Physician Payment Overhaul through the “SGR Fix” - Now What?

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On April 16, 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") to stave off the anticipated 21% cut to physician Medicare payments mandated by the SGR and permanently repeal the Sustainable Growth Rate ("SGR") formula for Medicare reimbursement to physicians. The SGR was enacted by Congress in 1997 to control escalating Medicare cost growth for physician services. However, Congress inevitably intervened each year to delay the significant payment cuts required under the SGR formula through a series of short-term "doc fixes" that have been an annual occurrence since 2003, and which have been publicly loathed by many in both Congress and the healthcare community.

On a summary level, the current legislation replaces the flawed SGR system -- originally designed to combat the Medicare spending growth that was driven primarily by the fee-for-service model that rewards service volume and intensity -- with a model focused on rewarding "quality over quantity" and "value over volume." Specifically, the formulaic method of setting base payment rates for physicians is eliminated, and replaced with modest 0.5 percent annual updates beginning in June 2015, as well as for each year from 2016-2019. While payment rates will remain stagnant from 2019-2025, providers participating in alternative payment model programs, such as accountable care organizations (ACOs) and medical homes, will have the potential to earn additional payments. Beginning in 2026, Medicare payments will increase by .75 percent each year for providers participating in an alternative payment model, and .25 percent each year for non-participating providers. In an effort to accelerate the
transition from volume-based reimbursement to value-based reimbursement, a merit based incentive payment system (MIPS) will be established beginning in 2019. The MIPS will replace three previous incentive programs in an effort to achieve a combined focus that will assess performance based on such factors as quality, resource utilization, clinical practice improvement, and meaningful use of electronic health records.

Many physician trade organizations, such as the American Medical Association, have lauded the repeal: “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.” However, there still is much uncertainty and many unanswered questions regarding the short-term and long-term impact of the SGR repeal and the ultimate fate of traditional fee-for-service payment models.

Perhaps the paramount question for many hospital executives and physician practice owners is whether the recent wave of hospital and health system acquisition of physician practices will increase, continue at the same pace, or decrease?

One of the primary catalysts for the increasing drive toward physician employment by hospitals is the increasing necessity to form clinical integration and other alignment strategies as a result of value-based reimbursement models. As discussed in a recent Medical Economics article, "The big question is why hospitals are working so hard to expand, both horizontally through mergers and vertically through acquisitions of practices, and what the fallout will be for physicians. Hospitals are facing growing financial uncertainty due to the tension between quantity and quality, between a known reimbursement scheme based on volume and a newer one based on value. 'We're at a point of inflection,' says Caroline Steinberg, vice president/trends analysis at the American Hospital Association. 'Hospitals feel like they have one foot on the boat and one foot on the dock' as the healthcare sector transitions from a primarily fee-for-service model to a new world of accountable care organizations and bundled payments." (The New England Journal of Medicine reported that more than 105 hospital mergers occurred in 2012 alone, a significant increase over the
approximate 50-60 mergers annually from 2005-2007). At the same time, many physician practices are increasingly considering the growing overhead (cost and administrative) burdens of owning and operating their own practice against the ability to focus on clinical patient care activities as hospital employees. As result of these forces, the American Hospital Association has indicated that, "between 2000 and 2010, hospital employment of physicians has increased by 32%. As of 2012, the majority of physicians were employees instead of owners."

While it may be apparent that some form of hospital-physician integration will occur at some level of participation by providers, this may be the only certainty under the myriad of alignment options available to industry stakeholders. Despite the direct employment model becoming increasingly prevalent in recent years, it is not the only way that physicians may align and integrate with hospitals (or with each other). Based on the level of independence the physician wishes to retain, other legal organizational structures and alignment relationships include: independent practice associations (IPAs), co-management arrangements, clinically integrated networks, ACOs, and bundled payment relationships, among others.

Within these types of integration models, there are additional legal governance and regulatory concerns related to structuring and implementing the integration model that will need to be addressed. For example, considerations related to Antitrust as an increasing number of physicians in a given geographic market become affiliated, as well as certain Fraud and Abuse considerations related to maintaining compliance with the Stark Law and Antikickback Statute, will need to be addressed. As these emerging models that reward value over volume gain momentum and continue to augment, or replace, traditional fee-for-service models, healthcare providers and stakeholders will need to balance the mechanism by which the various integration models are legally structured and organized against the associated risks and potential financial impacts resulting from this new form of alignment.
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