reporting/incentive programs.

    - Additional new money is also allocated specifically to help small practices ($20 million annually from 2016 to 2021).

5. Physicians participating in Alternative Payment Models (APMs), like ACOs and advanced PCMHs, can choose to take a different path than the MIPS program and will receive a 5 percent bonus each year from 2019 to 2024—this is entirely new funding and is on top of any current payment structures that are part of their APM (e.g., prospective care coordination fees, shared savings, etc.).

    - Read an ACP perspective article from the Annals of Internal Medicine on the changes made by MACRA. Compare the legislation to ACP's recommendations in a section-by-section analysis.

Who can I contact to learn more?

advocacy@acponline.org