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 17 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.