DISCUSSION DRAFT

SGR Repeal and Medicare Physician Payment Reform

Background

The Sustainable Growth Rate (SGR) formula – the mechanism that ties physician payment updates to the relationship between overall fee schedule spending and growth in gross domestic product (GDP) – is fundamentally broken. Although originally introduced as a mechanism to contain the growth in spending on physicians' services, a decade of short-term "patches" has frustrated providers, threatened access for beneficiaries, and created a budgetary dilemma from which Congress has struggled to emerge. Unless Congress acts by January 1, physician payments will be cut by approximately 24.4 percent in 2014. Over the last decade, Congress has spent nearly $150 billion on short-term SGR overrides to prevent pending cuts.

The 113th Congress has brought renewed commitment to repealing and replacing the flawed SGR update mechanism. This effort has been helped by the significantly reduced Congressional Budget Office score for a freeze of physician payments over the next ten years ($139 billion) and the bipartisan proposal reported out by the House Energy & Commerce Committee in July. Building on that effort, this bipartisan, bicameral discussion draft from the House Ways & Means and Senate Finance Committees seeks to move away from the current volume-based payment system to one that rewards quality, efficiency, and innovation.

Summary

The proposal would permanently repeal the SGR update mechanism, reform the fee-for-service (FFS) payment system through greater focus on value over volume, and encourage participation in alternative payment models (APM). The revised FFS system would freeze current payment levels through the ten-year budget window, while allowing individual physicians and other health care professionals (subsequently referred to collectively as "professionals") to earn performance-based incentive payments through a compulsory budget-neutral program. By combining the current quality incentive programs into one comprehensive program, this proposal would further value-based purchasing within the overall Medicare program while maintaining and improving the efficiency of the underlying structure with which professionals are already familiar.

Professionals who receive a significant portion of their revenue from an APM(s) that involves two-sided financial risk and a quality measurement component (referred to as an "advanced APM") would be exempted from the performance-based incentive program, and would instead receive a bonus payment starting in 2016. By providing funding for measure development priorities for professionals, the proposal would address the current gaps in quality measurement programs and ensure meaningful measures on which to assess professionals.

The proposal would encourage care management services for individuals with complex chronic care needs through the development of new payment codes for such services, as well as leverage physician-developed standard of care guidelines to avoid the unnecessary provision of services. It would also improve the accuracy of the physician fee schedule by setting a target for correcting misvalued services and allow for the collection of information on resources used in

furnishing services. The proposal would involve the health care professional community in furthering the measurement of resource use.

Recognizing the role of quality and resource use data in helping consumers make informed purchasing decisions and helping professionals improve their performance, the proposal would expand the data available to qualified entities (QEs) for quality improvement activities as well as the information available on the Physician Compare website.

Extenders and Additional Policy Priorities

Some policy priorities for Members on the Committees of jurisdiction and other stakeholders, as well as the health care extenders that traditionally travel with the annual SGR patches, are not contained in this discussion draft. Discussions continue to determine how bipartisan, bicameral agreement can be reached on those policies.

Comments

The Committees value your feedback on this proposal. Please submit written comments to the Finance SGR comments mailbox at sgrcomments@finance.senate.gov and the Ways & Means SGR comments mailbox at sgrwhitepaper@mail.house.gov by Tuesday, November 12, 2013.

I. SGR Repeal and Annual Updates

The proposal would permanently repeal the SGR update mechanism and provide updates of zero percent through 2023. Beyond 2023, professionals participating in an advanced APM(s) would receive annual updates of two percent, while all other professionals would receive annual updates of one percent.

II. Value-Based Performance (VBP) Payment Program

Under the proposal, Medicare payments to professionals would be adjusted based on performance on a single budget-neutral incentive payment program. Payments would be adjusted beginning in 2017 based on professionals' performance in a prior period. The Value-Based Performance (VBP) Payment Program represents a more streamlined approach than maintaining the three distinct programs that exist under current law. The VBP composite score and associated payment incentive incorporates the current law programs' emphasis on quality, resource use, and use of electronic health records (EHRs) in a cohesive manner.

Terminating Current Law Incentive Program Payment Reductions

Under the VBP program, the following current law payment penalties would sunset at the end of 2016:

- Failure to successfully report on quality measures (Physician Quality Reporting System, or PQRS), a two percent penalty;
- Budget-neutral payment adjustment based on quality and resource use (Value-Based Modifier, or VBM); and
- Failure to demonstrate meaningful use of certified EHR technology (EHR MU), a three percent penalty that can increase up to five percent starting in 2019.

The penalties that would have been assessed under PQRS, VBM, and EHR MU would now remain in the physician payment pool. This results in a significant increase in total physician payments as compared to the current law baseline. Assuming even a modest number of physicians will be subject to a penalty under these programs, the amount available for total physician payments would increase in the neighborhood of $10 billion over the period 2017-2023.[1]

Professionals Eligible for the VBP Program

The VBP program would apply to: physicians beginning with payment year 2017; physician assistants, nurse practitioners, and clinical nurse specialists beginning with payment year 2018; and all others paid under the physician fee schedule (as the Secretary determines appropriate) beginning with payment year 2019.

Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from an advanced APM(s) would be excluded from the VBP program.

Assessment Categories

The VBP program would assess eligible professionals' performance in the following categories: 1) Quality; 2) Resource Use; 3) Clinical Practice Improvement Activities; and 4) EHR Meaningful Use.

Quality measures used in the current law PQRS and other incentive programs would be used for the quality category. In addition, the Secretary would solicit recommended measures for inclusion annually, and funding would be provided to develop additional measures. Professionals would be given credit for attainment and achievement, with higher overall weight given to outcomes measures. To prevent duplicative reporting, professionals who report quality measures through certified EHR systems would meet the meaningful use clinical quality measure component.

Resource use metrics used in the current law VBM program and the methodology that is under development to identify resources associated with specific care episodes would be enhanced and used for the resource use category. The proposal would also establish a process to involve professionals in furthering the measurement of resource use through identifying episodes of care and require them to indicate their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode) on the claim form rather than having this determined by a formula. Payment would be reduced for a service if the professional failed to provide the information.

[1] Assumptions:
$100 billion in annual allowed charges
2% PQRS penalty hits 25% of physicians in 2017 and 10% 2018-2023
3% EHR meaningful use penalty hits 40% of physicians in 2017
4% EHR meaningful use penalty hits 35% of physicians in 2018
5% EHR meaningful use penalty hits 30% of physicians 2019-2023

Clinical practice improvement activities, which will prepare professionals to transition to an advanced APM(s), would be established through a collaborative process with professionals and other stakeholders and give special consideration to those practicing in rural areas and Health Professional Shortage Areas (HPSA). Specific activities from which professionals can select would fall under the following sub-categories:

- Expanded practice access, such as same-day appointments for urgent needs and after-hours access to clinician advice;
- Population management, such as tracking individuals to provide timely care interventions;
- Care coordination, such as timely communication of clinical information (e.g., test results) and use of remote monitoring or telehealth;
- Beneficiary engagement, such as establishment of care plans for patients with complex needs and self-management training; and
- Participation in any Medicare APM.

Because many of these criteria are components of medical homes, a primary care or specialist professional practicing in a certified medical home would receive the highest possible score for this category. A professional participating in any Medicare APM would automatically receive half of the highest possible score and could achieve the highest possible score by engaging in additional clinical improvement activities.

EHR Meaningful Use requirements, demonstrated by use of a certified system, would continue to apply to achieve compliance in this category.

Performance Assessment

Professionals would be assessed and receive payment adjustments based on a composite score that encompasses all of the applicable composite categories and associated measures. A professional would get a score in each category, which would add up to a single composite score. These scores would reflect the differences in professionals' performance and would be tied to VBP incentive payments. Because it is a budget neutral program, payment increases provided to professionals with high performance scores would be offset by payment reductions to poor performing professionals.

Professionals can opt to assess their quality performance (and other categories as the Secretary deems appropriate) at the group level, including the election of virtual groups for professionals in practices of ten or fewer. In addition, starting in 2014, group-level quality-reporting credit would be available for groups reporting to a qualified clinical data registry. The Secretary could also allow hospital or other facility-based professionals to have their quality assessment determined by the performance of their affiliated hospital or facility.

Weights for Performance Categories

Category	PY 2017 Weight	PY 2018 Weight	PY 2019 Weight
Quality	60% total with neither category less than 15%		30%
Resource use			30%
Clinical practice improvement activities	15%	15%	15%
EHR meaningful use[2]	25%	25%	25%
Total	100%	100%	100%

Performance Pool Funding

For 2017, the funding available for VBP incentive payments would be equal to eight percent of the total estimated spending for VBP eligible professionals. Eight percent is the projected 2017 amount tied to performance under the current law incentive programs. The entire funding pool for a year would be paid out to eligible professionals based on their VBP composite score for a specified performance period, with those achieving the highest scores receiving the greatest incentive payment. The funding pool would be increased to nine percent in 2018 and ten percent in 2019. Starting 2020, the Secretary would have the authority to increase, but not lower, the funding pool.

Assistance to Small Practices

The Secretary, through Quality Improvement Organization (QIOs) or other entities, would provide assistance to practices of ten or fewer eligible professionals located in HPSAs or rural areas to help them improve performance and to facilitate participation in advanced APMs. Ten million dollars would be available each year from 2014 to 2018 to provide such technical assistance.

Feedback for Performance Improvement

The Secretary would provide confidential feedback on performance in the quality and resource use categories to professionals on a timely basis, such as quarterly. Feedback may be provided using multiple mechanisms, such as a web-based portal or qualified clinical data registries. This system of timely and actionable feedback would replace the current confidential quality and resource use reports, thus avoiding the potential for redundant feedback mechanisms.

III. Encouraging Alternative Payment Model Participation

Recognizing that practice changes – as well as alignment of incentives across payers – are needed to support successful APM participation, professionals who have a significant share of their revenues in an APM(s) that involves two-sided financial risk and a quality measurement

[2] EHR meaningful use can drop to 15 percent once adoption reaches 75 percent; this chart assumes the 75 percent threshold is not met

component would receive a five percent bonus each year from 2016-2021. Alternatively, professionals who have a significant share of their 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 bonus.

The revenue threshold would be 25 percent of Medicare revenue for 2016-2017. For 2018-2021, professionals would have two options from which to choose. The first option would be Medicare revenue only, with a 50 percent threshold for 2018-2019 and a 75 percent threshold for 2020-2021. The second option would be a combination of Medicare and non-Medicare revenue. For 2018-2019, professionals must receive at least 50 percent of their total, all-payer revenue through an advanced APM, including at least 25 percent of their Medicare revenue. For 2020-2021, professionals must receive at least 75 percent of their total, all-payer revenue through an advanced APM, including at least 25 percent of their Medicare revenue. Professionals who select the second option must be willing to share their non-Medicare revenue data with CMS.

Illustrative Scenario for 2018-2019 – $400,000 in total, all-payer revenue and $100,000 in Medicare revenue

Option 1: At least 50 percent of Medicare revenue through an advanced APM

All-payer revenue threshold	50% of Medicare revenue threshold
N/A	$50,000 - $100,000

Option 2: At least 50 percent of total, all-payer revenue through an advanced APM, including at least 25 percent of Medicare revenue

50% of all-payer revenue	25% of Medicare revenue	Minimum amount of non-Medicare revenue in APM to meet the all-payer threshold
$200,000+	$25,000 - $49,999	$150,001 out of $300,000

Professionals who meet these criteria would be excluded from the VBP composite assessment and the EHR meaningful use information exchange and quality reporting requirements,[3] and the bonus would not be counted in any assessment of an APM's expenditures.

To make the bonus opportunity available to the greatest number of professionals, the Secretary is encouraged to test APMs relevant to specialist professionals and those that align with private and state-based payer initiatives.

[3] Professionals would only need to use a certified EHR product to be a meaningful user.

IV. Encouraging Care Coordination for Individuals with Complex Chronic Care Needs

The proposal would establish payment for one or more codes for complex chronic care management services, beginning in 2015. Payments for these codes could be made to professionals (physicians, physician assistants, nurse practitioners, and clinical nurse specialists) practicing in a patient-centered medical home or comparable specialty practice certified by an organization recognized by the Secretary who are providing care management services. In order to prevent duplicative payments, only one professional or group practice could receive payment for these services provided to an individual. Payments for these codes would be budget-neutral within the physician fee schedule.

V. Ensuring Accurate Valuation of Services Under the Physician Fee Schedule

The proposal would improve service-level payments under the fee schedule. It would: set a target for identifying and revaluing misvalued services, allow for the collection of additional information to better determine the value of services under the physician fee schedule, smooth downward payment adjustments, and direct the Government Accountability Office (GAO) to study the AMA/Specialty Society Relative Value Scale Update Committee (RUC) processes for making recommendations on valuation of physician services.

In each of 2016, 2017, and 2018, the target for identifying misvalued services is one percent of the estimated amount of expenditures under the physician fee schedule. If the target is met, that amount would be redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments for the year would be reduced by the difference between the target and the amount of misvalued services identified that year. This approach allows approximately $3 billion in reduced expenditures to remain in the physician payment system.

The Secretary would solicit information from selected professionals to assist in accurate valuation under the fee schedule. Professionals who submit the requested information may be compensated, while those who do not submit information would receive a ten percent payment reduction for all services in the subsequent year. Practices with ten or fewer professionals, as well as practices that submitted information the previous year, are exempted from these submission requirements.

The proposal directs the Secretary to ensure that the global payment for the work component of surgical procedures accurately reflects the average number/type of visits following surgery. Additionally, beginning with the 2015 physician fee schedule, total downward relative value unit (RVU) adjustments for a service of 20 percent or more (as compared to the previous year) would be phased-in over a two-year period.

VI. Recognizing Appropriate Use Criteria

The proposal would implement a program that would require ordering professionals to consult with appropriate use criteria for advanced imaging and electrocardiogram services. In

consultation with stakeholders, the Secretary would specify appropriate use criteria from among those developed or endorsed by national professional medical specialty societies or other entities. The Secretary would identify mechanisms, such as clinical decision support (CDS) tools, that could be used by ordering professionals to consult with appropriate use criteria and communicate to the Secretary that such consultation occurred. Payment would not be made for the advanced imaging or electrocardiogram service if consultation with appropriate use criteria did not occur. Prior authorization would apply to outlier professionals whose ordering is inconsistent as compared to their peers. Based on the experience with this program, the Secretary could expand the use of appropriate use criteria to other services.

VII. Expanding the Use of Medicare Data for Performance Improvement

The proposal would allow those that currently receive Medicare data for public reporting purposes (qualified entities, "QEs") to provide or sell non-public data analyses to physicians and other professionals to assist them in their quality improvement activities. The proposal would also allow QEs to provide or sell similar analyses to health insurers and employers meeting certain criteria.

The proposal would also expand the data available to QEs to include Medicare Advantage and Medicaid/CHIP data and require the Secretary to make data available to qualified clinical data registries to support quality improvement activities.

VIII. Transparency of Physician Medicare Data

The proposal would require HHS to publish utilization and payment data for physician and other practitioners on the Physician Compare website. In addition to the quality and resource use information that would be posted through the VBP program, this information would assist beneficiaries in selecting professionals by enabling them to search for professionals by name, specialty, and services. Professionals would continue to have an opportunity to review and correct their information prior to its posting on the website.