U.S. House Ways & Means & Senate Finance Committee Staff October 30, 2013

Discussion Draft
Sustainable Growth Rate Repeal & Medicare Physician Payment Reform

SETMA Provider Training November 19, 2013

Key Points of the SGR Discussion Draft

It would:

1. Repeal the flawed SGR mechanism, ensures payment stability for physicians, and ensures beneficiaries retain access to their physicians
2. Improve the physician payment system to reward value over volume, ensuring beneficiaries and taxpayers receive value for the money spent
3. Advance delivery system reforms and aligns public-private sector efforts
4. Improve the accuracy of payments for physician services

Key Points of the SGR Discussion Draft

5. Incorporate physician and stakeholder expertise
6. Utilize physician-developed guidelines to avoid provision of unnecessary services
7. Reduce administrative burden on providers by aligning current physician quality programs
8. Provide timely feedback data to physicians and makes more Medicare data publicly available

The Commonwealth Fund, Issue Brief *March 2013*

- http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/Mar/Paying-for-Value-Replacing-Medicares-Sustainable-Growth-Rate.aspx

- ***Paying for Value: Replacing Medicare's Sustainable Growth Rate Formula with Incentives to Improve Care***
  Stuart Guterman, Mark A. Zezza, and Cathy Schoen

- The Commonwealth March Issue Brief, reviewed by SETMA providers in April, 2013, seems to be the foundation of the Ways and Means and Finance Committees Proposal published October 31, 2013.

The Commonwealth Fund, Issue Brief March 2013 ABSTRACT

This brief sets forth policy options to improve the way health care providers are paid by Medicare. The authors suggest repealing Medicare's sustainable growth rate (SGR) formula for physician fees and replacing with a pay-for-value approach that would:

1. increase payments over time only for physicians and other providers who participate in innovative care arrangements;
2. strengthen primary care and care teams; and
3. implement bundled payments for hospital-related care.

The Commonwealth Fund, Issue Brief March 2013 ABSTRACT

- These reforms would be adopted by Medicare, Medicaid, and private plans in the new insurance marketplaces, with the goal of accelerating innovation in care delivery throughout the health system.
- Together, these policies could more than offset the cost of repealing the SGR formula, saving $788 billion for the federal government over 10 years and $1.3 trillion nationwide.
- Savings also would accrue to state and local governments ($163 billion), private employers ($91 billion), and households ($291 billion).

Recommendation for Further Reading

Center for Healthcare Quality and Payment Reform Testimony to the House Energy and Commerce Committee http://www.chqpr.org/

- *Ten Barriers to Healthcare Payment Reform and How to Overcome Them*
- *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care*
- *Using Partial Capitation as an Alternative to Shared Savings to Support Accountable Care Organizations in Medicare*
- *Is Shared Savings the Way to Reform Payment?*
  - *Download the Policy Brief*
- *Transitioning to Comprehensive Care Payment*
  - *Download the Policy Brief*.

SGR Rate Repeal and Medicare Physician Payment Reform

Definition of Sustainable Growth Rate formula ties physician payment updates to:

1. Relationship between overall fee schedule spending
2. Growth in gross domestic product (GDP)

SGR was introduced to contain growth in spending:

1. System broken with decade of short-term patches
2. Unless congress acts by January 1, 2014, physician payments will be cut by 24.4 percent in 2014.
3. Over last decade Congress has spent nearly $150 billion on short-term overrides to prevent cuts.

Proposal – Part 1

- Permanently repeal SGR update mechanism
- Reform the fee-for-service (FFS) payment system
- Greater focus on **value over volume**
- Encourage participation in **alternative payment models** (ACOs, Medicare Advantage, Medical Home).
- Freeze current payment levels for ten years

Proposal – Part 1 (cont.)

- Allow providers to earn performance-based incentive payments through a budget-neutral program
- By combining current quality incentive programs into one, would further value-based purchasing within the overall Medicare program
- Maintaining and improving efficiency of the underling structure which professionals are already familiar

Proposal – Part 2

- Professionals who receive a significant portion of their revenue from an **Advance Alternative Payment Model, which model has these elements:**
  1. Revenues from an Alternative Payment Model
  2. That involve two-sided financial risk
  3. And Quality measurement component

- Would be exempted from performance-based incentive
- Would receive a bonus payment starting in 2016
- By Providing funding for measure development priorities, the proposal would address current gaps in quality measurement programs and ensure meaningful measures on which to assess professionals.

Proposal – Part 3

- Encourage care management services with complex chronic care needs through development of new payment codes for services
- Leverage physician-developed standard of care guidelines to avoid unnecessary services.
- Improve accuracy of physician fee schedule by targeting correction of mis-valued services
- Allow for the collection of information on resources used furnishing services.
- Involve care professional community in measurement of resource use.

I. SGR Repeal and Annual Updates

Proposal

1. Permanently repeal the SGR update
2. Provide updates of zero percent through 2023
3. Beyond 2023, professionals participating in an Advanced Alternative Payment Plan (APMs) would receive 2% annual update
4. All others receive annual update of 1%

II. Value Based Performance (VBP) Payment Program Proposal

1. Payment adjusted based on performance on a single budget-neutral incentive program.
2. Payments adjusted beginning 2017 based on professionals' performance in prior period.
3. VBP more streamlined than three distinct programs:
4. VBP composite score incorporates current programs' emphasis on **quality**, **resource use** and **use of EHRs** in a cohesive manner.

Under VBP Current Payment Penalties Sunset At End Of 2016

1. Failure to successfully report on quality measures (PQRS) – 2% penalty
2. Budget-neural payment based on quality and resource use (value-based modifier)
3. Failure to demonstrate meaningful use of certified EHR – 3% that can increase to 5% percent starting in 2019.

The penalties under PQRS, VBM and EHR MU remain in the physician payment pool.

Penalties Remain in Payment Pool

Amount available for total payments increase by $10 Billion over period 2017-2023. Assumptions:

1. $100 Billion in annual allowed charges
2. 2% PQRS penalty hits 25% in 2017; 10% 2017-23
3. 3% EHR MU penalty hits 40% in 2016
4. 4% EHR MU hits 35% in 2017
5. 5% EHR MU hits 39% 2019 to 2023

Value-Based Performance (VBP)

Professionals Eligible for VBP program

1. Physicians begin with payment year 2017
2. PAs, NPs and Clinical Nurse Specialists year 2018
3. All others paid under physician fees year 2019

Professionals who treat few Medicare patients and those who receive a significant portion of revenues from Advance APM(s) are excluded from VBP

Value-Based Performance (VBP)

Assessment Categories

1. Quality
2. Resource Use
3. Clinical Practice Improvement Activities
4. EHR Meaningful Use

Quality Measures

1. PQRS and other incentive programs used for the quality category
2. HHS will solicit recommended measures annually
3. Funding provided to develop additional measures.
4. Professionals given credit for attainment and achievement with higher weight given to outcomes measures.
5. Professionals who report quality measures through certified EHR systems would meet the meaningful use clinical quality measure component.

Resource Use

- Resource use in VBM program and methodology under development for specific **care episodes** will be enhanced and used for this category. (Care episodes are physician DRGs*)
- **Providers' specific role** (primary care or specialty) in treating the beneficiary and the **type of treatment** (chronic or acute) will be designated on the claim form.
- Payment will be reduced for a service if the professional failed to provide the information.

Clinical Practice Improvement Activities

Activities which prepare professionals to transition to advance **Alternative Payment Methods** (APMs) drawn categories:

1. Expanded practice access, same day appointments for urgent needs and after-hour access to clinician advice.
2. Population management such as tracking individuals to provide timely care interventions
3. Care Coordination for timely communications of clinical information (test results) and use of remote monitoring or telehealth.
4. Beneficiary engagement, plan of care for complex needs and self-management training
5. Participating in any Medicare APM

Clinical Practice Improvement & Patient-Centered Medical Home

- 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 Alternative Payment Model automatically receives half of the highest possible score and could achieve the highest score by engaging in additional clinical improvement activities.

EHR Meaningful Use

- Use of a certified system would continue to apply.
- The only meaning use requirement is that a certified EMR is being used.

Performance Assessment

1. Payment adjustments based on a composite score
2. Composite score made up of score in each category
3. Scores would reflect the differences in professionals' performance
4. Scores tied to VBP incentive payments
5. Because budget neutral, payment increases provided to professionals with high performance would be offset by payment reductions to poor performing professionals.

Performance Assessment

- Professionals can opt to assess their quality performance at the group level, including the election of virtual groups for practices of ten or fewer.

- In 2014, group-level quality-reporting credit would be available for groups reporting to a quality clinical data registry.

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	25%	25%	25%
Total	100%	100%	100%

Performance Pool Funding

1. For 2017 funding available for VBP incentive 8% of the total estimated spending for VBP
2. The entire funding pool for a year would be paid out to eligible professionals based on their composite score
3. Those achieving the highest scores receiving the greatest incentive payment
4. Funding pool increase to 9% in 2018
5. Funding pool increased to 10% in 2019
6. In 2020, the Secretary has authority to increase, but not lower the funding pool.

Assistance to Small Practices

- Quality Improvement Organizations (QIOs) will provide assistance to practices of ten or fewer eligible professionals located in Health Professional Shortages Area (HPSA) or rural areas.

- Ten million dollars would be available each year from 2014 to 2018 to provide such technical assistance.

Feedback for Performance Improvement

- 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 through web-based portals or qualified clinical data registries.
- This system would replace the current confidential quality and resources use reports.

III. Encouraging APM Participation

Professionals who have:

- a significant share of their revenue in an Alternative Payment Model ,
- that involves two-sided financial risk and
- a quality measurement component

would receive a 5% bonus each year from 2016-2021.

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.

Revenue Threshold for Bonus

First Option:

1. Revenue threshold would be 25% of Medical revenue for 2016-2017
2. The threshold for 2018-2019 is 50% revenue.
3. The threshold for 2020-2021 is 75% revenue

Revenue Threshold for Bonus

Second Option:

Combination Medicare and non-Medicare revenue

- 2018-2019 50% total, all payer revenue through an advance APM, including at least 25% Medicare revenue. Professionals who select the second option must be willing to share their non-Medicare revenue with CMS.

Illustrative Scenario for 2018-2019 Option 1

- $400,000 in total, all-payer revenue
- $100,000 in Medicare revenue

All-Payer Revenue Threshold	50% of Medicare Revenue Threshold
N/A	$50,000 - $100,000

Illustrative Scenario for 2018-2019 Option 2

- At least 50% of total, all-payer revenue through advanced APM
- Including at least 25% of Medicare revenue

50% of All-Payer Revenue	25% of Medicare Revenue	Minimum Amount of Non-Medicare Revenue in APM To Meet All-Payer Threshold
$200,000+	$25,000-$49,999	$150,001 out of $300,000

IV. Encouraging Care Coordination for Complex Chronic Care Needs

- Establish payment for one or more complex chronic care management services beginning in 2013.
- Payments made to physicians, PAs, Nurse Practitioners and Clinical Nurse Specialists'. Practicing in patient-centered medical home.
- One professional or group practice could receive payment for these services provided to an individual.

V. Ensuring Accurate Valuation of Services

Proposal would improve service-level payments under the fee structure. It would do four things:

1. Set target for revaluing misvalued services
2. Allow for collection of additional information to better determine the value of services
3. Smooth downward payment adjustments
4. Direct GAO to study AMA Specialty Society Relative Value Update Committee (RUC) processes for making recommendations on valuation of physician services.

V. Ensuring Accurate Valuation of Services

- In 2016, 2017 and 2018, the target for misvalued services is one percent of estimated expenditures under physician fee schedule.
- If target is met, that amount would be redistributed in a budget-neural manner.

V. Ensuring Accurate Valuation of Services (cont.)

- If target not met, fee schedule payments would be reduced by the difference between the target and the amount of misvalued services identified by year.
- HHS would solicit information from professionals to assist in accurate valuation under fee service. (**Professionals who submit information may be compensated, those who do not will receive a ten percent payment reduction for all services in the subsequent year.)**

VI. Recognizing Appropriate Use Criteria

- Implement a program that would require ordering professionals to consult with "use criteria" for advanced imaging and electrocardiogram services.
- HHS will identify clinical decision support to be used by ordering professionals for appropriate use criteria and providers will report to HHS that the CDS was used.

VI. Recognizing Appropriate Use Criteria (cont.)

- Payment will not be made if consultation with criteria did not occur.
- Prior authorization would apply to outlier professionals whose ordering is inconsistent as compared to peers.

VII. Expanding Medicare Data for Performance Improvement

- This would allow those that currently receive Medicare data for public reporting purposes to provide or sell non-public data analyses to physicians to assist them in their quality improvement activities.
- The proposal would also expand the data available to Qualified entities to include Medicare advantage and Medicaid CHIP data.

VIII. Transparency of Physician Medicare Data

- Proposal requires 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 will assist patients in selecting professionals.
- Professionals would continue to have the opportunity to review and correct their information prior to its posting on the web.