



Sustainable Growth Rate (SGR) Repeal and Replacement Summary

Bipartisan legislation passed by Congress contains significant reforms to the Medicare physician reimbursement system.

The Medicare Sustainable Growth Rate formula (SGR) is a budget cap that was passed into law in 1997 as an attempt to control federal spending on physician services. Since 2003, Congress has routinely delayed devastating cuts that jeopardize beneficiary access to psychiatric services in the Medicare program through “patches” to scheduled SGR reductions. Some of these patches were for a scant few weeks, causing significant instability and administrative burden for physician practices. In March and April 2015, Congressional leadership conducted breakthrough negotiations based on recent bipartisan work to bring an end to the SGR once and for all. They have laid the groundwork for significant changes to Medicare physician reimbursement over the next decade and beyond with the passage of H.R. 2, the Medicare Access and CHIP Reauthorization Act (MACRA). The provisions of MACRA have significant implications for the practice of psychiatry and reimbursement of psychiatric services in addition to the activities of APA.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

SGR Repeal and Reimbursement Updates

- MACRA has permanently repealed the flawed SGR reimbursement formula.
- A stable period of annual updates (0.5%) is now in place through 2019. The 2019 rate is maintained through 2025, with the potential for additional adjustments through the creation of the new Merit-Based Incentive Payment System (MIPS – see below). Beginning in 2019 and ending in 2024, physicians may instead make themselves eligible for a 5% incentive payment based on participation in certain alternative payment models (APMs).
- Beginning in 2026, physicians who participate in these APMs will receive a 1% annual update, while all other physicians will receive a .5% annual update.

Creation of the Merit-based Incentive Payment System (MIPS)

- MACRA consolidates several current quality incentive and penalty programs into one system (MIPS) that affects Part B reimbursement beginning in 2019. The consolidated programs include the [Physician Quality Reporting System](#) (PQRS), [the Value-Based Modifier](#) (VBM), and [the Electronic Health Record Meaningful Use program](#) (MU). The penalties for these programs will sunset at the end of 2018, before MIPS begins.
- MIPS contains four categories of “performance assessment” including quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities. Weights are assigned to each category to create a total composite score of 0-100 for physicians based on their performance in these categories:
 - o *Quality measures (30%)* will be based on those in existing measurement programs in addition to other potential measure eligibility pathways, including processes for the Secretary of Health and Human Services to fund professional organizations to develop additional measures.
 - o *Resource use (30%)* will be largely based on the current VBM system with modifications
 - o *Meaningful use of electronic health records requirements (25%)* will be largely based on the current meaningful use program.
 - o *Clinical practice improvement activities (CPIAs, 15%)* that foster future participation in APMs will be established by the Secretary and must include activities in the following subcategories: expanded



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practice access, population management, care coordination, beneficiary engagement, and patient safety and practice assessment. Physicians would not have to perform activities in each of these subcategories to achieve the highest potential MIPS score. Participation in these activities may meet individual or institutional requirements, including certain maintenance of certification (MOC) or maintenance of licensure (MOL) requirements.

- Each physician's composite score will be compared to a performance threshold, which will be the average score of all MIPS participants for a given performance year. At the beginning of each performance period, physicians will know what composite score they must achieve to obtain incentive payments and avoid penalties.
- Payment adjustments will be made based on placement above or below the average threshold. Adjustments in either direction will be capped at 4% in 2018, 5% in 2019, 7% in 2020, and 9% in 2021. In addition to threshold comparisons, MACRA provisions allow for positive adjustment based on improvement in performance categories.
- MACRA dedicates \$20 million in annual funding (\$100m total) for small-practice MIPS implementation, as well as technical assistance for transition to alternative payment models.
- MIPS does not apply to certain professionals who do not exceed a low-volume beneficiary threshold (to be determined by the Secretary).

Promotion of Alternative Payment Models

- As mentioned previously, physicians who receive a significant share of their revenue through Alternative Payment Models that involve dual-sided risk may be eligible to receive a 5% bonus each year from 2019 through 2024 and to opt out of MIPS.
- MACRA establishes a Physician-Focused Payment Model Technical Advisory Committee composed of national experts in physician-focused payment models and innovative care delivery. The committee will study and vet delivery reform models to inform recommendations on approved APMs to the Secretary.
- By November 1, 2016, the Secretary is required to establish criteria for physician-focused payment models to follow a process of submission, review, and evaluation with input from the committee as well as the Medicare Payment Advisory Commission.
- Individuals and stakeholder organizations are encouraged to submit proposals to the committee and Secretary for physician-focused payment models.
- MACRA specifically permits testing of APMs that focus on non-primary care practitioners, small practices, Medicaid and CHIP integration, and statewide payment models.

Additional Notable Provisions Related to Physician Practice or Reimbursement

- Allows physicians who opt out of Medicare to automatically renew at the end of each two-year cycle.
- MACRA establishes \$75m for quality measure development to physicians and national physician societies. New measures can be adopted without endorsement by the National Quality Forum.
- Quality program standards created under MACRA explicitly cannot be used as a "standard of care" in medical liability actions.

A summary compiled by the House Energy and Commerce Committee of other MACRA provisions, including those on budgetary offsets, Medicare extenders, and the Children's Health Insurance Program (CHIP), can be found [here](#).

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