Permanent "Doc Fix" Legislation Substitutes Merit-Based Incentive Payment System for SGR, and Contains Other Reimbursement and Compliance Changes

In addition to finally repealing the so-called sustainable growth rate methodology ("SGR") for adjusting Medicare physician payments that Congress has overridden consistently since 2004, the newly enacted Medicare Access and CHIP Reauthorization Act of 2015 (the "Act"), signed into law April 16, 2015, contains other important Medicare changes. Among other things, the Act:

- establishes a new value-based physician payment adjustment methodology referred to as the Merit-based Incentive Payment System ("MIPS");
- provides new financial incentives for physician participation in alternative payment models;
- continues the Children's Health Insurance Program ("CHIP") through federal fiscal year 2017;
- amends the Civil Monetary Penalties Law ("CMP") prohibition on hospital payments to physicians to reduce or limit care to add a significant "medically necessary" qualifier; and
- commissions a report for the purpose of providing options for the expansion of other hospital-physician "gainsharing" arrangements.

Base Rate Adjustments. The Act replaces the SGR with a fixed 0.5% annual adjustment through calendar year 2019. In calendar years 2020–2025, the base rates will be maintained and physician compensation will be subject to adjustment under MIPS (described below). Beginning in 2026, physicians who receive a significant proportion of revenues through alternative payment models (described below) will receive a 0.75%increase, while physicians who do not so participate in alternative payment models will receive an increase of only 0.25%.

Merit-Based Incentive Payment System. Under MIPS, physicians will be assigned a composite performance score, on a scale of 0–100, based on measures of quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities. Specific performance metrics will include those existing under several previous Medicare physician incentive programs—the physician quality reporting system, the value-based modifier, and the meaningful use incentive program, all of which will be consolidated under MIPS, with their respective incentive payments to sunset in 2018 and be replaced in subsequent years by MIPS adjustments—and others to be developed by the U.S. Department of Health and Human Services ("HHS"). A threshold performance score will be set annually by HHS at the mean or median of all composite scores for a prior annual performance period. Performance exceeding the threshold will result in a positive adjustment, performance below the threshold will result in a negative adjustment, and performance at the threshold will result in no adjustment.

The potential percentage adjustment will increase in each period, from 4% in 2019 to 9% in 2022 and subsequent years. The individually applicable percentage adjustments will be linearly scaled based on performance (e.g., in 2019, a score at the threshold will receive no adjustment, a score of 100 will receive a 4% positive adjustment, and a score of 0 will receive a 4% negative adjustment). Additional incentive payments for exceptional performance, in an annual aggregate amount not exceeding $500 million per year through 2024, will be made to those with scores at the 25th percentile of the range between the threshold score and 100, or at the 25th percentile of actual scores above the performance threshold.

Incentives to Participate in Alternative Payment Models. The Act provides for an annual 5% bonus in calendar years 2019–2024 to physicians who receive a significant portion of revenue through alternative payment models ("APM Participants"). APM Participants also will be exempt from MIPS assessment. The

threshold portion of revenues to qualify for the bonus will increase from 25% in 2019–2020, to 50% in 2021–2022, to 75% in 2023–2024. There are two tracks available for meeting the revenue threshold: (i) participation in Medicare alternative payment models (i.e., the shared savings program, a Section 115A innovation model (other than a health care innovation award), or another federal demonstration program); and (ii) participation in a combination of Medicare alternative payment models and alternative arrangements with other payors (either involving participation as a patient-centered medical home, or involving more than nominal downside financial risk). HHS also has flexibility to use patient counts rather than revenue in determining whether the applicable threshold is met.

Amendment to CMP. A longstanding provision of the CMP penalizes a hospital that knowingly makes payments to physicians as an inducement to reduce or limit services provided to Medicare beneficiaries. The HHS Office of Inspector General ("OIG") has previously interpreted the law to prohibit even payments incentivizing physicians to provide fewer unnecessary services. The Act amends the CMP to include a "medically necessary" qualifier, so as to prohibit payments only if made as inducement to "reduce or limit medically necessary services." The Act also directs HHS, in consultation with OIG, to prepare a report to Congress within one year detailing options for amending fraud and abuse laws to permit worthwhile physician-hospital gainsharing arrangements that would otherwise give rise to civil monetary penalties.

Other Provisions. In addition, among other provisions, the Act:

- extends the moratorium on the "two-midnight" rule through September 2015;
- revises and delays for one year the scheduled reductions in Medicaid disproportionate share hospital allotments;
- continues CHIP through federal fiscal year 2017;
- extends funding through federal fiscal year 2017 for community health centers, the national health service corps, teaching health centers, and a variety of other health programs;
- provides broader access to Medicare claims data for providers and suppliers, self-insuring employers, health insurance carriers, medical societies and hospital associations, and other HHS-approved entities;
- prohibits Medicare supplement plans from providing newly eligible Medicare beneficiaries with full coverage of the Part B deductible;
- revises income-based adjustments to Medicare beneficiary premiums beginning in 2018; and
- phases in, over a period of not more than four years, a prohibition on the printing of social security numbers on Medicare cards.

If you have any questions, please contact any member of our health care group or your usual Ropes & Gray advisor.