

The American College of Surgeons SGR Repeal FAQ

How will the SGR be repealed?

Congress has reached a bipartisan, bicameral deal for the repeal of Medicare's sustainable growth rate (SGR) formula and to reform the Medicare physician payment system. *The SGR Repeal and Medicare Provider Payment Modernization Act of 2014* (H.R. 4015/S.2000) is strongly supported by the American College of Surgeons (ACS), as well as the broader physician community.

When does this legislation need to be enacted?

Medicare physician payments are scheduled to be cut by 23.7% on April 1, 2014. ACS and the broader physician community are pushing to pass H.R. 4015/S.2000 before April 1. Another patch is NOT the answer; we can't allow Congress to stall on this landmark legislation.

What can I do to help pass this legislation?

ACS has launched an all-out campaign to pass this legislation. We are urging Members of Congress and Senators to enact *The SGR Repeal and Medicare Provider Payment Modernization Act of 2014*. Without significant grassroots pressure, Congress could table the bill and enact another short term patch.

If all of medicine supports this bipartisan, bicameral legislation, why doesn't Congress just pass it immediately?

While the interested parties are united around a central bill and agree on policy, the answer relates to the political sphere. Under its rules, Congress must completely offset the cost of the legislation by cutting other programs in the federal health care budget – hospitals, pharmaceutical companies, medical device companies, nursing homes and skilled nursing facilities, and changes to the Medicare program structure, which may impact beneficiaries. These groups have already begun their efforts and we must answer the call or we will lose this opportunity

Politically, 2014 is an election year, one where control of the U.S. Senate is in question. There are some Members of Congress and Senators who do not want to be put in the position of choosing between interest groups. Others simply believe the cost of the legislation is too much given the current economic conditions.

How much has Congress spent over the last decade with its short term patches for the SGR?

Since 2003, Congress has enacted 16 short term patches for a combined **\$153.7 billion** – more than the total cost of the SGR repeal bill. Short term patches are a failed economic policy that only increases the cost of repealing the SGR and negatively impacts the country's overall budget.

What does the SGR Repeal bill do?

Some of the key provisions of this legislation include:

- full and permanent repeal of the SGR;

- an annual positive update of .5% from 2014-2018;
- maintenance of fee-for-service as a payment option;
- elimination of current law penalties from the existing quality programs, such as PQRS, meaningful use and the value based modifier (VBM) and combining these programs into a single Merit-Based Incentive Payment System (MIPS); which would be based on physicians achieving a threshold, or benchmark. Such a system makes it possible for all providers who reach these quality benchmarks to achieve positive incentives/payment updates;
- incentives to move into advanced alternative payment models (APMs), including 5% bonus payments from 2018-2023 and exemption from some other reporting requirements;
- the inclusion of appropriate pathways for surgeons to develop, test and participate in APMs, such as the Clinical Affinity Groups (CAGs) in ACS's Value-Based Update (VBU) proposal; and
- clarification that no standard or guideline created under federal health programs shall be construed as setting the standard of care for purposes of malpractice claims.

What does the SGR repeal mean?

Each year beginning in 2014 through 2018, all surgeons will receive a stable, annual payment update of 0.5 percent. This is a mandatory update, surgeons will no longer have to worry about potential cuts to the overall physician payment rate. From 2019 through 2023, the base physician payment rate will remain frozen at the 2018 rate.

In 2024 and beyond, surgeons meeting the requirements of the APM program would receive mandatory annual updates of one percent. All other surgeons would receive annual updates of 0.5 percent.

What happens to the Physician Quality Reporting System (PQRS), the Value-Based Modifier (VBM) that adjusts payment based on quality and resource use; and Meaningful Use of Electronic Health Records (EHR)?

The legislation consolidates the three existing quality programs into the MIPS program that rewards providers who meet performance thresholds, improve care for seniors, and provide certainty for providers. The MIPS program will assess the performance of eligible professionals in four performance categories: quality; resource use; Meaningful Use (MU) of EHRs; and clinical practice improvement activities. The penalties associated with the current programs are sunset at the end of 2017, including the 2 percent penalty for failure to report PQRS quality measures and the 3 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR MU requirements.

Surgeons with low numbers of Medicare patients and those who receive a significant portion of their revenues from eligible APM(s) are excluded from the MIPS.

How is the MIPS program different from current law if it is using existing programs?

Beginning in 2015, the existing programs (PQRS, EHR Meaningful Use, and the Value Based Modifier) will penalize surgeons for non-compliance. These penalties will grow to 7% or more of a surgeon's annual Medicare revenue. Under the MIPS program, these three programs will be

combined into a single composite score and the penalties sunset. Surgeons who achieve a composite score above the performance threshold are eligible for positive incentive payments.

When does MIPS begin?

The MIPS program will begin in 2018. Surgeons who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from eligible APM(s) will be excluded from the MIPS.

How does the Merit-Based Incentive Payment System (MIPS) work?

For those surgeons participating in the MIPS program, they will receive a composite performance score of 0-100 based on their performance in each of the four performance categories:

- quality;
- resource use;
- Meaningful Use of EHRs; and
- clinical practice improvement activities.

Each professional's composite score will be compared to a performance threshold that consists of the mean or median of the composite performance scores for all MIPS eligible professionals during a period prior to the performance period. Eligible professionals whose composite performance scores fall above the threshold will receive positive payment adjustments and eligible professionals whose composite performance scores fall below the threshold will receive negative payment adjustments.

How is the threshold for the MIPS program incentive payments calculated?

The threshold is the mean or median of the composite performance scores for all MIPS eligible professionals during a period prior to the performance period. The threshold resets each year, so a surgeon's composite score in one year does not affect their composite score the next year.

How will I know if my composite performance score meets the threshold?

Positive Adjustments

Surgeons whose composite performance scores are above the threshold will receive positive payment adjustments. These adjustments can be up to 4% in 2018 and grow over time to a maximum of 9% in 2021 and beyond. If the number of physicians attaining high composite scores is higher than those receiving lower scores, these incentives can be scaled down by up to 3% to help preserve budget neutrality.

Additional Incentive Payment

Surgeons achieving the highest performance scores are eligible for an additional positive payment adjustment. The performance threshold for exceptional performance will be set at the 25th percentile of the range between the initial performance threshold and 100 (e.g., if the performance threshold is a score of 60, the additional performance threshold would be a score of 70) or the 25th percentile of actual composite performance scores for MIPS participants with composite scores at or above the initial performance threshold (i.e., 75 percent of professionals who receive a positive payment adjustment would

receive an additional payment adjustment). Surgeons with composite scores above the additional performance threshold will receive an additional incentive payment.

Zero adjustments

Surgeons whose composite performance score is at the threshold will not receive a MIPS payment adjustment.

Negative Adjustments

Surgeons whose composite performance score falls between 0 and ¼ of the threshold (*e.g.* if the performance threshold is 60, then scores between 0 and 15) will receive the maximum possible negative payment adjustment for the year. Professionals with composite performance scores closer to the threshold will receive proportionally smaller negative payment adjustments. Negative adjustments will be capped at four percent in 2018, five percent in 2019, seven percent in 2020, and nine percent in 2021.

How will the MIPS program quality component be calculated?

The quality measures will consist of those currently used in the existing quality performance programs (PQRS, VBM, EHR) with additional measures solicited by the Secretary from professional organizations and others in the health care community. Measures used by qualified clinical data registries (QCDR) may also be used. The College is working closely with CMS to determine how to ensure its data registries – NSQIP or the Surgeon Specific Registry (SSR) for example – meet the QCDR requirements.

To the extent practicable, quality measures selected for inclusion on the final list will address all five of the following quality domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention.

How do I know which measures to choose for the MIPS quality component?

Each year, the Secretary of Health and Human Services (HHS) will publish a list of quality measures to be used in the forthcoming MIPS performance period through the normal rulemaking process, including a public comment period. Updates and modifications to the list of quality measures will also occur through this process. Eligible professionals will select which measures on the final list to report and be assessed on them.

How will the MIPS program resource use component be calculated?

The resource use assessment will include measures used in the current VBM program with an enhanced methodology through public input and an additional process directly engaging surgeons.

Surgeons will be allowed to report their specific role in treating the patient and the type of treatment used. This provision seeks to allay concerns that algorithms and patient attribution rules fail to accurately link the cost of services to a specific professional. In addition, the legislation seeks additional research and recommendations on how to improve risk adjustment methodologies so surgeons are not penalized for providing care to sicker or more costly patients.

How will the MIPS program EHR Meaningful Use component be calculated?

Current EHR Meaningful Use requirements will continue to apply to the MIPS assessment and composite score. ACS continues to advocate for changes to the Meaningful use program that make it easier for surgeons to comply with its requirements.

What does the legislation do about EHR interoperability?

The legislation requires that EHRs be interoperable by 2017 and prohibits providers from deliberately blocking information sharing with other vendor products. In addition, the legislation seeks to broaden the use of EHR technology by requiring the Government Accountability Office to report on barriers to expanded use of telemedicine and remote patient monitoring.

What are Clinical Practice Improvement Activities (CPIA) and how will they impact my MIPS composite score?

The CPIA assesses surgeons according to their effort to engage in clinical practice improvement activities. Professionals will be given credit for working to improve their practices and facilitate future participation in APMs. The menu of recognized activities will be established in collaboration with professionals, and must be applicable to all specialties and be attainable for small practices and professionals in rural and underserved areas.

If I work in a small or rural practice, how do I meet the MIPS program requirements and have the ability to achieve a composite score above the threshold?

Congress has set aside \$10 million annually from 2014 to 2018 to help practices in areas designated as health professional shortage areas or medically underserved areas. There will also be technical assistance available to help practices with 15 or fewer professionals improve MIPS performance or transition to APMs. ACS will also advocate for changes that allow surgeons to participate in MIPS in a way that best fits their practice environment.

What is the Alternative Payment Model (APM) program?

While the details of the APMs are not clear, the alternative payment would generally involve enhancing or replacing some of the current fee-for-service payments with a patient-level payment amount not related to volume or intensity. For example, surgeons might receive single bundled payments instead of some of their fee-for-service payments such as for a surgical procedure or a colonoscopy, or participating in an accountable care organization with a partially capitated payment could also qualify.

Professionals who receive a significant share of their revenue from an APM will receive a five percent bonus each year from 2018-2023. Participants must receive at least 25 percent of their Medicare revenue through an APM in 2018-2019, and this threshold will increase to 50 percent in 2020-2021, and 75 percent beginning in 2022. The policy also incentivizes participation in private-payer APMs.

If I meet the APM requirements, do I have to meet the MIPS requirements?

No. Surgeons who meet the APM requirements will be excluded from the MIPS assessment and most HER meaningful use requirements.

What if there are no Medicare APM options where I practice?

There will be two tracks available for professionals to qualify for the APM program and incentive payments. The first will be based on receiving a significant percent of Medicare revenue through an APM, and the second will be based on receiving a significant percent of APM revenue combined from Medicare and other payers. The second option makes it possible for professionals to qualify for the bonus even if there are no Medicare APM options available in their area.

Why is the bonus payment higher for APM-based surgeons as compared to MIPS-based surgeons?

Policymakers are relying on bonus payments for participation in an APM to encourage professionals to participate and test new APMs. Congress also recognizes the need for practice changes to facilitate such participation, and bonus payments promote the alignment of incentives across payers.

Does the legislation seek to change the valuation of physician service codes?

Yes. The legislation sets an annual reduction target of 0.5 percent of the estimated amount of fee schedule expenditures in 2015, 2016, 2017, and 2018 for misvalued services. If the target is met, that amount is redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments for the year are reduced by the difference between the target and the amount of misvalued services identified in a given year. If the target is exceeded, the amount in excess of the target is credited toward the following year's target.

The ACS believes this is bad policy and will advocate for changes in the future.

What are the legislation's requirements for public reporting?

No later than July 1, 2015, the Secretary will be required to publish utilization and payment data for professionals, including surgeons, on the Physician Compare website. (**hyperlink to ACS Physician Compare resources?**) For other health professionals, the Secretary will be required to publish the same data, but one year later, by July 1, 2016. This data will be available on the services most commonly furnished by health care providers, and will include the number of services and the submitted charges and payments for the services. The information will be searchable by the professional's name, provider type, specialty, location, and services furnished.

The website will also make clear, when appropriate, that the information may not represent a health care provider's entire patient population, nor include all services that the health care provider furnishes.

Will I be able to review my data before it is published?

Yes, the ACS advocated for a surgeon's ability to have the opportunity to review, and offer corrections to, the information before it is posted on the website.

What are Qualified Entities and why have they been granted access to Medicare claims data?

The legislation expands the current activities of Qualified Entities (QEs), consistent with applicable privacy and security laws. QEs will be permitted to provide or to sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and

hospital associations to assist them with their quality improvement activities, or to develop new APMs. QEs will also be permitted to provide or to sell non-public analyses to health insurers (who provide claims data to the QE) and self-insured employers, but only for the purposes of providing health insurance to their employees or retirees.

Provisions to ensure the privacy, security, and appropriate use of Medicare claims information are included in the legislation. QEs must have a data use agreement with providers and entities to which they provide data; and be subject to an assessment for breach of such agreement. Further, providers and entities receiving data and analyses are prohibited from re-disclosing them or using them for marketing purposes.

QEs that provide or sell data or analyses are required to submit an annual report to the Secretary that provides an accounting of: the analyses provided or sold, including the number of analyses and purchasers, the amount of fees received, and the topics and purposes of the analyses; and a list of entities that were provided or sold data, the uses of the data, and the fees received by the QE for such data. Claims data made available to QEs will also include Medicaid and Children's Health Insurance Plan data.

Health providers identified will have the opportunity to review and provide any needed corrections before the QE provides or sells the analysis to another entity.

Can physicians use the Medicare claims data to their benefit?

Yes, the Secretary will be required to make data available, for a fee that covers the costs of preparing the data, to requesting QCDRs to support quality improvement and patient safety activities, consistent with applicable privacy and security laws. ACS is working closely with CMS to determine how to ensure its data registries – NSQIP or the Surgeon Specific Registry (SSR) for example – meet the QCDR requirements.

Health care providers identified in public reports will have the opportunity to review and correct any errors found in the information before it's made publicly available.

What about medical liability protections?

While the legislation does not implement broad medical liability reforms, it seeks to provide assurance that participating in the MIPS cannot be used in liability cases. Under the legislation, the development, recognition, or implementation of any guideline or other standard under any federal health care provision, including Medicare, cannot be construed as to establish the standard of care or duty of care owed by a surgeon to a patient in any medical liability or medical product liability action or claim.

This provision would not preempt any state or common law governing medical professional or medical product liability actions or claims.