Story Behind 'The SGR Fix' in 900 Words Or Less

By ALEXANDRA HALL, GREG MOORE & SERENE ZENI

To understand the rationale underlying "the SGR fix" or the Medicare Access and CHIP Reauthorization Act of 2014 (HR2), it is necessary to start with the basic assumption that providers need to shift away from the fee-for-service model and that there is not already a focus on quality by the practitioner without forcing the issue through reimbursement. It will then appear that HR2 guides the payment system in the right direction. While the underlying concepts of quality seem simple to integrate into reimbursement, HR2 ignores the cost and complexity involved in instituting its measures on a provider level. Even after a provider invests in the cost of compliance, HR2 is broad enough that a provider can miss the mark on what it takes to qualify for an incentive or higher reimbursement.

I. The Immediate Fix

Before Senate approval of HR2 on April 14, 2015, Medicare payments for physician services were annually adjusted upward or downward by a conversion factor determined by the Sustainable Growth Rate formula (SGR). SGR intended to ensure the expense per Medicare beneficiary did not surpass the gross domestic product (GDP). However, due to the slow growth of the economy, SGR would have cut reimbursement for physician services by 21.2% by April 1, 2015.

HR2 avoids this massive decline by freezing the current conversion factor to 0 percent through June 2015, which means physicians will maintain their current compensation for services provided. The conversion factor will increase to .5 percent as of July 1, 2015, and continue at .5 percent every year through 2019, which will gradually increase physician reimbursement every year rates are recalculated. From 2020 to 2025, the conversion rate will return to 0 percent, leveling reimbursement during that period.

II. Not Catchy Enough For The Headlines

Where providers may get lost is in the actual details of reimbursement after the SGR fix is complete. The complex reimbursement model achieved by HR2 did not make the headlines when the public was pressuring the Senate to sign the bill into law.

As of 2026, HR2 incentivizes providers toward "quality" as opposed to volume consistent with the overall trend in health care. For this purpose, HR2 requires use of two conversion factors, which will apply to practitioners (including physicians, physician assistants, nurse practitioners, and clinical nurse specialists and certain other qualifying professionals) depending on whether they are reimbursed under a "qualifying" alternative payment model (APM). A provider qualifies by furnishing a particular threshold (depending on the year starting in 2019) of her services under an APM or an entity participating in an APM that falls under one of these payment systems as defined under the Social Security Act (SSA): (1) innovative payment models; (2) the shared savings; (3) a demonstration; or (4) any demonstration project required by federal law.

The reward for "qualifying" is reimbursement with a year upward conversion factor of .75 percent. The caveat is that she must also use certified electronic health record (EHR) technology, specific quality measures and either bear financial risk for participation or be a patient-centered medical home. A conversion factor of .25 percent will apply to professionals participating in non-qualifying APMs leaving the fee-for-service model available, but, theoretically, less attractive.

HR2 sunsets payment incentives under the physician quality reporting, value-based payment modifier, and meaningful use programs by 2018. HR2 establishes in its place the "Merit-based Incentive Payment System" (MIPS) in 2019 merging all three programs into one. MIPS is structured to evaluate overall provider performance by scoring performance in various categories and giving each category a relative value: "quality" (30 percent), "resource use" (30 percent), "clinical practice improvement activities" (15 percent), and "meaningful use of electronic health records" (25 percent). Each measure is largely dependent on provider reporting and studies with an additional incentive for "exceptional performance." The provider's MIPS score will factor into her reimbursement rate.

III. Just When You Thought You Understood "Meaningful Use"

HR2 reestablishes the current standards for data sharing. HR2 mandates and permits data sharing (even selling) in multiple contexts. Of course, HR2 continues to advocate for data privacy and security while expanding access to unidentifiable patient information.

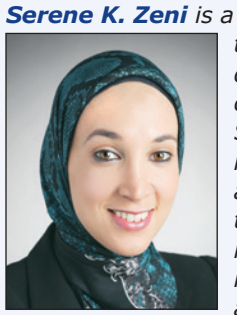
The extent of data sharing advocated by HR2 increases data security risks already prevalent in the health care industry. For example, HR2 sets a goal of achieving interoperability of electronic health record (EHR) systems by Dec. 31, 2018, and prohibits deliberate blocking of information sharing between electronic health records from different vendors by redefining meaningful use. This requirement may pose a challenge to providers given the Secretary's power

Story Continued on page 7

Alexandra A. Hall *is an associate in Clark Hill's Health Care Practice group. Alexandra practices in all areas of healthcare law and represents a variety of health professionals and organizations. Prior to joining Clark Hill, Alexandra supported healthcare providers in the Recovery Audit Contract ("RAC") and Medicare appeals process, conducted primary research regarding Medicare compliance and reimbursement issues, and assisted clients on regulatory and licensure matters. Alexandra also advised clients regarding changes in billing and documentation requirements with respect to the Fiscal Year 2014 Inpatient Prospective Payment System Final Rule.*

Greg Moore *chairs Clark Hill's Health Care and Behavioral Health Care Practice Groups. Mr. Moore has been a practicing health care attorney since 1991. During his entire career, he has focused on representing and counseling providers of all types and sizes including: behavioral health care companies, facilities and networks, behavioral health care information networks, medical groups, federally-qualified health centers, trade associations, nonprofit and for profit hospitals, international and domestic medical tourism companies.*

Serene K. Zeni *is a health care attorney that has devoted her entire career to health law. Serene represents health professionals and organizations establish and maintain quality, risk management, and compliance programs in a variety of settings. Her clients seek her assistance in an array of matters whether simple contract review and negotiation to aiding an entrepreneur in the health field establish and structure a new organization. Serene also has extensive experience in administrative law matters whether defending a professional's license against state prosecution or addressing controversies with state and federal agencies. While she concentrates her practice on health care, she also aids her clients in real estate transactions and estate planning. Serene practices out of the firm's Birmingham office.*



No-Fault Reform continued from page 1...

years of $100 premium rollbacks, limits provider reimbursement to 150 percent of Medicare reimbursement and places limits on home care.

Providers would like to see the system remain intact to avoid losses in coverage and huge losses in reimbursement; the Michigan Health and Hospital Association estimates its members' losses at $1.2 billion annually.

On the other side of the issue, insurers and some businesses argue that Michigan's auto insurance rates are among the highest in the country, 30 to 40 percent higher than in surrounding states and that MCCA claims are paid at a rate much higher than workers compensation or Medicare claims. The bill's supporters assert that the reforms would save drivers about $700 million annually.

Supporters further cite Insurance Institute of Michigan data, by way of example, that indicate reimbursement for a spinal x-ray fetches $227.55 from the MCCA, $55.89 from workers compensation and $77.06 from Medicare. By my own calculations, 150 percent of Medicare reimbursement for that procedure would be $83.84.

Opponents counter that the $100 annual savings to consumers for two years contains no ongoing savings and that the initial savings do not compare to the loss of benefits they anticipate. MHA acknowledges that rates from different payers for the same procedure vary, to some extent based on the volume of claims, but that volume would not come close to making up for the losses here. Failed amendments would have reduced rates by 20 percent and tied future increases to medical inflation, saving an estimated $500 million a year.

And so it goes.

Outside of the arguments on both sides of the issue are some fundamental questions that bear further scrutiny. The first is a question about the larger equity of several rates for the same procedure. There are a lot of explanations about why this circumstance exists, but debates like no-fault bring it to the surface in sharp relief.

A second issue is more philosophical. Apparently, an appropriation has been attached to the bill, making it immune to referendum. This is troubling for a number of reasons. If the voters of this state can decide a complex issue like same-sex marriage by plebiscite, why not an issue for which they are ostensibly holding the economic bag? If consumers will save money and be the primary beneficiaries of no-fault reform, shouldn't they be permitted to decide the fate of the current system directly? Reports indicate the bill was fast-tracked over a period of days. If that's all the scrutiny the Legislature deemed necessary, how complex can the issue be and what's the harm in letting the voters decide.

In any case a major change to a 43-year-old system merits a closer look and more extended debate.

EHR Technology continued from page 1...

perfectly good paper charting system. EHR is a new expensive version of the Emperor's New Clothes." And primary care physicians are generally happier with their EHR system than are medical sub-specialists and surgical specialists. EHR users are pleased with the facilitation of interoffice messages and tasking, data documentation, and facilitated electronic prescribing. They are not pleased with the negative effect on office productivity, disruption of attention to patient care, and vendor support.

Regarding incorporation of an EHR system into any medical setting, too often the emphasis is on the technological aspects of the computer system instead of how well the physicians, nurses, and technical staff will be able to integrate the technology into their daily work routine to enhance, rather than hamper, good patient care.

Dr. Ryan's Column comes to us courtesy of the Genesee County Medical Society. It is reprinted with permission and thanks.

Behind 'The SGR Fix' continued from page 6...

to adjust meaningful use penalties and decertify EHRs if not achieved.

The data sharing provisions of HR2 will generate further complications for professionals already struggling to comply with HIPAA and HITECH.

IV. The Provider Fix

Regardless of one's perspective on HR2, the practitioner must nonetheless prepare for its impact. Even if a provider chooses not to participate in Medicare, third party payers are more than likely to follow suit and the precedent established by HR2 will be inescapable.

The unpredictability of the value add or decline of HR2 is creeping into different contexts of provider arrangements. For example, recently drafted employment contracts accommodate for the contingency of a decline in reimbursement by shifting the burden of such decline from the employer to the employee.

Practitioners will need to reevaluate their current efforts to comply with quality measurements, data protection, and value performance. They will need to look at current and potential relationships with other providers and ensure such relationships accommodate for the potential decline in reimbursement in the long term. HR2 did not simply solve the SGR problem. Rather, it created numerous, long term challenges for which providers will need to truly understand to protect their bottom line and determine their professional success.