SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (H.R. 4015/S. 2000)
Frequently Asked Questions (FAQs)
Feb. 25, 2014

1. What are some key components of H.R. 4015/S. 2000 and what is the current status of the bill in the legislative process?

This legislation was introduced on Feb. 6, 2014 and is the product of years of policy development on the part of the three committees in the House and Senate with jurisdiction over Medicare. This legislation, the first of its kind, is comprehensive in its efforts to move us toward a new value-based payment and delivery system and it is now awaiting a vote in both chambers. Some key features include:

- Repealing the SGR, effective immediately, and replacing it with a system focused on quality, value, and accountability.
- Removing the imminent threat of physician payment cuts and ensuring a 5-year period of annual updates of 0.5 percent from 2014-2018 while transitioning to the new system.
- Consolidating the three existing quality programs into a streamlined and improved program that rewards physicians who meet performance thresholds and improve care for seniors.
- Canceling the existing Physician Quality Reporting System (PQRS) and EHR Meaningful Use penalties at the end of 2017, and adding these dollars back to physician payments instead of going to the federal government.
- Creating incentives for physicians to move voluntarily into Alternative Payment Models (APM) by 2018, including a 5 percent annual bonus payment for five years to physicians who receive a significant portion of their revenue from patient centered medical homes (PCMH) shown to improve quality.
- Mandating a process to improve the accuracy of Medicare relative value units (RVUs).

2. Does ACP support this legislation? If so, what is ACP asking of Congress now?

Yes, ACP supports this legislation, as does the majority of medicine, and we had significant input into the policy development throughout the process. See joint letter here: [http://www.acponline.org/acp_policy/letters/house_and_Senate_sgr_reform_letter_2014.pdf](http://www.acponline.org/acp_policy/letters/house_and_Senate_sgr_reform_letter_2014.pdf)

ACP urges both the House and Senate to schedule a vote on this legislation before April 1st when the next round of scheduled SGR cuts will go into effect. Members of Congress can aid in this effort by cosponsoring the bills and urging their leadership to expedite the bills to the floor for a vote.

3. If Congress is not able to pass a final bill before the April 1 deadline, would ACP support another short-term fix to give them time to work on the legislation?

ACP does not support short-term patches to the SGR. The time has come when we must repeal the formula once and for all.

4. SGR-repeal legislation has been introduced in the past and has failed. What makes this circumstance now any different?

Plenty is different. Never have we seen such comprehensive legislation to not only repeal the SGR but also systematically move us toward a new value-based payment and delivery system. This legislation does just that. The three Medicare committees, on a bicameral, bipartisan basis, reached agreement on the policy contained in this legislation, the first time that has ever happened. The estimated cost to repeal the
SGR has been the lowest it has ever been, making the time ripe for Congress to act on repeal. And, the vast majority of medicine supports this legislation, which has not been the case in the past.

5. **How is this bill better than current law? At least now, under the current SGR system, I know Congress will step in to prevent any scheduled physician payment cuts and I don't have to change my practice to get paid.**

First, it is important to note that we never have any guarantee that Congress will step in to prevent scheduled cuts. However, Congress has made a practice over the years of halting the cuts, but not until the eleventh-hour, or sometimes beyond the eleventh-hour. This creates on-going uncertainty and unneeded burden on practices, which prevents them from making practice improvements like hiring new staff or investing in health information technology. There is absolutely no stability under the current SGR system and it does not keep pace with the actual cost of providing services. Obviously for those practices, just having assurance of a stable payment system would be incredibly helpful.

This legislation finally moves us toward stable, predictable physician payments under a delivery system that is now focused on value, accountability, patient-centered care, with added efficiencies that will bring savings to the entire health care system. It also restores more than $100 billion to payment for physician services, offers multiple opportunities for physicians in private practice to earn higher updates, and gives the profession the leading role in offering alternative payment models, and designing the measures to evaluate performance.

6. **How would consolidating current law incentives programs under this bill improve things for my practice?**

Under the new Merit-based Incentive Program (MIPS), the name for what would be the consolidation of the existing incentive programs (PQRS, Meaningful Use, and the Medicare Value-Based Payment Modifier program) physician confusion and hassles would be greatly decreased. Currently if you choose to participate in more than one program you have to deal with significant differences in terms of measures, data submission options, and even timelines. Consolidating the programs into one would make it significantly easier for physician practices to participate in all three.

7. **How will my performance be measured under the new MIPS program?**

Physicians will receive a composite score on a scale of 0 to 100, based on their performance in four categories:

- Quality will account for 30 percent.
- Resource use will start at 10 percent, gradually rising over time to 30 percent.
- Meaningful Use will start at 25 percent, but with the option that CMS could over time adjust it down to 15 percent.
- And, Clinical Practice Improvement Activities will account for 15 percent.

Physicians will also receive credit for improvement they make from one year to the next. Essentially, this composite score would allow physicians to more clearly determine their eligibility for incentive payments. It empowers physicians to set their own individual conversion factor, rather than having it determined by a flawed formula or other external approach.

8. **Does the College support having clinical practice improvement activities as one of the performance categories by which physicians are measured under the MIPS program?**
Yes. Under current Medicare reporting programs, physicians receive little to no incentive payment for engaging in clinical improvement activities. And there is currently no ability for physicians to get credit for transforming to a PCMH under the current programs.

9. Each physician’s composite score will be measured against a performance threshold that will be established during a period prior to the performance period. Does ACP support this?

Yes, using a prior performance period to determine the threshold will allow physicians to know in advance what composite score they must achieve in order to obtain incentive payments and avoid penalties. The current Medicare reporting programs are not at all clear, transparent, or aligned in terms of performance thresholds that must be met. This approach empowers physicians to review their data and set performance goals for the following year.

10. I am in a solo practice that is not a medical home and I have limited staff and resources. Will my performance be assessed differently to account for these factors?

Every physician’s performance will generally be assessed the same under the MIPS program, which essentially allows physicians to set their own individual conversion factor above or below the baseline update; however, as opposed to the current Medicare reporting programs, physicians can receive credit for improvement from year to year, as well as credit for clinical quality improvement activities in which they engage (rather than their performance being determined strictly by existing quality measures). Additionally, technical assistance will be available to help practices with 15 or fewer professionals improve MIPS performance or transition to alternative payment models. The funding for this assistance will be $40 million annually from 2014 to 2018, with $10 million reserved for practices in areas designated as health professional shortage areas or medically underserved areas.

11. How does this legislation address penalties for not reporting on quality measures, and how is that different than current law?

Under current law, in 2018, physicians are faced with:
   a. 2 percent penalty for failure to report PQRS quality measures;
   b. 4 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR Meaningful Use requirements; and
   c. Additional negative adjustments under the Value Based Modifier program

All of these penalties could add up to 6-8 percent cuts as early as 2018 and 7-10 percent cuts in 2019. However, the new MIPS program aligns all of those incentive payments and caps them at more reasonable limits in the early years (4 percent in 2018), which gradually increase over time. This legislation keeps the money from physician quality incentive program penalties (in 2018 and beyond) in the physician payment pool; therefore, significantly increasing the total funds available to pay physicians. This money would be lost if the current system remains in place.

12. Will physicians be forced to participate in an ACO or other alternative payment model?

No, you will not be forced to join any alternative payment model, including an ACO. However, if you do, you have the opportunity for higher payments. Under this bill, you can remain in the fee-for-service program. However, this bill includes a new component to the fee-for-service system called the Merit-based Incentive Program (MIPS) that would base your adjustment on your own personal score (within a certain range).
One way to look at this is that under the SGR, you would be cut 24% on April 1. Under this bill, you could potentially get the following updates:

- 2014-2018: 0.5 percent updates
- 2018: the baseline update is 0.5 percent, plus/minus 4.0 percent based on measures of quality, practice improvement, resource use, and meaningful use (EHRs).
- 2019: the baseline update is 0 percent, plus/minus 5.0 percent based on measures of quality, practice improvement, resource use, and meaningful use (EHRs).
- 2020: the baseline update is 0 percent, plus/minus 7.0 percent based on measures of quality, practice improvement, resource use, and meaningful use (EHRs).
- 2021: the baseline update is 0 percent, plus/minus 9.0 percent based on measures of quality, practice improvement, resource use, and meaningful use (EHRs). (The 9.0 percent merit-based payment adjustment would remain in effect for subsequent years.)

So if you scored in the top tier, you would be receiving a positive incentive adjustment of up to 9 percent each year, on top of the baseline update, starting in 2021. Or if you want into a PCMH or other alternative payment model, you would be guaranteed annual updates of 5 percent each year, on top of shared savings or other revenue from the alternative payment model itself. The numbers speak for themselves: the bill gives you, and other physicians, far more opportunities to control your future reimbursements and get positive updates than under the SGR.

13. What are the incentives for physicians to participate in an APM?

While there is no requirement for any physician to participate in an alternative payment model, there is absolutely an incentive. Physicians who choose to participate will automatically receive a 5 percent payment bonus every year from 2018 to 2023. After that they will get updates of one percent starting in 2024. It’s important to note that this is new money for physicians who are participating in alternative payment models, on top of any incentives they are already receiving through their alternative payment model programs.

14. How does this legislation impact physicians who are contemplating transforming their practice into a patient-centered medical home (PCMH)?

This legislation treats medical homes in a very favorable light and helps advance this model of care more into mainstream healthcare, which ACP strongly supports. Through its incentives for APMs, this bill would allow for a more rapid and robust expansion of the PCMH and PCMH specialty practices (and other evidence-based models) throughout all of Medicare. It would also put the weight of law behind paying for a chronic care management code (or codes) and would ensure that PCMHs and PCMH-specialty practices could bill for them. And, under the MIPS program, physician performance and by extension payment is based in part on clinical practice improvement activities. There is currently no ability for physicians to get credit for transforming to a PCMH under the current programs.

15. What happens to the traditional fee-for-service system under this bill?

The traditional fee-for-service system will continue to exist for physicians who are unable to, or don’t wish to, transition to an alternative payment model. The bill will prevent the massive cuts that have been routinely threatened to fee-for-service payments under current law and will provide small, annual increases of 0.5 percent through 2018. After the baseline used to calculate payments will hold steady, with physicians earning an update based on their personal score under the Merit-based Incentive Program.

16. How does this legislation impact how services are valued under the Medicare physician fee schedule?
The bill sets an annual target of 0.5 percent in savings from misvalued fee schedule services from 2015 through 2018. If the target is met, the savings are redistributed to other services in the fee schedule; if not, across-the-board cuts would apply. Excess savings over 0.5 percent would carry forward and be applied to the 0.5 percent target in future years. The bill also allows the Secretary of Health and Human Services to collect information from physicians and other practitioners to assist with valuing services. Those who provide information would be compensated (up to a total of $2 million per year). Also, services with relative values that are reduced by 20 percent would be subject to a two year phase-in.

17. I am considering opting out of Medicare because it just isn't worth it to remain in the program? Does the bill address this issue in any way?

Under this bill, physicians (and other eligible professionals) can choose to opt-out of Medicare and choose private contracting with beneficiaries. Their opt-out election would be automatically renewed every 2 years. Regular reporting of the characteristics of the physicians that opt-out of Medicare will be provided to the public via a website.

18. Does this legislation advance the concept of balance billing?

No. Because the federal government pays the bills for Medicare enrollees, it determines the rules of payment. A majority of members of Congress will not support legislation that would allow physicians to charge beneficiaries more than the amount set by the government, because they are concerned that this could hurt vulnerable (and poorer) beneficiaries, and because it would be strongly opposed by senior citizen advocacy groups.

19. How does Congress intend to pay for this bill?

We do not know how Congress will propose to pay for SGR repeal or this legislation in particular.

ACP has previously offered our own Menu of Deficit Reduction Options for how to reduce government health care spending. Some of these options could be used to help pay for SGR repeal. Online at: http://www.acponline.org/advocacy/where_we_stand/medicare_reform/super_comm_menu.pdf.

20. In this congressional climate, what is the likelihood that this legislation will be enacted this year?

While overall, the Congressional climate is very partisan these days, achieving SGR repeal is supported by both sides of the aisle in the House and Senate. The SGR formula is known to be flawed and given the reduced cost associated with its repeal, according to the latest CBO estimates, most believe that now is the time to do so. Additionally, it is encouraging that the bills drafted to date on SGR repeal have been bi-partisan and bi-cameral. All three committees with jurisdiction over Medicare payments favorably reported out of each of their committees in 2013 a comprehensive SGR-repeal bill, which has never happened, and have now reached agreement on a single bill. This indicates strong momentum on the part of the committees to repeal the SGR as soon as possible. So, while it is not a guarantee that the repeal will happen in 2014, many critical elements are aligned that make its likelihood more realistic than ever before.