

Goodbye, Sustainable Growth Rate—Hello, Merit-Based Incentive Payment System

Robert B. Doherty, BA

After years of haunting physicians with the specter of scheduled Medicare payment cuts, the Sustainable Growth Rate (SGR) formula has been put to rest. On 16 April 2015, President Obama signed the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA), which, in addition to repealing the SGR, put in motion policies to transform physician payments from a system that rewards volume to one that recognizes value. Congress established the SGR in 1997 to ensure that annual payment increases did not exceed growth in the overall economy, as measured by per capita gross domestic product. The inherent mismatch between economic growth, which physicians cannot control, and overall annual growth in spending on services included in the Medicare physician fee schedule, which individual physicians have limited influence over, has led to scheduled cuts in Medicare payments every year from 2002 through 2015. The SGR did not differentiate between the most or least efficient physician.

Although Congress overrode the cuts every year except 2002, physicians never knew whether the next cut would be implemented. The usual solution was a temporary patch that replaced the cut with a fee freeze or tiny percentage increase. Worse, Congress masked the cost of the patch by pretending that it would be paid for by an even deeper cut the next time around. Consequently, physicians were facing a 21% cut on 1 April 2015 until the MACRA reversed it. The MACRA, though, is about more than SGR repeal: It's also about accelerating changes in Medicare payment policies to recognize value rather than volume. It offers physicians more stability and potentially more control over reimbursement in the following ways.

First, payments are *stabilized*. The MACRA provides physicians with baseline annual Medicare payment updates of 0.5% from 1 July 2015 through 31 December 2018, allowing time for transition to "value-based" payments.

Second, physicians have more *choice and control* over how they are paid. Beginning in 2019, annual updates on physician payments will be based on a physician's successful participation in a new quality reporting program called the Merit-Based Incentive Payment System (MIPS) or in an alternative payment model (APM). Physicians, or their practices, will decide annually in which they wish to participate.

The MIPS is for physicians who want to continue to be reimbursed under traditional Medicare fee-for-service, with payments adjusted annually on the basis of their performance in 4 weighted subcategories: clinical quality, meaningful use of health information tech-

nology, resource use, and practice improvement. Their annual Medicare update will be 0.5% in 2019 plus or minus 4% based on their composite score for the measures applicable to each of the 4 subcategories. From 2020 through 2025, physicians will start with a "baseline" annual update of 0% plus or minus a performance adjustment of 5% in 2020, 7% in 2021, and 9% between 2022 and 2025. Beginning in 2026, their annual baseline update will be 0.25% plus or minus 9%. Payments can never be reduced by more than the amount set by the statute (for example, 5% in 2020).

The maximum positive amount available in any given year will depend on how many physicians score below, at, or above a threshold to be set by the U.S. Department of Health and Human Services through rulemaking. "Exceptional performers"—those scoring in the top 25th percentile—will receive an added annual performance adjustment of up to 10% from 2019 through 2024, funded by up to \$500 million that the MACRA authorizes annually to reward top performers. Physicians who choose the MIPS pathway will know the scoring threshold that they need to meet for a positive performance adjustment and be able to review their data to set performance goals.

The MIPS holds promise to streamline and harmonize Medicare quality reporting because it will replace the existing Medicare Physician Quality Reporting System, Value-Based Payment Modifier program, and meaningful use programs, potentially reducing the confusion and hassles that stem from 3 separate reporting programs with their own deadlines, measures, and penalties. The current Physician Quality Reporting System and meaningful use penalties for 2019 (which could total up to 7%) will be canceled, putting those dollars back into the physician payment pool.

The APM program is intended for physicians who want to participate in alternative practice models that involve accepting financial risk for the quality and effectiveness of care, like accountable care organizations or advanced patient-centered medical homes. The U.S. Department of Health and Human Services will establish the criteria for selection of these models, but the statute states that patient-centered medical homes are the only models that would not have to accept financial risk to qualify as an APM, as long as they show the capability to increase quality without increasing costs, or decrease costs without decreasing quality. Physicians will be supported by their APM's payment rules and will receive annual baseline increases of 5.0% on fee-for-service payments from 2019 through 2024. Those who choose an APM will potentially have considerable control over whether their APM is able to

achieve cost-savings that would result in even higher payments.

Certainly, the transition to the MIPS and APMs will not be trouble-free. A Brookings Institution report notes that “Success will mean physicians will have measures that they believe should be the object of efforts to improve practice (and data showing them how to improve on the measures), the measures can be consistently applied to a variety of alternative payment models and Medicare's other payment systems, and consumers and others will be able to compare providers, all with less administrative burden” (1). Another analysis suggests that physicians' response to the MIPS could depend on whether the information provided on cost and quality performance was actionable and credible (2). The composite score's complexity could affect physicians' perceptions of whether it is actionable. Finally, there is growing recognition that quality measurement that is insufficiently evidence-based and burdensome can be counterproductive.

The APM pathway has its own challenges: “The evidence on alternative payment models is mixed . . . most alternative payment model initiatives will take years to realize their full effects . . . [and] providing opportunities for small physician practices . . . to participate in alternative payment models will remain a challenge” (2), although the MACRA sets aside funding to help small practices.

Now that the SGR is gone, physicians must advocate to ensure that the MIPS and APMs measure the right things, do not add to administrative burdens or

undermine professionalism, offer true choice, and improve the quality of care—a tall order.

From the American College of Physicians, Washington, DC.

Acknowledgment: The author thanks Shari M. Erickson, MPH, and Kolton Gustafson.

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M15-0992.

Requests for Single Reprints: Robert B. Doherty, BA, American College of Physicians, 25 Massachusetts Avenue NW, Suite 700, Washington, DC 20001.

Author contributions are available at www.annals.org.

Ann Intern Med. 2015;163:138-139. doi:10.7326/M15-0992

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Annals of Internal Medicine

Author Contributions: Conception and design: R.B. Doherty.
Analysis and interpretation of the data: R.B. Doherty.
Drafting of the article: R.B. Doherty.
Critical revision of the article for important intellectual content: R.B. Doherty.
Final approval of the article: R.B. Doherty.
Administrative, technical, or logistic support: R.B. Doherty.
Collection and assembly of data: R.B. Doherty.