SGR Repeal and Medicare Provider Payment Modernization Act of 2014—H.R. 4015/S. 2000

Frequently asked questions

What are some of the key features of the legislation?
Many features of this bill represent improvements over current law. Some of the most important include the following:

- The SGR is permanently repealed, effective immediately.
- Positive, if modest, payment updates of 0.5 percent are provided for five years, from 2014 to 2018.
- Physicians in alternative payment models (APMs) receive a 5 percent bonus from 2018 to 2023.
- In 2024 and beyond, physicians in APMs qualify for a 1 percent update; all others will receive 0.5 percent annual update.
- The fee-for-service payment model is retained, and physician participation in APMs is entirely voluntary.
- Technical support is provided for smaller practices to help them participate in APMs or the new fee-for-service incentive program, funded at $40 million per year from 2015 to 2019.
- Funding is provided for quality measure development, at $15 million per year from 2014 to 2018. Physicians retain their preeminent role in developing quality standards.
- Current quality incentive and payment programs are consolidated and streamlined, and the aggregate level of financial risk to practices from penalties has been mitigated in comparison to current law.

Are there provisions that the AMA opposes?
This is not the bill we would have written ourselves. There are still some things about the quality programs, for example, that we hope to see more streamlined. Nothing in this bill prevents us from advocating for future legislation. In fact, because the SGR and its accumulated debt are eliminated, future modifications will not face the same budgetary obstacles.

How much will the legislation cost? How does that compare with the cost of annual patches?
We have not seen an official score from the Congressional Budget Office. Recent reports estimate the full cost of H.R. 4015/S. 2000 at somewhere between $125 and $130 billion over 10 years. The cumulative cost of annual patches over the past 12 years has been over $150 billion. And each individual patch costs more each year—the last full-year patch cost over $25 billion.

How will the cost of the legislation be offset? What financial offsets will the AMA support?
The budget offsets have not yet been identified. Congress has a large menu of offsets from which to choose. House and Senate leaders will need to select the mix of offsets they believe will best balance the concerns of their constituents and the members of their party caucuses. We will offer an opinion on offsets after we see the proposal package crafted by Congress.

Is the AMA concerned about opposition from other provider groups whose payments may become the source of budget offsets?
Certainly a number of groups have been vocal about supporting elimination of the SGR formula while saying they do not believe their members should be a source for offsetting the costs. That is among the insidious features of the SGR formula. Clearly, physicians have to worry about the financial stability of their practices and Medicare patients have to worry about continued access to their physicians. But also, policymakers must repeatedly turn to other provider groups to help offset the costs of a short-term patch. The sad truth is that continuing the cycle of annual patches to the SGR formula is no bargain for anyone. All stakeholders would be far better off if the formula were just eliminated altogether.

Do other physician groups support the legislation?
The vast majority of state and national physician organizations have publicly stated their support for the legislation.

Why does the AMA oppose a short-term patch?
Patches are fiscally irresponsible, costing taxpayers and others far more in the long run than fully reforming the payment system. They undermine the stability of the program, making it impossible for practices to plan for their investments and causing them to constantly reassess the financial risks associated with caring for Medicare patients. And they stymie the practice innovations and improvements in health care delivery that seniors deserve.

Why is the AMA supporting legislation that only provides updates of 0.5 percent for five years?
Annual updates to reflect increases in practice costs are important. There also are other payment policies that will have a significant effect on practice sustainability. Five years of 0.5 percent updates will provide much needed stability for physician practices.

How does the legislation support transitions to APMs?
The bill provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment. Physicians participating in patient centered medical homes, widely recognized to lower costs of care, would not be required to assume downside financial risk. Other models would require some degree of downside risk in addition to the opportunities for increased revenues that most APMs provide if the physician practice generates savings. To encourage physicians to take on this risk, and provide a financial cushion, the legislation provides 5 percent bonus payments from 2018 to 2023 for those who join new models. This provides a transition period to support successful implementation of new models. Another advantage is that physicians would only be subject to the quality reporting requirements for their APM; they would be exempt from the new MIPS quality program described below. The bill also supports the use of telemedicine in new models of care and creates an advisory panel to consider physicians' proposals for new models.

What is the Merit-based Incentive Payment System or MIPS?
Beginning in 2018, H.R. 4015/S. 2000 provides for bonuses ranging from 4-9 percent for physicians who score well in the MIPS, a new pay for performance program under the current Medicare fee-for-service payment policy. The current scheme of penalties under PQRS, Electronic Health Records/Meaningful Use (MU), and the value-based payment modifier (VBM), would end at the close of 2017. In 2018, the MIPS program would become the only Medicare quality reporting program. Performance under the MIPS would be based upon four categories: quality, resource use, meaningful use, and clinical practice improvement activities. These would build and improve upon the current quality measures and concepts in PQRS, MU, and VBM. Physicians are specifically encouraged to report quality measures through certified EHR Technology or qualified clinical data registries. Participation in a qualified clinical data registry would also count as a clinical practice improvement activity.

In many respects, the MIPS program would be more attainable for physicians than current quality programs. The MIPS program presents the first real opportunity for high performing physicians to earn substantial bonuses, and for all physicians to avoid penalties if they meet quality thresholds. Several new aspects of the MIPS program support physicians scoring better, and receiving more credit for their efforts, than under current programs.

Would the MIPS do a better job of rewarding physicians for high quality performance than current programs?
Performance scoring under the MIPS program has several advantages over current quality programs:

- The MIPS does not employ the VBM's "tournament model" which requires both winners and losers, thereby potentially penalizing even-high performing physicians since someone has to be a loser. In the MIPS, if all physicians perform at or above the performance threshold, no one would get a penalty.
- Performance assessment under the MIPS program would be according to a "sliding scale"—versus the current "all or nothing" approaches used in PQRS and MU. Credit would be provided to those who partially meet the performance metrics.
- The bill has guidelines for the weighting of the four performance categories, yet specifically allows administrative flexibility for those in practices or specialties that are at a disadvantage in meeting quality or MU requirements.
- At the start of each performance period, physicians would know the threshold score for successful performance, and they would receive quarterly feedback on their individual performance
- Physicians could receive substantial credit for clinical practice improvement activities and for improving (and achieving) quality of care.
- Physicians with a low level of Medicare claims, and those who are in APMs, would be exempt from the MIPS requirements and payment adjustments.

The MIPS also presents the first real opportunity for physicians to earn substantial bonuses for providing

high quality of care. For exceeding the performance threshold, physicians could earn bonuses of up to: 4 percent in 2018; 5 percent in 2019; 7 percent in 2020; and 9 percent in 2021 and beyond. Additional funding is provided for exceptional performance, up to $500 million per year, from 2018 through 2023. So even if all physicians score above the threshold, some will still receive incentive payments. Unlike current law, the MIPS penalties provide greater certainty, and have a maximum range in future years.

Is H.R. 4015/S. 2000 consistent with AMA policy on pay-for-performance?
The AMA has worked throughout the negotiations on this legislation to bring it more closely in line with our policy on pay-for-performance. As a result of AMA advocacy, the pending legislation more closely aligns with our P4P policy than previous legislative proposals and is an improvement over current law.

AMA policy states that pay-for-performance programs must be voluntary, and only provide positive rewards without any financial penalties. This policy is not reflected in current law governing the Medicare program, or in many private insurance P4P programs. Under current Medicare law, physicians are subject to payment reductions for failing to meet PQRS, MU and VBM requirements. As a result of AMA advocacy, H.R. 4015/S. 2000 would sunset these three programs and their related penalties in 2018. As noted above, while the new MIPS program would impose penalties for failure to achieve specified thresholds, the risk of potential cuts has been reduced. A previous tournament model approach has been scrapped and the MIPS program guarantees bonuses from 2018 through 2023, paid for with new funding. The MIPS program also allows for variation in care based on clinical judgment, an important AMA principle for P4P and quality reporting programs.

Does the bill include any liability protection for physicians?
Yes, the bill contains a provision similar to the Standard of Care Protection Act. This will protect physicians by preventing quality program standards and measures (such as PQRS/MIPS) from being used as a standard or duty of care in malpractice cases.

How does the bill support chronic care management services?
H.R. 4015/S. 2000 would require Medicare to reimburse, under at least one payment code, monthly care management services for individuals with chronic care needs. Payment would go to one professional practicing in a patient-centered medical home or comparable specialty practice certified by a recognized organization. No linkage is required to an annual wellness visit or initial preventive physician examination.

How would the bill affect 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 AMA/ Specialty Society Relative Value Scale Update Committee (RUC) has identified billions of dollars' worth of misvalued services in the past several years. While the AMA does not support this provision, we are optimistic that the target can be reached so across-the-board cuts can be avoided.

Other valuation provisions of H.R. 4015/S. 2000 would allow 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. One provision of particular concern would allow the Secretary to "smooth" relative values within a group of services, with details left to the regulatory process. While the meaning of this is unclear, the AMA would continue its longstanding advocacy for accurate valuation of individual physician services based upon actual costs and relative values, as required under current law. The Government Accountability Office (GAO) would be required to issue a report on the RUC process within a year of enactment.

Would new "Appropriate Use" criteria apply to ordering certain services?
The bill contains a provision supported by physician specialty organizations that would require physicians and other practitioners who order advanced diagnostic imaging services to consult certain "appropriate use" criteria that are developed or endorsed by national professional medical societies. Wide exemptions would apply for emergencies, inpatients, APMs, and in significant hardships on a case-by-case basis (such as practicing in a rural area without internet access). Ordering "outliers" falling within the top 5 percent for a two-year period would be required to obtain prior authorization. The bill requires at least one clinical decision support

tool to be made available free of charge. The GAO would report to Congress on other services that could potentially benefit from clinical decision support tools, such as radiation therapy and clinical diagnostic laboratory services.

What does the bill say about the release of physician claims data?
The bill would allow the public release of physician claims data. The bill includes key safeguards that ensure physicians have an opportunity to review and submit corrections prior to publication of their data and a disclaimer clarifying that such information may not be representative of a physician's entire patient population. The bill also retains provisions that the AMA has supported that allow the sale of data and analyses by Qualified Entities, with certain safeguards.

Are there other provisions that help physicians?
Physicians who choose to opt out of Medicare to engage in private contracting could elect to automatically renew their status; they would no longer be required to renew their opt-out status every two years. The bill also requires regular reporting about physicians who choose to opt out of Medicare. The Secretary would be required to issue a report on gainsharing between physicians and hospitals, with recommendations for a permanent program. The GAO would be required to report on barriers that prevent the use of telemedicine and remote patient monitoring. And the bill sets a target of achieving interoperability of electronic health records by 2017. It also prohibits the deliberate blocking of information sharing between vendors of different EHR products.

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