The SGR Repeal and Medicare Provider Payment Modernization Act (H.R. 4015/S. 2000)
Snapshot of Key Issues

Introduced Feb. 6, 2014

KEY ISSUES FOR ACP	IS BILL CONSISTENT WITH ACP POLICY?	IS BILL AN IMPROVEMENT OVER CURRENT LAW?
SGR Repeal and Base Payment Updates		
SGR Repeal: The flawed SGR mechanism is permanently repealed, averting a 23.7 percent SGR-induced cut scheduled for April 1, 2014.	Yes, after 11 years, 16 patches, and $154 billion wasted. It is time to pass SGR-repeal now!	Yes, after 11 years, 16 patches, and $154 billion wasted. It is time to pass SGR-repeal now! It is a recognized by all that it is a flawed formula.
Payment Updates 1: Professionals will receive an annual update of 0.5 percent in each of 2014 through 2018. The rates in 2018 will be maintained through 2023.	Yes, this allows for 5 years of positive, stable, and predictable updates.	Yes, the alternative is a nearly 24 percent cut in 2014, followed at best by a freeze in payments, but more likely deeper cuts.
Payment Updates 2: Physicians will also be eligible for additional updates through the new Merit-Based Incentive Program (MIPS) (which is discussed further below).	Yes, ACP has long held that we should move to a value-based payment system focused on quality of care and care coordination.	Yes—the MIPS program is discussed further below.
Payment Updates 3: In 2024 and subsequent years, professionals participating in Alternative Payment Models (APMs) that meet certain criteria would receive annual updates of one percent, while all other professionals would receive annual updates of 0.5 percent.	Yes, ACP is strongly supportive of incentivizing movement toward APMs, as well as providing ongoing positive, stable, and predictable updates for all physicians.	Yes, as noted above, alternative is a nearly 24 percent cut in 2014, followed at best by a freeze in payments, but more likely deeper cuts.
Establishment of the Merit-Based Incentive Program (MIPS)		
MIPS: Payments to professionals will be adjusted based on performance in the unified MIPS starting in 2018. The MIPS streamlines and improves on the three distinct current law incentive programs: • The Physician Quality Reporting System (PQRS) that incentivizes professionals to report on quality of care measures; • The Value-Based Modifier (VBM) that adjusts payment based on quality and resource use in a budget-neutral manner;	Yes, The College strongly supports alignment across the various CMS reporting programs to reduce the reporting burden on physicians.	Yes, each of these programs currently has variation in terms of measures, data submission options, and payment timelines—which results in significant confusion and hassles for physicians. The new MIPS program would completely unify these programs.

KEY ISSUES FOR ACP	IS BILL CONSISTENT WITH ACP POLICY?	IS BILL AN IMPROVEMENT OVER CURRENT LAW?
and • Meaningful use of EHRs (EHR MU) that entails meeting certain requirements in the use of certified EHR systems.		
Current-law Penalties: The penalties associated with the current law incentive program will sunset at the end of 2017, including: • 2 percent penalty for failure to report PQRS quality measures • 3 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR MU requirements.	Yes, the College strongly supports sunsetting these penalties, as they are the result of programs that are not well aligned and that result in significant confusion and hassles.	Yes, as noted above, the variation across these programs results in significant confusion and hassles for physicians. The new unified MIPS program would align the payment incentives across these programs.
Penalties Realigned: The money from penalties that would have been assessed would now remain in the physician fee schedule, significantly increasing total payments compared to the current law baseline.	Yes, the College is strongly supportive of keeping these funds in the physician payment pool.	Yes, keeping the money from the penalties in the physician payment pool significantly increases the total funds available to pay physicians. <u>This money would be lost if the current system remains in place</u>.
Performance Assessment: Physicians will receive a composite performance score of 0-100 based on their performance in each of the four performance categories listed below:	Yes, ACP is supportive of a transparent and aligned system of assessing physician and other professionals' performance.	Yes, this composite score would allow physicians to more clearly determine their eligibility for incentive payments. <u>In essence, it empowers physicians to set their own individual conversion factor, rather than having it determined by a flawed formula or other external approach.</u>
• Quality (30 percent) – will measures from PQRS, VBM, EHR MU; and those from qualified clinical data registries	Yes, ACP strongly supports alignment across the various CMS reporting programs to reduce the reporting burden on physicians.	Yes, this approach reduces confusion and hassle as all of the quality measures would be aligned where appropriate.
• Resource Use (initially 10 percent, going up to 30 percent) – will engage physicians to ensure accurate resource use assessments.	Yes, ACP is supportive of establishing accurate approaches to measuring resource use—and specifically of directly engaging physicians to ensure that the algorithms and patient attribution rules accurately link the cost of services to a physician, rather than depending solely on outside processes (such as episode groupers).	Yes, under the current Value-Based Payment Modifier (VBM) program, resource use is being determined solely by external processes (such as episode groupers); however, the MIPS program would also directly engage physicians to help improve the accuracy of resource use measurement.
• Meaningful Use (25 percent, but could be	Yes, in general, ACP supports the overall goals and	Yes, this approach reduces confusion and hassle as all of

KEY ISSUES FOR ACP	IS BILL CONSISTENT WITH ACP POLICY?	IS BILL AN IMPROVEMENT OVER CURRENT LAW?
adjusted down to 15 percent)	objectives of the MU program and appreciates that it would be brought into greater alignment with the other CMS reporting programs.	the quality measures would be aligned where appropriate.
• Clinical Practice Improvement Activities (15 percent) – includes a menu of activities, including MOC performance improvement models; and physicians in certified primary care PMCHs and PCMH specialty practices will get the highest possible score.	Yes, the College is supportive of this new element of a value-based incentive program as clinical improvement activities can be a means of attaining improved and high performance. And, ACP strongly supports the inclusion of PCMH models as an approach that would receive the highest score.	Yes, in the 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.
Under MIPS, physicians will also receive credit for improvement from one year to the next in the determination of their quality and resource use performance category score and may receive credit for improvement in clinical practice improvement activities.	Yes, the College has long advocated for payment for improvement over time and and believes that this approach will help cut down on inappropriate competition among physicians and other EPs.	Yes, in the current Medicare reporting programs, physicians receive little to no credit for improvement from year to year.
Performance Threshold: Each eligible professional's composite score will be compared to a performance threshold that will be established during a period prior to the performance period. Therefore, physicians will know what composite score they must achieve to obtain incentive payments and avoid penalties at the beginning of each performance period.	Yes, the College appreciates that 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	Yes, 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.
Payment Adjustments: Payment adjustments (negative for those below the threshold; zero for those at the threshold; positive for those above the threshold): • 2018: capped at +/- 4 percent • 2019: capped at +/- 5 percent • 2020: capped at +/- 7 percent • 2021 and beyond: capped at +/- 9 percent Plus – the potential for additional incentive payments (described below).	Yes, ACP supports this phased approach to implementing the new payment incentives. It is a much more logical, aligned, and transparent approach that will allow physicians to better understand what incentive they can expect (and strive for) and when.	Yes, under current law physicians are faced with a 2 percent penalty for failure to report PQRS quality measures; 3 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR MU requirements; and additional negative adjustments under the VBM program—all of which could add up to 5-8 percent cuts as early as 2018 and 7-10 percent cuts in 2019. Whereas, this new program aligns all of those incentive payments and caps them at more reasonable limits in the early years, which gradually increase over time. And none of the current programs give meaningful credit to

KEY ISSUES FOR ACP	IS BILL CONSISTENT WITH ACP POLICY?	IS BILL AN IMPROVEMENT OVER CURRENT LAW?
		physicians for improvement over time or for their clinical improvement activities.
Additional Incentive Payments: Additional incentive payments – those physicians that have high performance scores above the threshold will also receive additional positive payment adjustments –beyond the caps listed above.	Yes, ACP strongly supports this additional payment incentive, as it will enable the higher performing physicians to receive incentive payments even if all professionals perform above the threshold (which would make the budget neutral payment pool very limited in its ability to provide rewards).	Yes, this is new money allocated specifically as additional payment to high performing physicians. This new money does not exist within the current Medicare reporting/incentive programs.
Technical Assistance for Small Practices		
Technical Assistance: Technical assistance will be available to help practices with 15 or fewer professionals improve MIPS performance or transition to alternative payment models (APMs)—discussed further below. Funding 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.	Yes, ACP strongly supports assistance and funding to help small practices with this transition.	Yes, this is new money allocated specifically to help small practices. There is currently no funding assistance available for the existing Medicare reporting programs and very limited assistance available for APM transition (mostly limited to practices participating in CMS Innovation Center projects).
Alternative Payment Models (APMs)		
APMs: Physicians who participate in APMs will receive a 5 percent bonus each year from 2018-2023 (and annual updates of 1 percent in 2024 and subsequent years)	Yes, ACP is strongly supportive of providing bonuses to participants in APMs.	Yes, this is new money for physicians participating in APMs—and is on top of any current payment structures that are part of their APM (e.g., prospective care coordination fees, shared savings, etc.).
APMs are defined as: • Those that involve risk of financial losses and a quality measure component (e.g., the Medicare Shared Savings Program) • PCMHs that have been proven to work with the Medicare population—PCMH APMs are exempt from the financial risk requirement.	Yes, ACP has been strongly supportive of both ACOs and PCMHs—and views these models as a solid base and starting point for the development of additional evidence-based alternative delivery and payment system models that reward value over volume.	Yes, current law has led to the testing of the PCMH model within Medicare, with the potential for its expansion; this bill would allow for a more rapid and robust expansion of the PCMH (and other evidence-based models) throughout all of Medicare. It provides incentives necessary to enable physicians to transition their practices and would offer beneficiaries greater access to medical homes.
APM Advisory Committee: A Technical Advisory Committee will be established to consider new physician-focused APM proposals.	Yes, ACP is supportive of expanding the list of APMs to ensure that all specialties and practice sizes have the opportunity to participate.	Yes, there is no provision under the current law that specifically calls for physician and other stakeholder input into the development of new APM models that are

KEY ISSUES FOR ACP	IS BILL CONSISTENT WITH ACP POLICY?	IS BILL AN IMPROVEMENT OVER CURRENT LAW?
		applicable across specialties, ensure small practice participation, and align better with private- and state-based payer initiatives.
Measure Development		
Funding for Measure Development: $15 million of funding will be provided annually from 2014 to 2018 for quality measure development.	Yes, ACP strongly supports the development of measures that will fill gaps in current measures and ensure that there are applicable measures for all specialties.	Yes, this is new money – there is currently no direct federal funding provided for quality measure development.
Paying for Chronic Care Management		
Chronic Care Mgmt Payment: At least one payment code for care management services will be established to pay physicians for the management of care for individuals with chronic conditions. Payment for such services will be made to professionals practicing in a patient-centered medical home or comparable specialty practice certified by an organization(s) recognized by the Secretary.	Yes, the establishment of these codes has been a top priority of the College for several years. ACP is also strongly supportive of payment for these services being made to professionals practicing in a patient centered medical home or comparable specialty practice certified by an organization(s) recognized by the Secretary.	Yes, current law does not require payment for the management of individuals with chronic conditions. CMS recently finalized via rulemaking that they will be paying for a similar code starting in 2015; however, the details of how that code will be implemented have not been finalized. This bill would 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.
Opting out of Medicare		
Medicare Opt-Out: Physicians (and other eligible professionals) could chose to opt-out of Medicare and chose private contracting with beneficiaries. Their opt-out election would be automatically renewed every 2 years.	Yes, ACP supports the primacy of the relationship between a patient and his/her physician, and the right of those parties to privately contract for care, without risk of penalty beyond that relationship. However, the contracts should have certain essential patient protections.	Neutral – the bill allows for automatic renewal of a physician's decision to opt-out of Medicare.
Regular reporting of the characteristics of the physicians that opt-out of Medicare will be provided to the public via a website.	Yes, ACP is generally supportive of transparency in payment information, as long as there are reasonable review and appeal processes in place for physicians.	Yes, it provides beneficiaries with information on physicians and other EPs that chose to opt out of Medicare.