SGR Repeal & Medicare Physician Payment Reform

February 2014

"SGR Repeal and Medicare Provider Payment Modernization Act of 2014"

TOP LINE

- Repeals the Medicare sustainable growth rate (SGR).
- Establishes a period of stability in Medicare physician payments, while providing pathways for physicians to receive higher payments for practice and quality improvements.
- Provides 0.5% positive update each year for 2014 to 2018. Payment rates in years 2019 to 2023 will be at 2018 levels.
- Provides $200 million to assist small physician practices with transformation activities – $40 million per year for 5 years.
- Shifts emphasis away from fee-for-service payments towards new payment models that support advanced delivery models demonstrating higher quality care.
- Recognizes and financially rewards Alternative Payment Models (APM) such as the patient centered medical home. In years 2018 to 2023 qualifying APMs are eligible for a 5% bonus payment.
- Consolidates existing quality improvement programs – physician quality reporting system (PQRS), value-based modifier (VBM), meaningful use of electronic health records (MU) – into a single Merit-Based Incentive Payment System (MIPS).
- Incentivizes and finances the development of physician quality measures.
- Validates and finances care coordination codes in the Medicare physician fee schedule.
- Creates a process and benchmarks to evaluate misvalued codes in the Medicare physician fee schedule and redistribute those savings to undervalued services.
- Creates appropriate use criteria for high cost/high utilization services.
- Increases transparency and availability of Medicare data for both physicians and patients.

CONGRESSIONAL ACTION

- July 31, 2013 – The House Energy and Commerce Committee approved the "Medicare Patient Access and Quality Improvement Act of 2013" (HR 2810)
- December 12, 2013 – The House Ways and Means and Senate Finance Committees approved the "Medicare Patient Access and Quality Improvement Act of 2013." (HR 2810/S 1871)
- December 2013 – House and Senate approved the "Pathway for SGR Reform Act of 2013." Provides a 0.5% positive update for all allowable Medicare services provided between January 1, 2014 and March 31, 2014.

PHYSICIAN PAYMENT

- Repeals and eliminates the Medicare sustainable growth rate (SGR).
- Provides 0.5% positive update for years 2014 to 2018.
- For years 2019 to 2023, physician payments are frozen at 2018 levels.
- Starting in 2024, payments for physician services provided in an Advanced APM are increased 1% per year – all other physician payments increase at 0.5% per year.

ALTERNATIVE PAYMENT MODELS (APMS)

- Physicians who have a significant share of their Medicare revenues in an APM(s) that involves two-sided financial risk and a quality measurement component would receive a 5% bonus each year from 2018-2023.
- Physicians who have a significant share of their Medicare revenue in a patient-centered medical home model that has been certified as maintaining or improving quality without increasing costs, are also eligible for the 5% bonus each year from 2018-2023.
- Physicians participating in a qualifying APM are exempt from the reporting and performance thresholds established by the Merit-Based Incentive Payment System (MIPS).
- Establishes a non-governmental technical advisory committee (TAC) to develop APMs independently of CMMI.

ASSISTANCE TO SMALL PRACTICES

- The Secretary, through Quality Improvement Organization (QIOs) or other entities, would provide technical assistance to practices of 15 or fewer eligible professionals located in HPSAs, rural, and other medically underserved areas to help them improve performance and to facilitate participation in eligible APMs. Forty million dollars would be available each year from 2015 to 2019 to provide such technical assistance.

CARE COORDINATION PAYMENTS

- Creates, starting in 2015, a Medicare payment within the fee-for-service system complex chronic care services. Care coordination payment will compensate eligible physicians for those services generally provided outside a traditional face-to-face encounter.
- Physicians who are participating in a PCMH or comparable specialty model certified by an organization recognized by the Secretary are eligible for the payments. Physicians not participating in a PCMH or similar model are not eligible for care coordination payments.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

- Combines existing programs – meaningful use, physician quality reporting system (PQRS), and value-based modifier (VBM) into a single Merit-Based Incentive Payment System (MIPS). All existing incentive and penalty programs are phased out at the end of 2017.
- Under the proposal, Medicare payments to physicians would be adjusted based on performance In the MIPS.
    - The MIPS will consist of 4 assessment categories: Quality, Resource Use, Clinical practice improvement activities, and EHR Meaningful Use.
- Physicians can opt to assess their quality performance at the group level, including the election of virtual groups for physicians in practices of ten or fewer.

- Beginning in 2018, CMS will adjust payments to MIPS eligible professionals upward or downward based on a composite performance score (using a scale of 0 to 100). The adjustment can be no greater than 4% (or less than -4%) in 2018; no greater than 5% (or less than -5%) in 2019; no greater than 7% (or less than -7%) in 2020; and no greater than 9% (or less than -9%) in years 2021 and thereafter.

ACCURATE VALUATION OF SERVICES

- Creates a process to identify misvalued services and redistribute the savings within the physician fee schedule if the savings meet a target of at least 0.5% of the estimated amount of fee schedule expenditures annually in 2015-2018.
- Allows for approximately $2 billion in reduced expenditures to remain in the physician payment system and be assigned to undervalued services.
- Directs the Government Accountability Office (GAO) to study the RUC. We had asked for this through MedPAC but this is just as good.

TRANSPARENCY

- Expands information available on the physician compare website to include information on physician payment and quality utilization.
- Physicians will be able to review and correct all information prior to posting

Comparison to Current Law

	Current Law	H.R. 4015/S. 2000
Base Medicare Payment Rate	-24.1% in 2014	0.5% 2014-2018 0.0% 2019-2023 2024 & beyond 1% for Participants in APM 0.5% for all others
Physician Quality Reporting System	-2% in 2017 & beyond	Penalties sunset in 2018 PQRS included in MIPS
Electronic Health Records Meaningful Use	-3% in 2017 -4% in 2018 -5% in 2019 & beyond	Penalties sunset in 2018 MU included in MIPS Established goal of interoperability by 2017
Value-Based Modifier	-2% in 2017 & beyond	Penalties sunset in 2018 Secretary may apply VBM to physicians "as appropriate"
Merit-Based Incentive Payment System (MIPS)	Not applicable	Bonus of penalty up to 4% in 2018 5% in 2019 7% in 2020 9% in 2021 & beyond
Alternative Payment Models	Center for Medicare & Medicaid Innovation Projects	5% bonus payment in years 2018-2023 for successful participation. APM must have 2-sided risk except for PCMH
Care Coordination Fee	CMS will implement a care coordination fee for chronic care patients in 2015	Creates, starting in 2015, a Medicare payment within the fee-for-service system complex chronic care services. Care coordination payment will compensate eligible physicians for those services generally provided outside a traditional face-to-face encounter Physicians who are participating in a PCMH or comparable specialty model certified by an organization recognized by the Secretary are eligible for the payments. Physicians not participating in a PCMH or similar model are not eligible for care coordination payments
Small Practice Assistance	Not applicable	$40 million per year for years 2015-2019 ($200 million total) $10 million for small practices in HPSA medically underserved communities
Technical Advisory Committee	Not applicable	Panel will review all APMs for inclusion in the program
Measure Development	Not applicable – voluntary	$15 million per year for years 2014-2018 ($75 million total) Physician organizations are eligible for funding
Appropriate Valuation of Physician Services	CMS discretion – no directive	Creates a process to identify misvalued services and redistribute the savings within the physician fee schedule Allows for approximately $2 billion in reduced expenditures to remain in the physician payment system and be assigned to undervalued services

		Directs the Government Accountability Office (GAO) to study the RUC
Appropriate Use Criteria	Modest appropriate use criteria programs with respect to imaging and laboratory services	Physicians must consult appropriate use criteria for certain imaging services Outliers (based on 2 years of data) subject to prior authorization requirements
Physician Data Access	Not applicable	CMS required to provide quarterly feedback reports at the physician level
Physician Claims Data	CMS will release physician claims data starting in June	Physician claims released to the public and qualifying entities
Standard of Care Protection Act	Not applicable	Included