House Energy & Commerce July 18 Discussion Draft – SGR & Other Provisions

Stabilizing Medicare Fee Updates (Phase I): The **SGR would end after 2013**.

- From 2014 to 2018, the **update would be 0.5 percent per year.** In the years from 2019 and beyond, the 0.5 percent annual update would continue, but there would be incentives and potential penalties under the new Update Incentive Program.
- **Scheduled penalties would remain**, under the Value-Based Modifier (**VBM**); Physician Quality Reporting System (**PQRS**); and Electronic Records Meaningful Use (**MU**).

Physician Reporting System to Improve Accuracy of Relative Values: A new "reporting group" of physicians would engage in, and could receive payments for, periodic reporting on the **accuracy of relative values**, including service volume and time. $1 Million would go to the CMS Program Management Account, per fiscal year, for this purpose.

- For fee schedules in 2016, 2017 and 2018, Medicare would have to identify misvalued services and make relative value adjustments resulting in a net reduction in spending of "up to 1 percent." These would not be subject to budget neutrality; these funds would be taken from the pool of spending for Medicare physician services.

Update Incentive Program (UIP) (Phase II): A new Section 1861(q) in the Social Security Act would create a **new quality reporting system** The new UIP would trigger **incentives and offsets, beginning in 2019**, unless a physician or other eligible professional (EP) is in an alternative payment model.

- **Quality Comparison by Peer Cohort:** EPs would select their "Peer Cohort" (by specialty, certification, practice area or disease). Each Cohort would have a "quality measure set" of quality measures and clinical quality improvement activities in five "quality domains" (clinical care; safety; care coordination; patient & caregiver experience; and population health & prevention). Outcome, process, and patient experience measures are encouraged.
- **Relationship to Other Programs:** Starting in 2019, **UIP Peer Cohort final quality measure sets would replace PQRS quality measures.** But **PQRS reporting and penalties would remain** in force. Several provisions require alignment of various aspects (including group reporting) with existing programs (PQRS, MU, Physician Compare, and resource use reports under the Physician Feedback program).
- **Quality Adjustments: Are based on composite scores,** compared with those for the selected Peer Cohort: 1 % incentive payment for scores of 67% or higher; 0 adjustment for scores from 34 to below 67%; and a 1 % offset for scores below 34%.
- **Failure to Report:** Would cut reimbursement to **95% of the fee schedule amount,** starting in 2019, unless the annual "caseload" is below a minimum threshold.
- **Timely quarterly feedback reporting** would be required at the individual level, via an electronic interactive mechanism.
- **$100 million** from the Medicare Trust Fund would go to administer the UIP.

Alternative Payment Models (APMs): A new process for development, testing, and approval of APMs would begin in 2015.

- An unspecified "independent entity" with appropriate expertise would evaluate APM proposals and recommend which move forward for testing and final approval by the Secretary of HHS.
- APM proposals would require a demonstration project of at least 3 years, unless already substantially evaluated or this requirement is waived. The rules on timing of decisions on applications, recommendations, and approval of APM are very loose, so these could take years. They would have to reduce spending and increase quality of care, to be approved.
- Participation in an APM would constitute satisfactory quality reporting for UIP and PQRS. However, payment adjustments for MU and quality reporting would apply to APM payments.

- **$2 billion** from the Medicare Trust Fund would go to the APM program, including payments to APMs. No more than 2.5 percent ($45 million) would go to the "contracting entity."

Expanding Availability of Medicare Data: Section 3 of the bill would increase access and use of Medicare claims data by:

- Allowing qualified entities to use the data for "additional analyses (as determined appropriate by the Secretary of Health and Human Services)." The qualified entities would not have to publicly report these analyses, as required by current law, but could sell them to providers and suppliers.
- Providing claims data (in a form and manner TBD) to a) suppliers and providers to facilitate the development of new models of care; and b) qualified clinical data registries for purposes of linking such data with other information to support quality improvement.

Medical Liability/Standards of Care: The **bill incorporates language from the Standard of Care Protection Act**, which AMA has supported to limit medical liability claims. This language prevents provisions from the Affordable Care Act from establishing health care provider standards of care in medical malpractice cases.

Care Coordination and Medical Homes: The bill calls for codes and reimbursement for complex chronic care management services by practices certified as medical homes or a "patient-centered specialty practice" by the National Committee for Quality Assurance (NCQA), or an equivalent certification.

Additional Reports and Evaluations: MedPAC (the Medicare Payment Advisory Commission) and the Government Accountability Office would be required to evaluate and issue reports on the UIP, APMs, and certain other provisions of the bill.