Health Policy Review

Analysis of the Carrot and Stick Policy of Repeal of the Sustainable Growth Rate Formula: The Good, The Bad, and The Ugly

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The Balanced Budget Act which became law in 1997 was designed to help stem the increasing in costs of healthcare. The Sustainable Growth Rate (SGR) formula was incorporated into that law as a method of helping balance the budget through a complex formula tying reimbursement to the growth in the economy. Soon after its inception, the flawed nature of the formula, linking the balancing of the federal budget to physician professional fees was realized. Congress has provided multiple short-term fixes known as SGR patches over the years so as to avoid generally progressively larger negative corrections to professional reimbursement. The near annual SGR correction requirement has been compared to Groundhog Day in the legislative arena. Over the years, physician and other providers faced numerous looming, large cuts. Most recently, on April 1, 2015 physicians faced a 21.2% cut in provider payments. To the surprise of many, in April 2015 a bipartisan bicameral effort permanently repealed the Medicare SGR formula for controlling provider payment.

The repeal of SGR means the temporary measures to override the growth rate formula will no longer dominate Medicare policy discussions and now the focus turns to continue payment reforms. The MACRA provides physicians and other health care professionals with stable fee update for 5 years and it follows with a new incentive program, termed the Merit-based Incentive Payment System (MIPS) replacing and consolidating pre-existing incentive payment programs: meaningful use of electronic health records (EHR), physician quality reporting system, and the value-based payment modified. Thus, payments to clinicians will be subjected to adjustments based on participation in MIPS or other approved alternative payment mechanisms. This legislation also creates numerous other regulations.

The MACRA has been criticized for providing insufficient statutory updates, enacting a flawed quality and performance improvement program associated with MIPS and inappropriate use of utilization and payment data. Thus, the MACRA offers physicians a predictable schedule for Medicare rates – a carrot, and controls the physician behaviors with payment reforms analogous to a stick. Thus, it could be said that this legislation embodies some good, bad, and ugly aspects.

Key words: Balanced Budget Act, sustainable growth rate, alternative payment models, Medicare Access and CHIP Reauthorization Act of 2015, Merit-based Incentive Payment System, payment reform, payment modernization, health information technology

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On April 16, 2015 after 17 years, 8 months, and 9 days with the stroke of his Executive pen, President Obama ended the infamous "unsustainable" Sustainable Growth Rate formula (SGR). These years saw numerous acts of Congress, and innumerable debates and seemingly endless conjecture about the SGRs fate. Sequentially, on March 26 and then April 14 2015, the House and Senate overwhelmingly passed the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing the SGR and stopping the 21% cut to Medicare physician payments that was set to go into effect on April 1, 2015 (1-4). The President hailed the new Medicare package as a "significant bipartisan achievement." He also said, "it also improves physician reimbursement because it starts encouraging payments based on quality, not the number of tests that are provided or the number of procedures that are applied, but whether or not people actually start feeling better. It encourages us to continue to make the system better without denying services." MACRA provides a permanent fix for the SGR based on numerous proposals and 2 years of negotiations between the parties in both houses, with a far-reaching package of reforms and consequences (4,5). The MACRA has mistakenly been called a "doc-fix" which unfortunately could create the impression that it is a bill to benefit an influential group at the expense of others (4-7). MACRA rids us of the unfair, illogical payment policy which led to continuous threats of cuts in the annual or even semiannual SGR exercise (6,8). In short, the Act has been promoted as changing Medicare payment policies to support greater value, quality, effectiveness, and efficiency for patients, the Medicare program, and to taxpayers, and to support all providers, not just physicians, to achieve greater value.

The carrot of MACRA provides physicians and other health care professionals stable fee updates for 5 years with an increase of 0.5% per year through 2019, the MIPS, program which essentially replaces and consolidates preexisting incentive payment programs including the meaningful use (MU) of EHRs, the physician quality reporting system (PQRS), and the value-based payment modifier.

With MIPS and alternative payment models (APMs), the stick starts in 2019 which is concerning given the ever changing dynamics in Washington. Value-based payments have been advocated since the birth of Medicare (9,10). Consequently, the correction of the SGR may result in a new set of problems specifically targeting health care (11). In fact, some organizations already oppose MACRA because it has insufficient statutory updates that fail to cover the cost of medical price inflation. This has the potential to result in major cuts in services in combination with penalties of up to 9%. It has been said that the Merit-Based Payment System combines existing programs with vague legislative language lacking clarity on the intended structure and impact of key components, increasing the regulatory burden and finally inappropriate use of utilization and payment data which not only misleads the public, but causes consumers to reach inaccurate conclusions about physicians practices (12).

Consequently, it is time to examine multiple aspects of the carrot and stick policy of legislative SGR reform – the good, the bad, and the ugly.

A Look Back at the Sustained Growth Rate Formula

The sustainable growth rate system was put in place to control the cost of Medicare payments for physicians and other providers as a result of the Balanced Budget Act of 1997, replacing the Medicare Volume Performance Standards, or MVPS (13). From 1980 to 1990, Medicare payments to providers were based on charges, producing escalating Medicare spending; growing at an annual rate of 13.4%. Consequently, Congress reformed the system by determining the rate paid for services by the resources or inputs necessary to perform them and by restricting annual increases for services based on the total volume of services delivered. This formula known as MVPS appears to have worked initially providing steady growth of only 1% or 2% per year from 1992 to 1997. However, Congress went further, and rather erroneously in our opinion, striking a budget deal in 1997 with President Clinton which included a refinement to the aspect of Medicare physician payment rates linked to volume growth, the newly labeled SGR. The SGR was essentially envisioned to ensure that a yearly increase in the expense per Medicare beneficiary would hold at the same level or below the growth of the gross domestic product (GDP) (14,15). The Medicare Payment Advisory Commission (MedPAC) advised the U.S. Congress on the expenditures from the previous year and the target expenditures of the current year. For a short period, the SGR increased payments when the growth rate of spending on physician services fell short of growth in the GDP. However, it also slashed payments when physician spending grew more rapidly than GDP. With faltering economy and reduction in real GDP, the main factor that seems to have been consid-

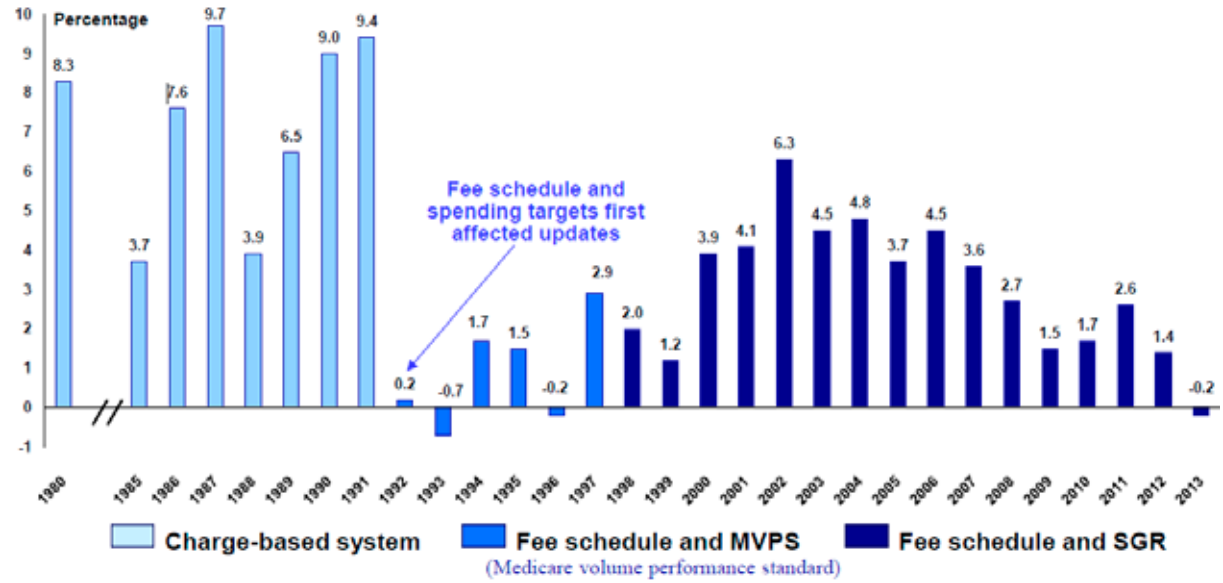
ered was the utilization rate driving the SGR algorithm with prices, the number of Medicare beneficiaries, and changes in the law, which accounted to minimal proportion. There was no significant effect until 2002, by which time the budget was balanced and relevance of the law became questionable. In 2002 the Medicare based payment rates for provider services were cut by 4.8%. This drastic action suddenly received attention from of patients physicians and legislators, including Congress, and the flaws in the law started surfacing. The only silver lining in this legislation was that the implementation of the physician fee schedule update to meet the target SGR could be adjusted or suspended by Congress. Consequently, Congress has stepped in with short-term legislation since 2003 and passed a law to block the cuts generated by SGR formula. Initially there was faint hope that these intrusions would be temporary and a permanent fix with repeal of SGR will be coming; however, after a few years, it became clear that was not forthcoming (15). Table 1 shows the histo-

Table 1. *History Sustainable Growth Rate patches*.

Year	Legislation	Payment Period	Scheduled Payment Update	Legislated Payment Update	Offset Over 10 Years?	Offset by Health Savings?
2003	Consolidated Appropriations Act, 2003	2003	-4.4%	1.4%	No	No
2004 2005	Medicare Prescription Drug, Improvement, and Modernization Act	2004-2005	-4.5% (2004) -3.3% (2005)	1.5%	Yes	Yes
2006	Deficit Reduction Act of 2005	2006	-4.4%	0.2%	Yes	Yes
2007	Tax Relief and Health Care Act	2007	-5%	0%	Yes	Yes
2008	Medicare, Medicaid, and SCHIP Extension Act	Jan-June 2008	-10.1%	0.5%	Yes	Yes
2009	Medicare Improvement for Patients and Providers Act	July 2008-2009	-10.8% (2008) -16% (2009)	0% (2008) 1.1% (2009)	Yes	Yes
	DOD Appropriations Act, 2010	Jan-Feb 2010	-21%	0%	Yes	Yes
2010	Temporary Extension Act	Mar. 2010	-21%	0%	No	No
	Continuing Extension Act	Apr-May 2010	-21.2%	0%	No	No
	Preservation of Access to Care for Medicare Beneficiaries...Act^	June-Nov 2010	-21.2%	2.2%	Yes	Partially
	Physician Payment and Therapy Relief Act	Dec. 2010	-23%	0%	Yes	Yes
2011	Medicare and Medicaid Extenders Act	2011	-25%	0%	Yes	Yes
2012	Temporary Payroll Tax Cut Continuation Act	Jan-Feb 2012	-27.4%	0%	Yes	No
	Middle Class Tax Relief and Job Creation Act	Mar-Dec 2012	-27.4%	0%	Yes	Yes
2013	American Taxpayer Relief Act	2013	-26.5%	0%	Yes	Yes
2014	Pathway for SGR Reform Act^	Jan-Mar 2014	-20.1%	0.5%	Yes	Yes
2015	Protecting Access to Medicare Act^	Apr 2014-Mar 2015	-24%	0%	Yes	Yes

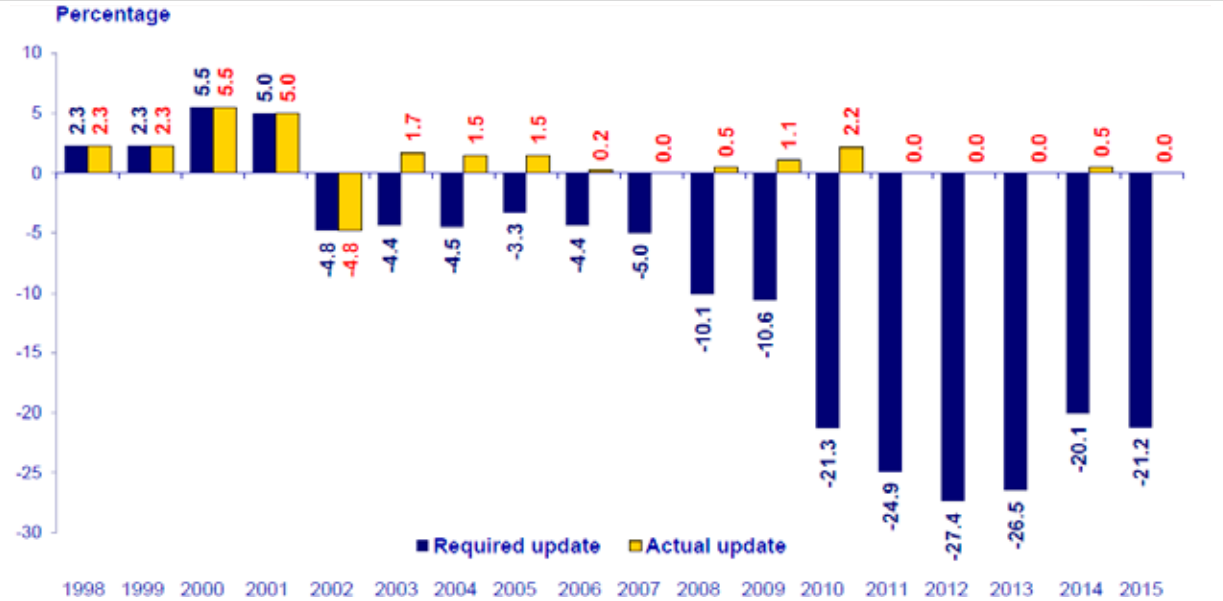
^Doc fix technically paid for over ten years but partially does so with timing shifts or gimmicks.
Source: Congressional Research Service, Congressional Budget Office.

ry of SGR patches, whereas, Fig. 1, shows the increases of growth and volume and intensity of Medicare physician services per beneficiary (15). Fig. 2 shows actual updates compared to required updates from 1998 to 2015 (15). Figs. 3 and 4 show increased volume growth has impacted physician spending more than input prices



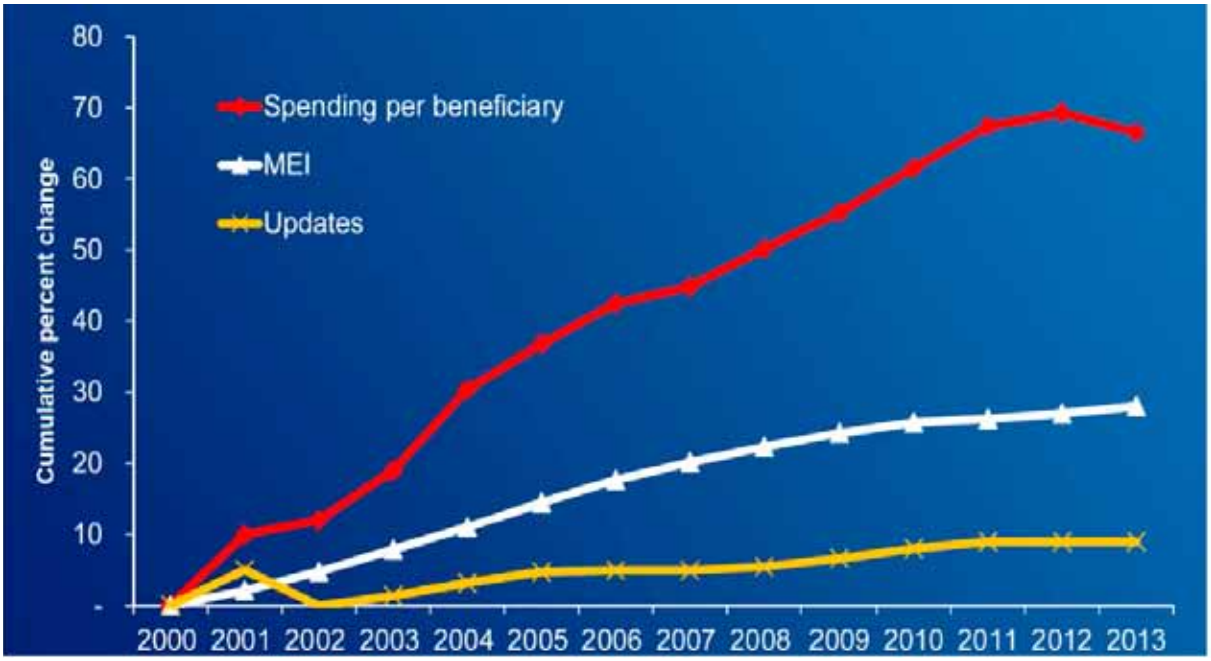
Source: Data from CMS and the Boards of Trustees of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds.

Fig. 1. *Growth in volume and intensity of medicare physician services per FFS beneficiary,1980-2013.*



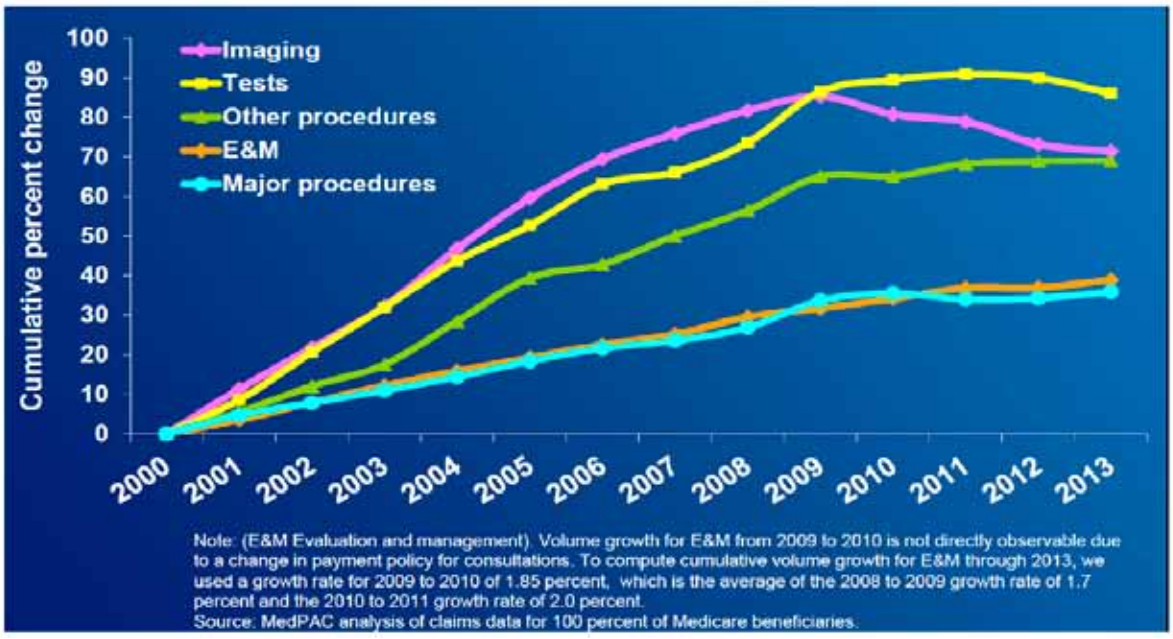
Source: Data from the Boards of Trustees of the Federal HI and SMI Trust Funds, CMS Office of the Actuary, and Congressional Research Service. Notes: Beginning with 2008, required updates are a result of both the SGR formula and legislative changes. In 2003 and 2010, the increase became effective on March 1st and June 1st, respectively. In 2015, the 0 percent update is in effect through March 31st; After that, a 21.2 percent cut is set to take effect.

Fig. 2. *Actual updates compared to required updates, 1998-2015.*



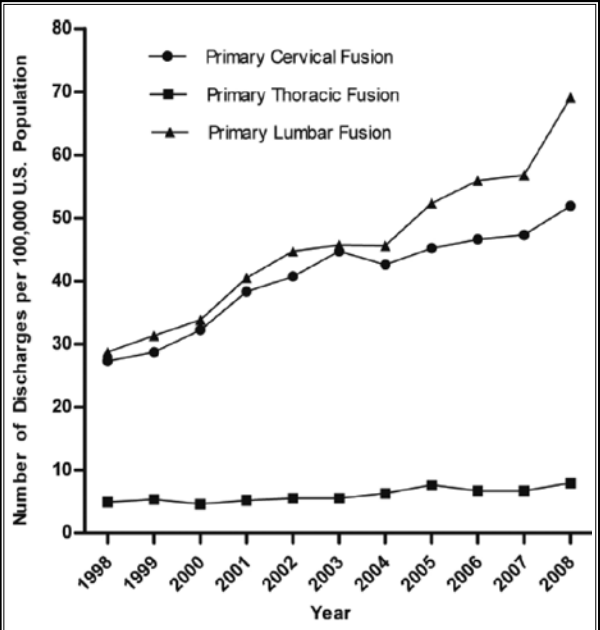
Source: MedPAC, December 18, 2014 presentation (data are preliminary)

Fig. 3. *Increased volume growth has impacted physician spending more than input prices and payment updates, 2000-2013.*



Source: MedPAC, December 18, 2014 presentation (data are preliminary)

Fig. 4. *Increased volume growth by type of service, 2000-2013.*



Source: Rajaee SS, Bae HW, Kanim LE, Delamarter RB. Spinal fusion in the United States: Analysis of trends from 1998 to 2008. *Spine (Phila Pa 1976)* 2012; 37:67-76 (18).

Fig. 5. *National estimates of annual rates for primary cervical fusion (International Classifi cation of Diseases, Ninth Revision, Clinical Modification [ICD-9]: 81.01–81.03), primary thoracic fusion (ICD-9-CM: 81.04–81.05), and primary lumbar fusion (ICD-9-CM: 81.06–81.08) discharges from 1998 to 2008.*

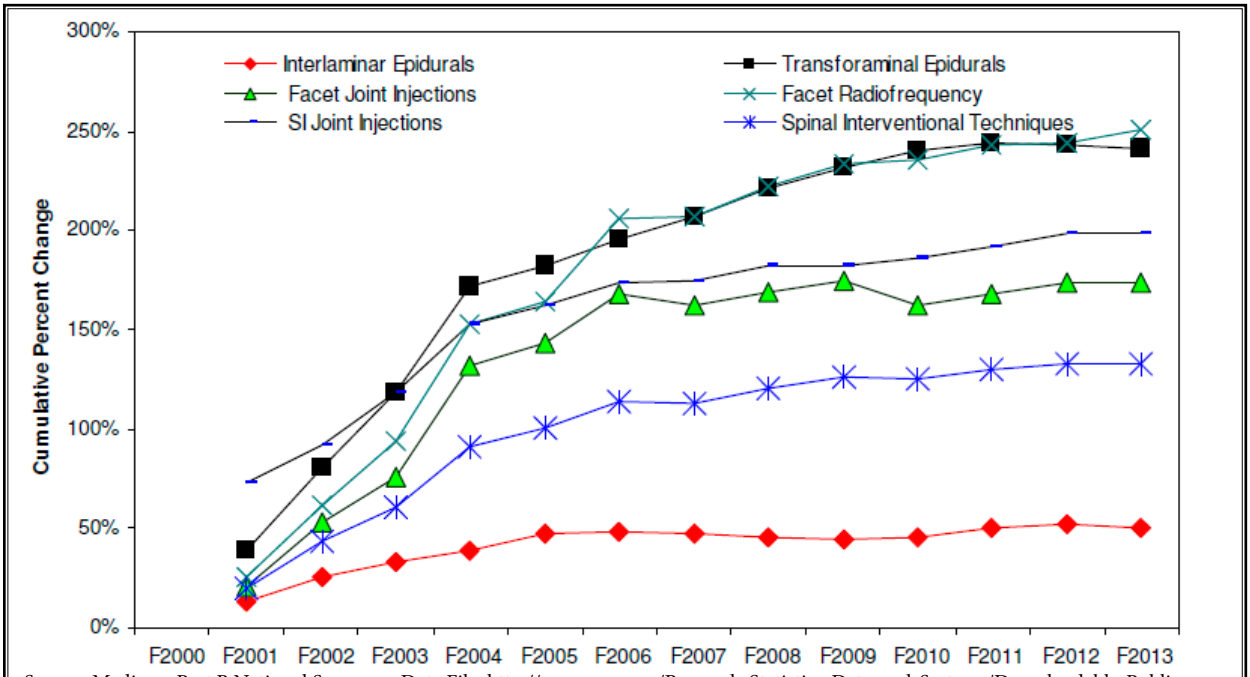
and payment updates from 2000 to 2013 and increased volume growth for various services also had significant impact (15). Figs. 5 and 6 show the contributions of surgery and interventional pain management techniques and their escalating growth (16,17). Overall, all services related to controlling pain and disability have increased along with their prevalence (16-33).

Consequently, over the years, the cost of the repeal of SGR has been increasing, which was estimated to be less than $50 billion for a 10 year fix in March 2005, increased to a high of over $350 billion in 2011, and, was reduced to $137 billion in 2015, as shown in Table 2 (34).

Finally, a permanent fix with the repeal of SGR has come in 2015, eliminating the rituals of Groundhog Day that have been present since 1997 in reality, and have increased in intensity since 2003.

Medicare Access and CHIP Reauthorization Act of 2015

MACRA or H.R. 2, includes multiple provisions with the major provision being to replace the SGR formula used by Medicare to pay physicians with new systems for establishing annual payment rate updates for provider's services (5,34-39). Further, it would also temporarily extend the Children's Health Insurance Program



Source: Medicare Part B National Summary Data File. http://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-National-Summary-Data-File/Overview.html

Fig. 6. *Growth of spinal interventional techniques.*

Table 2. CBO estimates of the cost of simple SGR fixes.

Date of Score	Fee Freeze 10-Year Score (billions of dollars)	MEI Update 10-Year Score (billions of dollars)
March 2005	$48.6	$154.5
March 2007	$177.7	$262.1
May 2009	$285	$344
June 2011	$297.6	$358.1
July 2012	$271.0	$362.0
November 2012	$243.7	(no estimate)
February 2013	$138.0	(no estimate)
May 2013	$139.1	$224.8
November 2014	$118.9	$204.3
January 2015	$137	(no estimate)

Source: Farb J. Medicare's physician payment system and the Sustainable Growth Rate (SGR). February 26, 2015. www.nhpf.org/UPLOADS/HANDOUTS/FARB-SLIDES_02-06-15.PDF (34)

(CHIP) and increase premiums for Part B and Part D of Medicare for beneficiaries with income above certain levels. Finally, MACRA would also make numerous other changes to Medicare and Medicaid. Table 3 shows differences between payment policies and other regulations under SGR and MACRA.

SGR Repeal and Medicare Provider Payment Modernization

Title I describes SGR repeal and Medicare provider and payment modernization with major specifications of the new payment system as follows:

- 0.5% per year increase of Medicare payment rates for services paid under physician fee schedule from 2016 through 2019.
- From 2019 to 2025 payment rates for services on physician fee schedule would remain at 2019 level.
- Starting in 2019, 2 programs influence the physician payments with their participation.
  - Alternative Payment Models or APMs program
  - MIPS
- For 2026 and subsequent years, there would be 2 payment rates for services on the physician fee schedule.
  - For providers paid through an APM program, payment rates would be increased each year by 0.75%.
  - For other providers, payment rates would be increased each year by 0.25%.
- Providers who opted to participate in MIPS would receive payment that would subject to positive or negative performance adjustments.
  - The performance adjustment for an individual provider would depend on that provider's performance compared to a threshold.
  - H.R. 2 also would provide $500 million each year from 2019 to 2024 as an additional performance adjustment for providers in this program who achieved exceptional performance.
- From 2019 through 2024, providers receiving a substantial portion of their revenue from APMs would receive a lump sum payment after each year equal to 5% of their Medicare payments for services reimbursed according to the physician fee schedule in that year.
  - Providers with smaller amounts of revenue from APM would receive either no adjustment to their payments or the MIPS performance adjustment if they reported measures and activities under that program.

Table 3. *The differences between SGR and Medicare Provider Payment Modernization Act of 2015.*

	SGR	MACRA
Annual Medicare Update for Physician Services	• -21.2% SGR cut takes effect April 1, 2015. • Future SGR cuts could exceed 25%.	Annual Update of: (0% January through June 2015 (0.5% July 2015 through 2019 (0% in 2020 through 2025 (2026 & beyond: 1% for APM participants; 0.5% for all others.
Pay for Performance/ Quality Reporting Programs	PQRS + MU + VBM Maximum Total Penalties • 2015: 4.5% • 2016: 6% • 2017: 9% • 2018: 10% or more • 2019: 11% or more • 2020: 11% or more PQRS: Physician Quality Reporting System MU: EHR Incentive Program/Meaningful Use VBM: Value-Based Payment Modifier	MIPS Maximum Penalties & Bonuses • 2015 – 2018: PQRS, MU, VBM continue. • 2019: 4% (Extra bonus possible) • 2020: 5% (Extra bonus possible) • 2021: 7% (Extra bonus possible) • 2022 & after: 9% (Extra bonus 2022 – 2024) All physicians could earn a bonus if they meet MIPS quality standards. Extra bonus 2019 – 2024: Up to 10% for exceptional performance (up to $500 million/year). MIPS has more accurate assessment, scoring, flexibility, predictability than under PQRS, MU, or VBM. MIPS abandons current VBM "tournament" model (requiring penalties to equal bonuses).
EHR Meaningful Use (MU)	No clear timeline or enforcement tools to achieve interoperability.	MU measures count 25% in MIPS. Interoperability is a goal by 2018; Secretary may adjust penalties and/or decertify EHRs if this is not achieved.
Alternative Payment Models (APMs)	No guaranteed payment update or bonus for physician participation in medical homes, ACOs, or other existing APMs. Limited support for physicians to develop new payment models.	5% bonus payment for 2019 – 2024 for successful participation in eligible models. APMs must bear more than nominal risk, or be a qualifying medical home. Physicians can propose new APMs. $20 million/year (2016 – 2020) in technical assistance for small practices to develop new models or participate in MIPS.
Quality Measure Development Funding	None.	$15 million/year (2015 – 2019) for measure development; $75 million total. Excess available through FY 2022.
Physician Data Access	Data provided by CMS through physician feedback program. No requirements on timeliness.	Requires CMS to provide timely (such as quarterly) feedback reports at individual physician level.
Physician Claims Data	Physician 2012 claims data released by CMS. Qualified Entities (QEs) authorized to do public reports using the data.	Establishes an annual release of physician data with no explicit safeguards. Expands QE authority to provide non-public reports and data with explicit protections. Provides data to qualified clinical data registries (QCDRs).
Standard of Care Protection Act	No protections.	Included. Quality program standards do not set standard of care in medical liability actions.
Opting Out of Medicare	Renew status every 2 years or face serious consequences.	Status continues indefinitely; no need to renew every 2 years.
Chronic Care Management (CCM) Services	Medicare started paying for CCM services in 2015, but could end those payments in the future.	Permanently requires Medicare to pay for care management of patients with chronic health problems, without requiring an annual wellness visit or initial preventive physical examination.

Medicare and Other Health Extenders

Title II describes Medicare and other health extenders with several Medicare provisions, including some that increase payments for certain low volume and small rural hospitals, physicians, therapy services, and ambulance providers, which were scheduled to expire on April 1, 2015.

- H.R. 2 would extend the increased payment amounts through the end of either fiscal year 2017 or calendar year 2017 for certain low volume and small rural hospitals, physicians, therapy services, and ambulance providers.

- H.R. 2 would extend for 2 years the eligibility of Medicare Advantage Plans for special needs individuals to participate in the Medicare program.
- H.R. 2 would permanently extend 2 programs:
  - The qualifying individuals program, subsidizing Medicare Part B premiums for certain low-income Medicare beneficiaries.
  - Transitional Medical Assistance (TMA) under Medicaid, which requires states to provide continued medical coverage for certain families who become ineligible for medical assistance because of increased earnings.
  - Title III refers to CHIP which is currently funded only through 2015, even though there are sufficient funds to cover most projected expenditures in 2016 as well.
- H.R. 2 would extend the funding of CHIP through 2017.
  - The additional CHIP costs would be offset somewhat by reductions in Medicaid costs and by premium tax credit and cost-sharing subsidies, as many CHIP enrollees would be expected to receive coverage in Medicaid or subsidized coverage in the health insurance marketplace if CHIP fundings were to expire.

Offsets

Title IV of H.R. 2 includes a number of provisions that would result in savings to the Medicare and Medicaid programs. The significant provisions are as follows:

- Premium subsidy for Medicare and Part B and Part D premiums extending to more beneficiaries beginning 2018.
- Limited updates for payment rates for skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospices, and long-term care hospitals to 1% from 2018.
- Increase the net allocation from 2017 through 2020 and decrease in net allotments from 2021 to 2015 for Medicaid disproportionate share hospital payments.
- Replace the current formula of a 3.2% increase in payment rates for inpatient hospital services to an increase of 0.5% each year from 2018 through 2023.

IT Provisions

- Promotion and definition of interoperability
- Matrix to measure interoperability
- Multiple incentives in MIPS

Other Provisions

- Consideration of measures regarding Medicare benefit with smart cards
- Modifying Medicare DME documentation requirement
- Requiring valid prescriber national provider entities on pharmacy claims
- Guidance and application of common rule of clinical data registries
- Elimination certain civil money penalties
- Repeal of duplicative Medicare secondary pay provision
- Plan for expanding data of annual CERT report
- Payment for global surgical packages.

The Good – Carrot

MACRA provides multiple benefits to physicians and other health care professionals including stable, predictable Medicare payment rates, consolidation of complicated incentive programs, encouragement to participate in a value-based system, and improvement of meaningful data publication by CMS, interoperability of health IT, and above all, facilitation for independent practices to participate in APMs (5,35,39,40).

A Predictable Schedule for Medicare Rates

Providers will receive 0.5% annual increase to current Medicare rates from 2015 to 2019 without invoking the Groundhog Day each year (6). However, from 2019 to 2025, the 2019 rates will be maintained with 2 opportunities for additional payments based on adjustments to performance in the MIPS or additional reimbursement by participating in APMs. Subsequently, in 2026 and beyond, rates will increase annually by up to 0.75%, with physicians participating in APMs receiving larger increases (5,40).

Thus, MACRA would avoid implausible payment reductions including the 21.2% decrease that was scheduled for April 1, 2015, avoiding multiple short-range physician payment issues resulting from the current SGR system approach.

Consolidation of Complicated Incentive Programs

Multiple programs related to meaningful use, PQRS, and value-based modified programs have been causing strain for physicians with a sense of a lack of direction, understanding, and fear of penalties (41-44). However, MACRA presumably provides relief through MIPS by consolidating MU, PQRS, and value-based mod-

ified programs. This has been promoted as good news for providers even though requirements of each program may remain largely unchanged, the streamlining may make it easier for providers to manage, particularly as quality measures are harmonized. While the good news is that penalties under each program will sunset at the end of 2018 and be replaced with MIPS payment adjustments, starting 2019, the penalties will be 4% for MIPS program and will increase to 9% by 2022. This is in contrast to 13% which was envisioned by 2019 with the present system (5,35,40,42).

MACRA outlines multiple parameters for weighing the MIPS factors for performance storing purposes, and for taking into account both improvement and achievement (5,36). Based on the composite performance scores compared to the threshold, eligible professionals will either receive a positive adjustment, no adjustment, or a negative adjustment, following a linear distribution. Practitioners whose composite performance scores reach above the threshold receive a positive payment adjustment, with proportionally larger incentive payments for high performers; however, the magnitude of positive payment adjustments will vary, and will maintain budget neutrality considering the amount of negative payment adjustments, with a cap of 3 times the annual cap for negative payment adjustment. Further, an additional adjustment may be available for exceptional performance on a linear distribution basis, with high performance receiving larger incentive payments equaling $500 million annually for each year from of 2019 to 2024.

While those achieving composite performance scores at the threshold will receive no MIPS payment adjustment and also will not be penalized, negative adjustments will be 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and subsequent years. The maximum negative adjustment will apply to eligible professionals whose composite performance score falls between zero and one-fourth of the performers' threshold and smaller negative adjustments will apply to composite performance scores closer to the threshold. In this scenario, negative adjustment will fund positive payment adjustments for professionals with composite performance scores above the threshold – a zero sum game.

Encouragement to Participate in Value-based System

The MACRA went to great lengths to encourage physicians to participate in so-called value-based APMs. Thus far, it is fair to say that few practitioners understand even the basis of APMs and what the appropriate implementation of these programs will look like even though some of them have been in existence since 1965. However, the silver lining in this law is that those who join APMs are largely exempt from the penalties associated with MIPS, and will receive higher Medicare reimbursement rates. The act also provides measures for independent physicians to join APMs. However, as a preferred method of participating in the value-based care approach, providers may want to be members of a Patient-Centered Medical Home (PCMH) or meet several criteria regarding taking on risk through an approved APM. Some of these approaches like the PCMH might be difficult for interventional pain physicians to participate in.

MACRA provides multiple guidelines for APMs beyond the present existing models focusing on coordinating care, improving quality, and reducing costs. Consequently, the secretary of Health and Human Services is directed to establish criteria for physician-focused payment models, including models for specialist physicians. Thus, interventional pain physicians may be able to submit APMs for example with a PCMH type of entity.

MACRA also provides 2 tracks for APM participation, with one track requiring a higher portion of Medicare revenue attributable to an APM, and a second track that recognizes IPM revenue from both Medicare and other payers. To be considered a qualifying APM participant, a variable rate of Part B payments to the professional during various periods starting in 2019 have been identified ranging from 25% to 75%.

Facilitating Independent Practices

One could argue that one of Congress' "macro" intents with the enactment of MACRA appears to be facilitation and support of independent practices. In contrast to the Affordable Care Act (ACA), which has focused on consolidation of practices and hospitals (45), MACRA includes a number of policies intended to facilitate or compliment independent practices.

First and foremost, MACRA stabilizes payment irrespective of practice settings with 0.5% increase until 2019.

The elimination of multiple quality parameters of meaningful use, PQRS, and value-based payment modifiers leading to 13% of penalty, with consolidation into MIPS is considered to assist independent practices. Further, unaffiliated providers can be evaluated in MIPS as a virtual group, helping them lessen the burden of program requirements without sacrificing their independence.

MACRA provides several new pathways for approval of innovative APM models, such as the independent risk management model that would allow independent physicians to share risks without having to affiliate with a large system or Accountable Care Organizations (ACO). This will facilitate smaller specialties such as interventional pain management to incorporate APMs.

Congress is also looking at ways in which fraud and abuse laws like the Anti-Kickback Statute may unintentionally be making it difficult for physicians specifically the independent practitioners, to share risk and value-based models.

MACRA also addresses additional issues related to quality measures. MACRA legislates that, in lieu of an existing mandate that quality measures be endorsed by the NQF, which is an expensive onerous bureaucratic organization, the CMS itself must pursue publication of evidence-based measures in a peer review journal. The disadvantage of NQF's multi-stakeholder process for endorsing measures was that the process was lengthy, complicated, expensive, and impractical. While the mandate is that they be submitted for publication in peer reviewed journal, since it does not require actual publication, some have questioned the value of such quality measures as a substitute for gaining evidence-based meaningful, clinical, and consumer support.

Other potential advantages for independent physicians include qualified entities established under ACA will be able to provide providers with nonpublic analysis of CMS claims data, aimed and quality improvement activities and enabling their participation in value-based care models. It also enables qualified entities to share data with providers about their own care and quality.

Finally, MACRA provides interoperability of health IT regulations which may help cub the expensive IT management fees that are a hardship for many independent providers (44).

Meaningful Data Publication by CMS

The data published by CMS has been a major concern for physicians because of numerous inaccuracies and the way data has been provided without providing context or describing the cost (46-50). Despite these challenges, the CMS claims database is considered as one of the best tools available for improving outcomes while reducing costs. There are some critics who claim that it has been guarded too closely while some claim that CMS has not adequately disclosed this data. The ACA (45) established qualified entities that could request access to CMS claims data, even though use of such data was too limited to be useful for care improvement (40).

However, under MACRA, qualified entities are able to provide providers with nonpublic analysis of CMS claims data, aimed at quality improvement activities and enabling their participation in value-based care models. In addition, qualified entities also may be able to share data with providers about their own patients, including information on care provided by other clinicians for comparative purposes. Some believe that this will be a key in offering physicians full information on patient care, unlocking their ability to manage over-utilization and greatly improving care coordination.

Interoperability of Health IT

Under MACRA some of the numerous issues related to health IT have been addressed (41-44). To achieve this purpose, MACRA has set a statutory goal of widespread interoperability of EHRs by 2018 (5). MACRA also prohibits the blocking of information sharing, such as disabling technical capabilities to exchange information, or imposing policies that discourage providers from sharing information with clinicians from competing hospitals.

The Bad - Stick

Even before the President signed MACRA into law, multiple new reports have surfaced offering new approaches to control Medicare expenditures (39,51,52). Realists have described the aspects of the law which will adversely affect medical practices, health care expenses in the future, and ultimately physician payments – the stick. Moreover, skeptics have described perceived harsh realities and ugly aspects of MACRA. The bad aspects include the penalties under MIPS, APMs, continued incentives for IT with very little regulation, and finally increased health care costs with a potential decrease in provider payments beyond what they would have been with SGR.

Merit-Based Incentive Payment System

As described earlier, to accelerate the move from volume-based to value-based payment, a MIPS is to be established beginning 2019 that will replace 3 previous incentive programs with a combined value-based payment program that assesses the performance of each eligible provider based on quality, resource utilization, clinical practice improvement activities, and meaningful use of certified electronic health record technology. Technical assistance would be available only to a small

portion of practices and practices in health professional shortage areas, with $20 million provided for implementation of MIPS. With an enormous bureaucracy created by EHRs and value-based health payment systems which are engulfing the medical practices, it would be impossible to judge how these regulations will affect medical practices, leading to speculations that it may actually be worse than what it is now (41-44). In addition to this, the issue of ICD-10, which is supported by the IT industry, amongst others, continues to hang over physicians' heads without a definitive decision and with the potential to cause another ICD-10 based Groundhog Day (43).

Even though 3 existing programs have been merged into one under MIPS, providers must still continue to try to meet the CMS's requirements for the meaningful use of health IT, which would account for 25% of the score. Quality and resource utilization would each account for 30%, and clinical practice improvement activities would contribute the remaining 15% (53). Further, these proportions also vary as time goes on. If at least 75% of providers are clearing the meaningful use bar, its weight could be lowered to as little as 15%. However, currently, about 50% of eligible physicians are facing Medicare penalties because they are unable to meet the IT requirements. While missing the mark means a guaranteed and fixed penalty currently, under MACRA, it would be only one component of a score that yields a sliding scale of bonuses and penalties. Further, it also has been stated that in comparison to meaningful use, the new program based on MACRA might be more punitive.

The American Society of Plastic Surgeons (12) described the quality and performance improvement programs as flawed with multiple short-comings. The deficiencies they described include the broad legislative language which lacks clarity on the intended structure and impact of key components; increase in the regulatory burden that physicians now face by holding them accountable to existing program requirements, while adding clinical practice improvement activities without engagement in innovative clinical practice activities and a surrogate for satisfying existing program requirements independently; heavy reliance on existing initial MIPS putting many small specialties at a disadvantage as many of them still may not have resources to develop and maintain a registry; and inadequate and unfair distribution of penalties and payments. These flaws and deficiencies also apply to the developing specialty of interventional pain management.

The legislation also penalizes for lack of timely exchange of clinical information to patients and other providers and after-hour access to clinical advice, a category that could be fulfilled through video visits or secure messaging with providers, which also raises numerous practical issues in its management and experience.

Incentives to Health Care Technology

Health IT was recently named as one of the top 10 patient safety concerns of Economic Cycle Research Institute (ECRI) (44,54,55). Congress, without appearing to notice these issues has provided multiple benefits to the IT industry – a large carrot and a small stick. (53,56-58). MACRA will benefit the IT industry along with Telehealth providers, predictive analytic companies, and more. In addition, as the present technologies are not punitive enough, MACRA also encourages technologies other than EHRs to participate in MIPS score type clinical practice improvement activities. The bill specifically names Telehealth and remote monitoring as a potential score booster with numerous negative consequences for practices including multiple practical implications and expense. Importantly, it would be difficult for practicing physicians to bear the expenses with only a 0.5% increase for the first 5 years and no increases for the next 5 years plus expenses for the implementation of ICD-10 along with continued inflation (44). Even the skeptics in the IT industry are stating that this legislation creates the possibility of driving the adoption of health IT tools beyond what meaningful use requires. Other so-called conservative estimators in IT industry, who continue to reap the benefits of the legislations and regulations have stated that it will be incrementally positive for the industry, even though they are disappointed that they do not have the same magnitude of opportunity that the Health Information Technology for Economic and Clinical Health Act (HITECH) enabled them under the stimulus package, with repeating of the benefits and throwing many practices out of business creating substantial impact on health care quality (42,44,57). In addition, thus far, the EHR incentive program, enacted as the HITECH provision of the 2009 stimulus law (57), has paid out more than $29.1 billion to hospitals, physicians, and other professionals for adopting and using health IT. Meanwhile, the Office of National Coordinator for Health Information Technology's (ONC) new certification rule may also signal a new direction for the agency to ensure EHR systems perform as advertised, which again have been promoted as beneficial to providers but continue to become more expensive and onerous.

Health care delivery experts have cautioned that when the champagne of SGR repeal is finished, we should take a closer look at the disadvantages of the new Medicare physician payment system (59). Others have warned that the SGR fix makes things worse rather than better for Medicare (58-66). Further, it also triggers several rule violations since Congress failed to follow PAYGO (pay-as-you-go) rules (67). In addition, it has been stated that SGR has slowed health care cost growth because 98% of the patches since 2004, have been fully paid for resulting in $140 billion deficit reduction, despite the SGR cuts not having been implemented except for 4.3% in 2002. As we have described earlier, the SGR formula was created as part of the 1997 Balanced Budget Act to control rising costs of Medicare by essentially capping the growth of provider payments. Consequently, since 2003, Congress has admitted that the SGR called-for cuts were too deep and they have provided temporary patches to replace these cuts with more targeted savings. Thus, SGR has actually done a great deal to control health care costs by keeping provider payment updates modest and pushing policy-makers to offset the cost of avoiding cuts. Essentially it has been shown that the Congress's temporary fixes have offset 120 out of the 123 months of fixes with equivalent savings, 98% of the expenses were saved and almost all of these savings came from health care programs. Figure 6 shows how SGR patches have been offset 98% of the time since 2004. Figure 7 shows the offset achieved 90% of the time since 2004 with SGR patches, and Fig. 8 shows that SGR has resulted in $150 billion in deficit reduction. In addition, the ACA

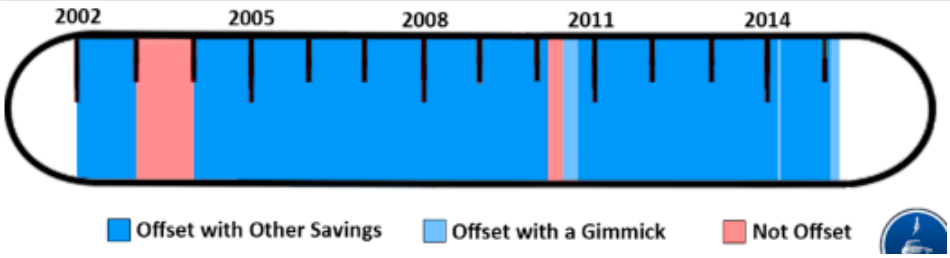
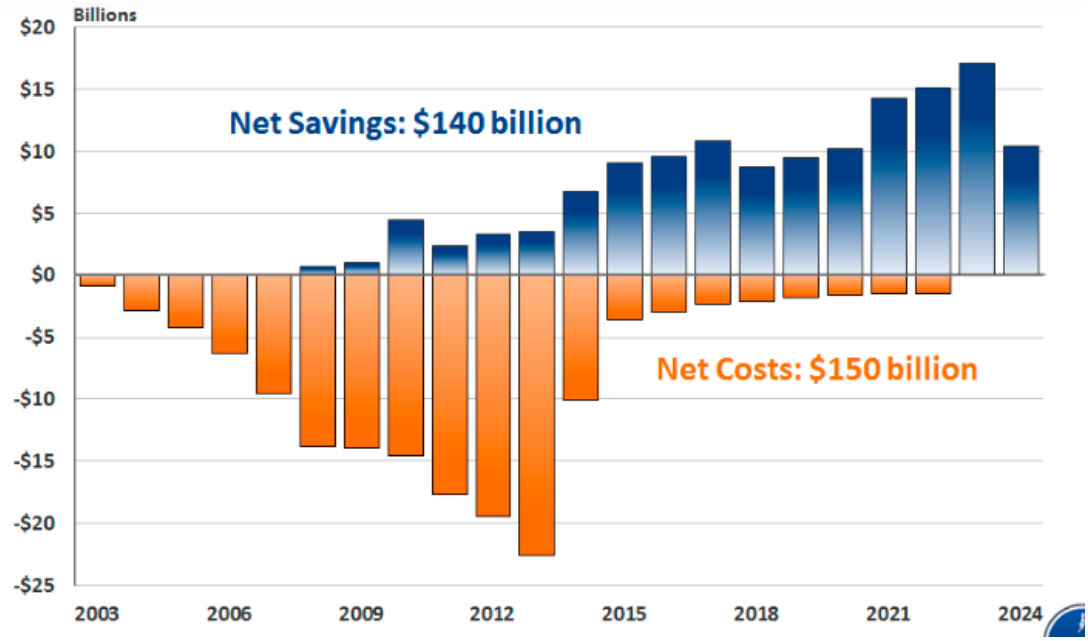


Fig. 7. *SGR patches have been fully offset 98% of the time since 2004.*



Note: Estimates are the cumulative totals of "doc fix" bills passed since 2002, as scored by the Congressional Budget Office before final passage, extrapolated beyond 10 years by CRFB.

Fig. 8. *SGR has resulted in $140 billion in deficit reduction.*

also used the savings from SGR to offset its price tag. However, if Congress had provided fairly for providers as they do for federal employees and all other types of employees in the nation, at least at Medicare Economic Index (MEI) level updates over the last decade, costs would have been another $60 billion higher, which would have saved numerous practices, but others consider that they were the savings benefiting the taxpayer. Table 1 shows the historical payment fixes with SGR patches. Table 3 shows the estimated fiscal year costs and savings under MACRA.

Payments in the Future

The estimated financial effects of MACRA have been published by the Office of Chief Actuary of Centers for Medicare and Medicaid Services describing that while MACRA avoids the significant short-range physician payment issues, it never addresses important long-range concerns. If future legislation is not forthcoming in the next 20 years with 10 congressional and 5 presidential terms, these payment adjustments are not expected to keep pace with the average rate of physician cost increases. Consequently the specified rate would be inaccurate in years when levels of inflation are higher or when the accumulative effect of price updates not keeping up with the physician cost becomes too large. The Chief Actuary also anticipated that physician payment rates under MACRA would be lower than scheduled under the current SGR formula by 2048 and would continue to worsen thereafter.

The Ugly – Stick Only with No Carrot

The ugly aspects of MACRA include the preparation for multiple modifications and repeal straining the troubled Medicare, reduced physician payments, and finally increased power of the IT industry and policy wonks.

Medicare program has had troubles since its inception (9,10). Medicare was enacted in 1965 by President Lyndon B. Johnson and former President Harry Truman was awarded with the first Medicare card on July 30, 1965. Historically, President Truman proposed a national health insurance plan in 1945 even before the national health insurance services in England in 1948. The legislation was opposed by most Republicans, as well as the American Medical Association (AMA). Medicare program was thought by some to represent socialized medicine or at least it would engender a mountain of red tape and regulations that would bury the physician patient relationship irretrievably forever. While some of these fears may have come true, Medicare has grown enormously, and is now supported by Republicans, as well AMA and almost all physicians. The increasing expenses of Medicare which went beyond numerous multiples of estimations led to multiple regulations: Professionals Standards Review Organizations (PSROs) to ensure quality of services, quality improvement organizations until 1984, SGR, and finally, the MIPS has been passed by Congress. Thus, practitioners have been losing ground because Medicare reimbursement rates have gone down or stayed the same, and practice costs and regulatory burdens have increased (Fig. 9). As Chief Actuary of Medicare has stated if no legislative action is taken payments under MACRA would be lower than scheduled under the current SGR formula by 2048 and also would continue to worsen thereafter. These aspects have provided significant ammunition for health care policy makers as well as the IT industry and other beneficiaries to attack the

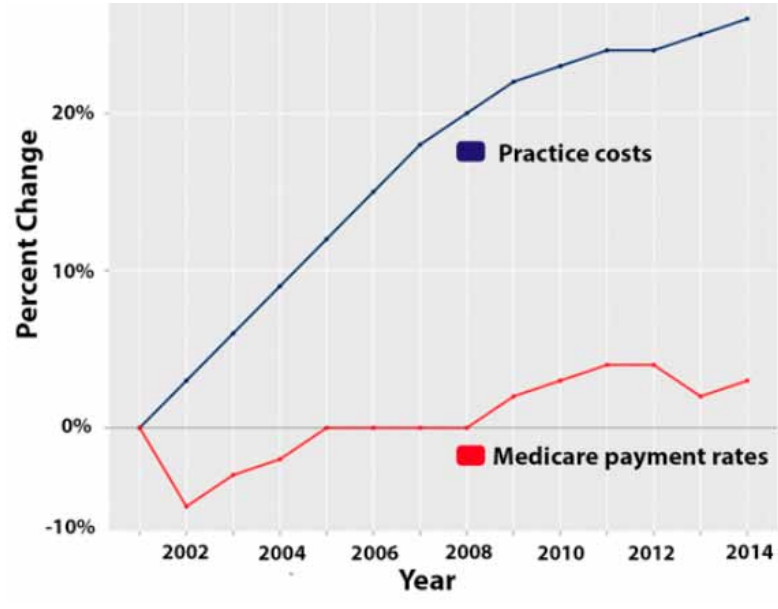


Fig. 9. *Losing ground: Medicare reimbursement rates and practice costs.*

repeal and project on multiple adverse aspects of MACRA. Some are utilizing this as an opportunity for more policies and creation of bigger bureaucracies.

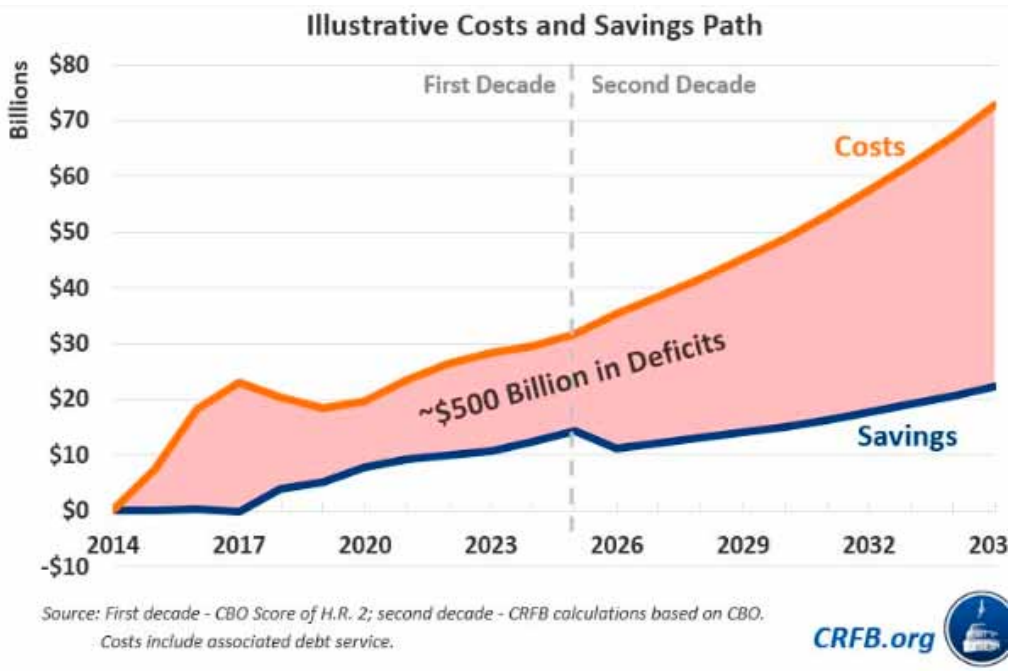
Importantly, providing support for critics as shown in Table 4 and Figs. 10 and 11, SGR costs will continue to exceed savings producing $500 billion in deficits by 2035. The Congressional Budget Office (CBO) estimated that the spending increases in the legislation will total $210 billion over the next decade. Only about one-third or $70 billion of this spending would be offset by a combination of provider reductions, increased means testing of Medicare premiums, and other minor reforms, with increasing deficits as shown in Figs. 10 and 11.

It has been estimated that based on the President's fiscal year 2016 budget baseline, and long range estimates based on the 2014 annual report of the Board of Trustees of the federal hospital insurance and federal supplementary medical insurance trust funds (66) Significant deficits were shown in the Medicare program itself even without MACRA. Figure 12 shows the impact of spending as a percentage of GDP for Part B from 2014 to 2084 which essentially shows lower spending under MACRA even though it appears to be onerous. However, because of MACRA which eliminates the large physician payment reduction that was scheduled for April 1, 2015, spending under the proposed generally follows the projected baseline estimates for the next 10 years. Consequently, the projections of expected growth show a slower growth pattern than under the projected baseline for the remainder of the 75 year pro-

Table 4. *Estimated federal fiscal year costs (+) or savings (−) under H.R. 2 (in billions)*

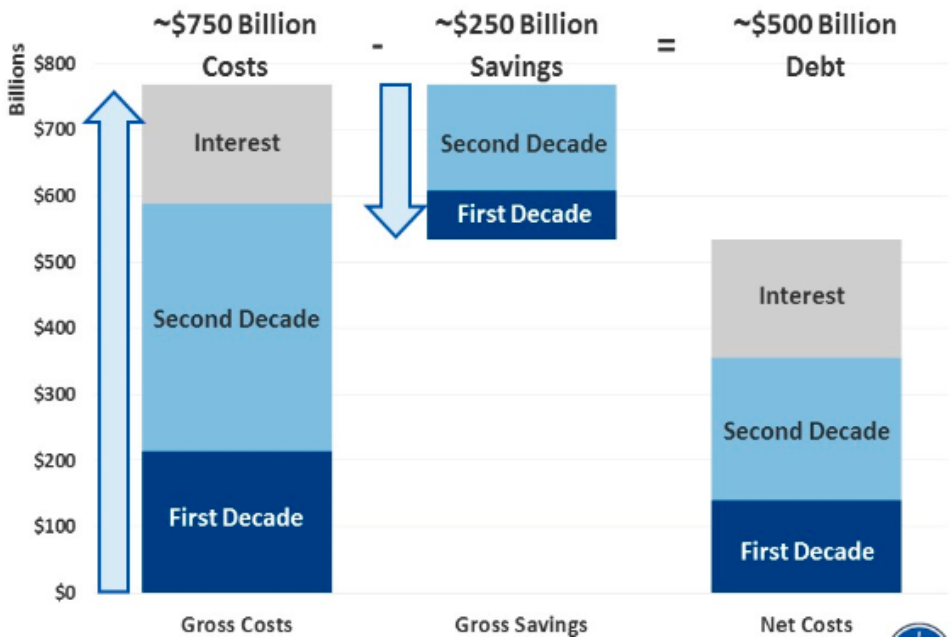
(in billions)

Provisions	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2015-25
Total	6.9	13.1	15.7	9.9	6.1	8.4	8.8	10.0	10.1	8.2	5.5	102.8
Physician payment update	5.4	9.1	6.1	8.2	10.9	15.7	17.2	18.7	19.2	19.3	20.7	150.5
Other Medicare	0.9	2.7	3.4	−5.2	−7.4	−9.2	−9.5	−9.2	−8.8	−9.4	−10.5	−62.2
Medicaid/CHIP	0.5	1.4	10.1	10.3	2.9	2.2	1.5	1.0	0.2	−1.1	−4.1	25.0
Marketplace	0.0	−0.1	−3.8	−3.4	−0.2	−0.4	−0.5	−0.5	−0.5	−0.6	−0.6	−10.5



Source: First decade- CBO score of H.R. 2; second decade – CRFB calculations based on CBO. Costs include associated debt service.

Fig. 10. *SGR costs continue to exceed savings.*



Source: CRFB calculations based on CBO score of H.R. 2, 3/2/2015. Costs are cumulative through 2035.

Fig. 11 *SGR bill would add roughly $500 billion to debt in 2035.*

jection period after 2049. Thus, the long-term outlook of MACRA appears to be beneficial even though projections up to 2035 show it adding $0.5 trillion in deficits over a period of over 20 years (Fig. 12).

Figure 13 provides an illustrative comparison of Medicare prices for physicians' services under the current law, the projected baseline, and MACRA relative to the MEI. Physician prices, over the next decade, under the projected baseline from the 2014 trustees' reports are assumed to grow at about 0.6% per year, or roughly the average payment update over the 10 years. The payment rates under MACRA appear to be similar to those under the projected baseline by the end of the short range period up to 2025, although the year to year growth rates may differ. However, these updates are less than the increase in the MEI.

Summary

For over 10 years, providers have watched the same scene play out each and every year as Groundhog Day of the medical profession with SGR formula threatening automatic Medicare reimbursement cuts of up to 30%. The SGR was designed to counter the tendency towards spending drought driven by the FFS model that rewards volume and intensity as a part of the Balanced Budget Act of 1997. However, soon after its enactment the SGR was recognized as a seriously flawed concept and formula that has been an ongoing impediment to real payment reform and also causes substantial anxiety to provider community each year. Each year the SGR cuts and expenses continue to grow larger with temporary patches provided, until finally, providers were facing a cutoff 21.2% in Medicare payments starting April 1, 2015. The MACRA is a bipartisan and bicameral legislation supported by President Obama.

The good aspects include a predictable Medicare payment schedule with consolidation of complicated incentive programs, encouragement to participate in a value-based system, meaningful data publication by CMS, interoperability of health IT, and above all, facilitation of independent practices to participate in APMs (5,35,39).

The bad aspects include the continued bureaucracy which will affect medical practices, health care expenses in the future, and ultimately physician payments – the stick. The skeptics have described perceived harsh realities and the ugly aspects of MACRA. The bad aspect include the penalties under MIPS, APMs, continued incentives for IT with very little regulation, and finally increasing health care costs with potential decrease in

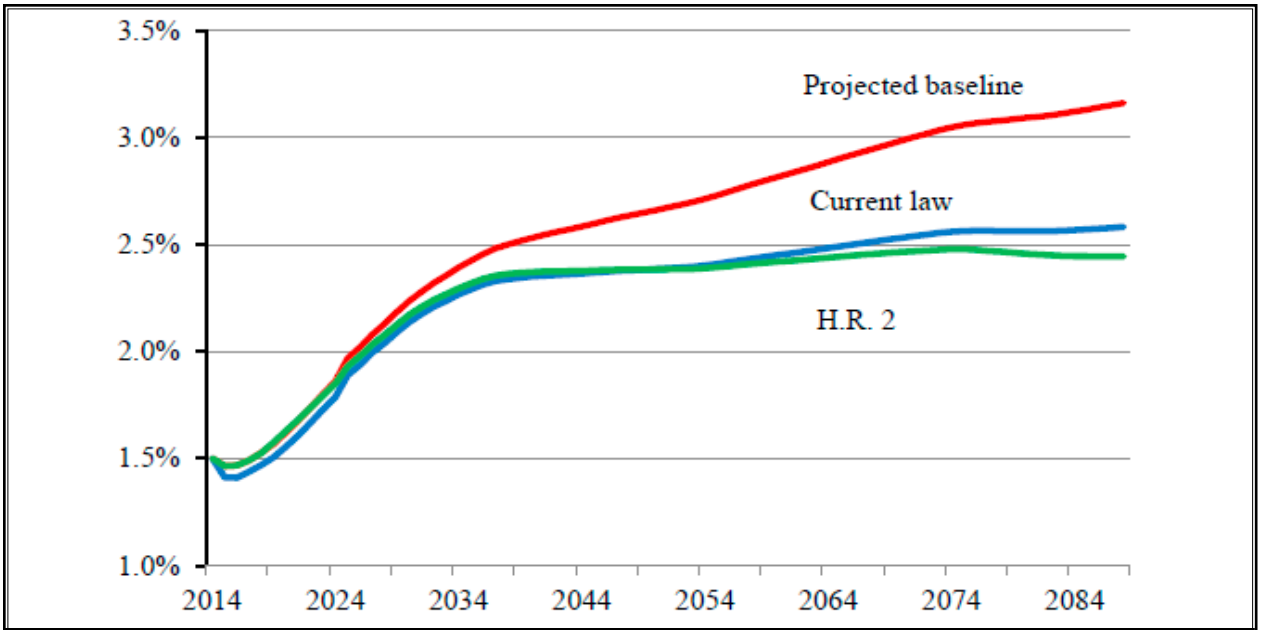


Fig. 12. *Part B spending as a percentage of GDP.*

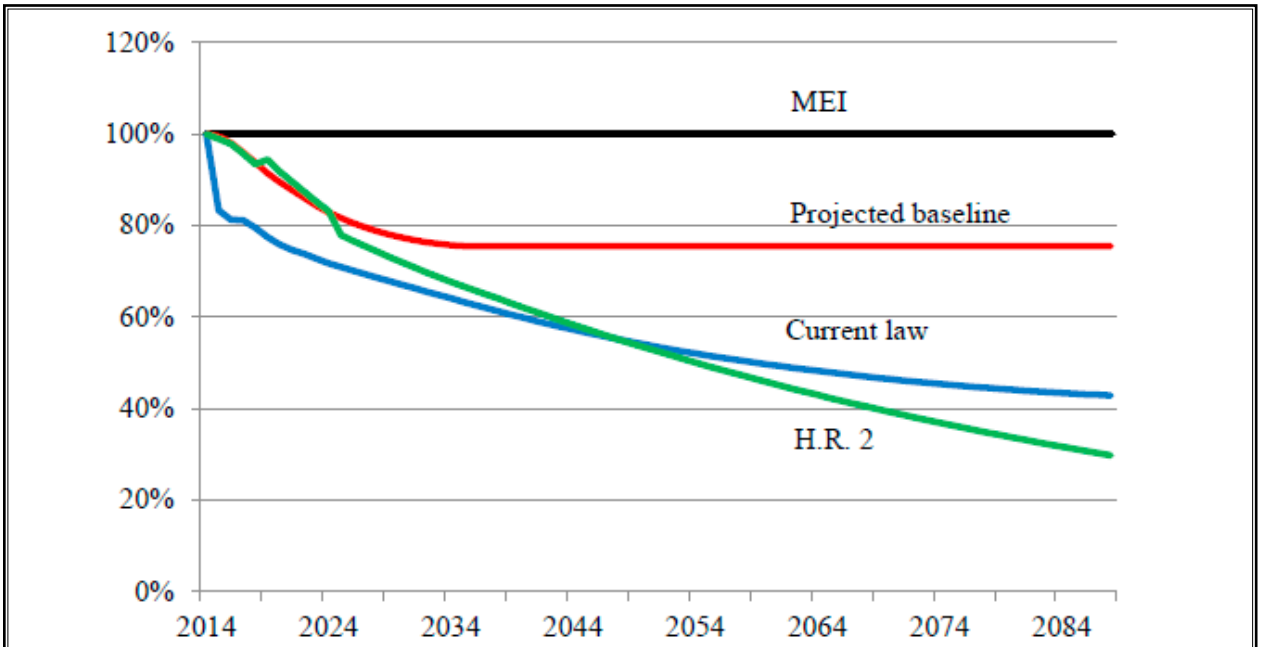


Fig. 13. *Illustrative comparison of Medicare prices for physicians' services under current law, the projected baseline, and H.R. 2 relative to the MEI.*

provider payments beyond what they would have been with SGR.

Finally, the ugly aspects include projected reductions in payments with the legislation higher than previous projections and continuing decline of reimbursements without taking into consideration the demand of regulations. The ugly aspects of MACRA include the preparation for multiple modifications and repeal

straining the troubled Medicare, reduced physician payments, and finally the increasing power of IT industry and policy wonks. In addition, budget deficits will continue to be blamed on physician payments.

Overall, the repeal provides an opportunity for physicians to relax to some extent and focus on patient care. Those who are able to participate in the APMs and MIPS will benefit even though we would not call that reaping the benefits. However, medicine continues to be under scrutiny from regulators, policy wonks, and requiring a hefty dose of IT. It is our hope that MACRA slows the interference of these groups into the physician-patient care relationship.

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