February 6, 2014

REPEALING AND REPLACING THE SGR

- The Sustainable Growth Rate (SGR) formula is a budget cap passed into law in 1997 to control physician spending, but it has failed to work.
- Since 2003, Congress has spent nearly $150 billion in short term patches to avoid unsustainable cuts imposed by the flawed SGR. The most recent patch will expire on March 31st.
- Building on bipartisan legislation unanimously reported out of the House Energy & Commerce and Ways & Means Committees, and reported out of the Senate Finance Committee, the unified legislation from the three committees repeals the SGR and transitions Medicare away from a volume-based system towards one based on value.

Repeals the SGR and provides stability and 5 years of payment updates

- Repeals the SGR and replaces it with a system focused on quality, value, and accountability.
- Removes the imminent threat of draconian cuts to Medicare providers and ensures a 5-year period of annual updates of 0.5 percent to transition to the new system.

Improves the existing fee-for-service system by rewarding value over volume and ensuring payment accuracy

- Consolidates the three existing quality programs into a streamlined and improved program that rewards providers who meet performance thresholds, improve care for seniors, and provide certainty for providers.
- Implements a process to improve payment accuracy for individual provider services.
- Incentivizes care coordination efforts for patients with chronic care needs.
- Introduces physician-developed clinical care guidelines to reduce inappropriate care that can harm patients and results in wasteful spending.
- Requires development of quality measures and ensures close collaboration with physicians and other stakeholders regarding the measures used in the performance program.

Incentivizes movement to alternative payment models (APMs)

- Provides a 5 percent bonus to providers who receive a significant portion of their revenue from an APM or patient centered medical home (PCMH).
- Participants need to receive at least 25 percent of their Medicare revenue through an APM in 2018-2019. This threshold increases over time. The policy also incentivizes participation in private-payer APMs.
- Establishes a Technical Advisory Committee (TAC) to review and recommend physician-developed APMs based on criteria developed through an open comment process.

Expands the use of Medicare data for transparency and quality improvement

- Posts quality and utilization data on the Physician Compare website to enable patients to make more informed decisions about their care.
- Allows qualified entities (QEs) to provide analysis and underlying data to providers for purposes of quality improvement, subject to relevant privacy and security laws.
- Allows qualified clinical data registries to purchase claims data for purposes of quality improvement and patient safety.