Health Law Daily Wrap Up, TOP STORY: Ding dong, the SGR is dead!, (Apr. 15, 2015)

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After 12 years of "doc fixes" that overrode the Sustainable Growth Rate (SGR) limitation on Medicare physician reimbursements rather than allowing the SGR to be implemented, Congress finally broke the cycle by passing legislation that will repeal the statutory requirement to slash physician payments when spending targets have been exceeded. Late on April 14, 2015, the Senate passed H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, without amendment. The bill is on its way to President Barack Obama's desk; the President released a statement that he "will be proud to sign it into law."

**Background.** Congress enacted the SGR as sec. 4503 of the Balanced Budget Act of 1997 (P.L. 105-33) after determining that the national fee schedule (NFS) system’s target-setting factor, which was linked to the growth in medical inflation, was not as effective in limiting growth in Medicare expenditures on physician services as expected. The SGR is linked to changes in the U.S. gross domestic product (GDP), rather than medical inflation. Using the SGR target, the fee schedule update (Soc. Sec. Act sec. 1848(d)(4)) is adjusted to reflect the comparison of actual expenditures to target expenditures; if expenditures exceed the target, the update is reduced, and if expenditures are less than the target, the update is increased (Soc. Sec. Act sec. 1848(f)).

The SGR did not succeed, due in part to Congress’s refusal to allow its implementation. Each year, CMS announces a conversion factor after it calculates the SGR. The conversion factor may result in a payment increase if physician spending increases are below the increase in GDP, but a payment cut if physician spending increases are above the increase in GDP. Four years after the SGR was implemented, it resulted in a negative update, requiring a 4.4 percent reduction in physician payments. Congress stepped in, passing legislation that replaced the 4.4 percent reduction with a 1.4 percent increase, resulting in a physician payment rate 5.8 percent higher than called for by the SGR. In the 12 years following that first law, Congress has enacted similar delays, called “doc fixes,” postponing the SGR target for periods of time between one month and two years, and instead maintained fees at the previous year’s level or given a small increase. This caused the difference between the SGR rate and the temporary Congressional rate to grow uncontrollably, to the point where using the SGR would result in payment cuts between 20 and 30 percent. Every time the current temporary law expired, physicians faced uncertainty as to what rates they will be paid, while Medicare beneficiaries faced the loss of their providers (see Reforming the broken Sustainable Growth Rate—why a temporary “doc fix” is not enough, and what might be, April 15, 2014).

**2014’s repeal attempt.** A number of legislative solutions for the SGR were proposed during the decade of doc fixes, but none gathered enough support for viability until 2014. With a looming expiration of another temporary suspension of the SGR scheduled for March 31, 2014, three Congressional committees unanimously reported out bipartisan legislation to repeal the SGR. The House Energy & Commerce Committee, the House Ways & Means Committee, and the Senate Finance Committee provided a fact sheet that summarized their agreement (see Congressional leaders agree to repeal SGR and increase physician pay, February 6, 2014). When the House of Representatives voted on the SGR Repeal and Medicare Provider Payment Modernization Act of 2014, which was designated H.R. 4015, Ways & Means Committee Chairman Dave Camp (R-Mich), amended the bill. Camp’s amendment added language to delay the Patient Protection and Affordable Care Act’s (ACA) (P.L. 111-148) individual mandate penalty (see Democrats and other health care professionals protest attaching delay in individual mandate penalty to SGR “fix”, March 14, 2014). The Camp amendment doomed the bill, as President Obama released a Statement of Administration Policy condemning the amendment, and threatening veto. Instead of an SGR repeal, Congress settled for passing yet another temporary doc fix, the Protecting Access to Medicare Act of 2014 (P.L. 113-93). The law included a one-year break from the SGR, and also delayed implementation of the International Classification of Diseases, 10th Edition, Clinical Modification/
Procedure Coding System (ICD-10) until at least October 1, 2015 (see Senate agrees to another temporary “doc fix,” delays ICD-10, April 1, 2014).

The Medicare Access and CHIP Reauthorization Act of 2015. As 2014’s doc fix extension neared its March 31, 2015, expiration, the same three Congressional committees announced another agreement to repeal the SGR. The 2015 bill has many similarities to the pre-amendment SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (see House passes SGR repeal, March 26, 2015). The law will increase physician payments by 0.5 percent for the period from July 1 through December 31, 2015, and for each calendar year (CY) from 2016 through 2019; for CYs 2020 through 2025, the increase will be set at 0.0 percent. Beginning in 2026, updates will be calculated using two conversion factors: one for physicians who have met the combined requirements for meaningful use of electronic health records (EHR), quality reporting, and alternative payment models (APM), and another for those who have not. Physicians qualifying for APM treatment will receive a 0.75 percent update, while the others will receive a 0.25 percent increase.

The law will extend several expiring Medicare provisions, including:

- the 1.0 “floor” on the Geographic Practice Cost Index;
- the ambulance add-on payment;
- the Medicare rural home health add-on;
- the exceptions process for therapy caps;
- special payments or adjustments to Medicare-dependent hospitals and low-volume hospitals; and
- funding for development of quality measures.

It also delays enforcement of the “two-midnight rule” concerning inpatient hospital services until September 30, 2015.

The law makes permanent the Medicaid benefits for “qualified individuals”—Medicare beneficiaries with incomes between 120 percent and 135 percent of the federal poverty level—and the transitional medical assistance program, which continues assistance for parents whose income increases because of employment or child support payments. It also extends other Medicaid-related programs, including home visits to new mothers, infants and young children; abstinence education; personal responsibility education; and family-to-family information centers for children with disabilities or special needs.

On March 26, 2015, the House of Representatives passed the bill with a bipartisan vote of 392 to 37, with four Representatives not voting. The Senate declined to consider the bill before taking a recess (see Overworked from budget passage, Senate recesses before SGR repeal vote, March 27, 2015), while physicians across the country prepared for a large reduction in payments (see Countdown to April 1: CMS, docs prepare for cut in case SGR isn’t fixed, March 25, 2015). CMS processes payments with a lag; therefore, as long as the Senate took action on the bill by April 15, 2015, the SGR reduction that would be in effect beginning on April 1 would not occur. On April 14, 2015, at 9:30 PM, the Senate voted in favor of the bill, without amendments, by a margin of 92 to eight.

Cost of law. As the Senate prepared to vote, the CMS Chief Actuary released a memorandum predicting that the bill will add $150.5 billion in budget costs for fiscal years (FYs) 2015 through 2025, although some of the costs are partially offset by additional provisions. Therefore, the Actuary noted that although H.R. 2 provides a short-term solution to problems caused by the SGR system, it anticipates that future legislation will be required to address other long-term problems (see Elimination of the SGR will increase federal spending by $102.8B, April 13, 2015).

In its analysis of H.R. 2, the Congressional Budget Office (CBO) estimated that the bill would increase direct spending by $145 billion and increase revenues by $4 billion between 2015 and 2025, resulting in a $141 billion increase in federal budget deficits.

Reactions. Reaction to the passage of the bill has generally been positive. House Speaker John Boehner (R-Ohio) called the bill “a big deal.” The President and CEO of the Mayo Clinic announced that the clinic “is pleased,” but warned, “The road to value-based payment will be challenging.” The American Medical Association
said, “Passage of this historic legislation finally brings an end to an era of uncertainty for Medicare beneficiaries and their physicians—facilitating the implementation of innovative care models that will improve care quality and lower costs. Patients will be able to get the care they need and deserve.”

The American Academy of Family Physicians applauded the bill, saying, “For more than a decade, elderly and disabled Americans didn’t know whether they would continue to receive the medical care they needed.... But with today’s passage of the Medicare Access and CHIP Reauthorization Act, these patients can put those worries behind them.” House Ways and Means Committee Chairman Paul Ryan (R-Wisc) agreed, “Years of hard work have finally paid off. Medicare is now on sounder footing, and our seniors have more security.”

**CMS update.** CMS sent a Medicare Learning Network MLN Connects® email to providers regarding the Act. The agency explained that it instituted a 10-business day processing hold for all impacted claims with dates of service on or after April 1, 2015, as part of “an effort to minimize financial effects on providers,” and explained that “Medicare Administrative Contractors (MACs) have been instructed to implement the rates in the legislation.” However, “a small volume of claims will be processed at the reduced rate based on the negative update amount,” but claims paid at the reduced rate will be automatically reprocessed at the new payment rate. CMS says, “No action is necessary from providers who have already submitted claims for the impacted dates of service.”

Companies: Mayo Foundation for Medical Education and Research; American Medical Association; American Academy of Family Physicians