ACP American College of Physicians℠
INTERNAL MEDICINE | *Doctors for Adults*

The SGR Repeal and Medicare Provider Payment Modernization Act (H.R. 4015/S. 2000)
"Key Improvements over Current Law"
Prepared by the Division of Governmental Affairs and Public Policy

Feb. 21, 2014

1. After 11 years, 16 patches, and $154 billion wasted. It is time to pass SGR-repeal now!

2. The bill establishes stable positive updates of 0.5% for the first 5 years (with rates then remaining stable from 2018-2013). The alternative is a nearly 24 percent cut in 2014, followed at best by a freeze in payments, but more likely deeper cuts.

3. The existing Medicare quality reporting/incentive programs (PQRS, VBM, and MU) vary significantly in terms of measures, data submission options, and payment timelines—which results in significant confusion and hassles for physicians. The new Merit-based Incentive Program (MIPS) program would unify these programs.

4. 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.

5. The new MIPS composite score would allow physicians to more clearly determine their eligibility for incentive payments. 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. Physicians will be able to proactively review their data in order to set their performance goals. The current Medicare reporting programs are not at all clear, transparent, or aligned in terms of performance thresholds that must be met.

6. In the current Medicare reporting/incentive 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. The MIPS program would change that and give credit for overall improvement from year to year, as well as for engaging in specific clinical improvement activities.

7. Under current law, in 2018, physicians are faced with:
    - 2 percent penalty for failure to report PQRS quality measures;
    - 4 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 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.

8. On top of the base positive incentive payments that high performing physicians would receive in the MIPS program, they can also receive additional payment. In aggregate, this additional payment would be up to $500 million per year from 2018 to 2023. This new money does not exist within the current Medicare reporting/incentive programs.

9. Additional new money is also allocated specifically to help small practices ($40 million). There is currently no funding assistance available for the Medicare reporting programs and very limited assistance available for Alternative Payment Model (APM) transition (mostly limited to practices participating in CMS Innovation Center projects).

10. Those physicians participating in APMs would also receive a 5 percent bonus—this is entirely new funding and is on top of any current payment structures that are part of their APM (e.g., prospective care coordination fees, shared savings, etc.).

11. 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.

12. Additionally, 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.