Modifications to the October 30th, Bipartisan, Bicameral Discussion Draft to Repeal the SGR and Reform Medicare Physician Payment

Below is a description of changes to the October 30 discussion draft made in response to feedback from physician organizations and other stakeholders. These changes do not preclude additional future changes.

SGR Repeal and Annual Updates

- Two Medicare Payment Advisory Commission reports to Congress in 2016 and 2020 studying the relationship between professional spending and utilization of professional services paid under Medicare Part B, and total expenditures under Medicare Parts A, B, and D.
    - These reports will show how efforts by professionals to ensure appropriate utilization impact total program spending.

Single, Consolidated Incentive Program, the Value-Based Performance (VBP) Program

VBP Funding Pool Amount

- The funding pool change is shown in table below. This phase-in approach allows professionals time to adjust to the single, consolidated incentive program (while tying less payment to performance than under current law in the initial years of the program).

	Proposal	Revised Proposal
2017	8%	4%
2018	9%	6%
2019	10%	8%
2020	Secretary has discretion to increase above 10%	10%
2021		Secretary has discretion to increase above 10% but not more than 12%

Maximum Upside Adjustment

- Establishes maximum upside incentive equal to the pool funding percentage (e.g., +4% in 2017). The downside risk for any individual professional, as stated in the initial proposal, continues to be no lower than the incentive pool funding percentage (e.g., -4% in 2017). Capping the upside incentive provides certainty over the range of payments professionals receive.

Reducing Lag Times

- Reduces lag times by requiring that the performance period be as close as possible to the payment year.

Performance Categories

- Professionals receive credit for improvement from one year to the next in the determination of their quality and resource use performance category score. The

Secretary may give credit for improvement in the other two performance categories. This responds to the concern that assessing performance only on achievement pits professionals against each other.

- Makes explicit that measures used in qualified clinical data registries can be used to assess quality performance even if they do not have consensus-based entity endorsement.
- Adds activities to the illustrative list in the clinical practice improvement category that would be attainable for surgeons and other specialists (e.g., using a clinical quality data registry, following surgical checklists, conducting a maintenance of certification practice assessment, use of shared-decision making mechanisms).
- Requires the Secretary to issue a request-for-information to solicit recommendations for selecting and specifying the criteria for clinical practice improvement activities.
- Requires the Secretary to take into consideration the circumstances of small practices and practices located in rural areas and HPSAs in establishing clinical practice improvement activities.
- As feasible and applicable, accounts for the cost of covered Part D drugs in the resource use performance category.
- Requires GAO to report to Congress on alignment of quality measures in Medicare fee-for-service, Medicare Advantage, and private sector and make recommendations on how to reduce professional administrative burden.

Professionals to Which VBP Program Applies

Include nurse practitioners, clinical nurse specialists, physician assistants, and certified registered nurse anesthetists in the VBP program starting in 2017 (rather than 2018).

Technical Assistance

- Increases the annual funding in 2014-2018 to $25 million, up from $10 million. Makes all small practices (10 or fewer eligible professionals) eligible for technical assistance to help succeed in the VBP or move to an APM. Priority for this funding will be given to small practices with low composite scores or practices in rural areas or HPSAs. Technical assistance could be provided through quality improvement organizations, regional extension centers, regional health collaboratives, and other appropriate entities.

Studies of VBP Impact

- Requires GAO to evaluate the VBP in 2018 and 2021, including an assessment of the provider types, practice sizes, practice geography, and patient mix that are receiving payment increases and reductions.

Encouraging Alternative Payment Model Participation

- Changes the six-year period that APM participation bonuses are available from 2016-2021 to 2017-2022 to give professionals more time to prepare.
- Creates a new "partial qualifying APM participant" category for professionals who come within a narrow margin of qualifying APM participation. Based on stakeholder concerns regarding the retrospective determination of APM participation, these partial qualifying APM participants will have the option of: 1) reporting VBP quality measures and receiving the corresponding incentive payment; or 2) not participating in the VBP

program and receiving no payment adjustment. The partial qualifying APM participant revenue thresholds are:
    - 2017-2018: 20% of Medicare revenue
    - 2019-2020: 40% of Medicare revenue or 40% of all-payer revenue and 20% of Medicare revenue
    - 2021 and subsequent years: 50% of Medicare revenue or 50% of all-payer revenue and 20% of Medicare revenue
- Clarifies that Medicare Advantage (MA) contracts that involve risk for the professional are counted toward the all-payer threshold that triggers the 5% APM participation bonus payment.
- Encourages the testing of models relevant to specialist physicians.

Ensuring Accurate Valuation of the Physician Fee Schedule

- Reduces the target for finding misvalued services from 1% to 0.5% from 2015-2018 and count amounts found in excess of the target in one year toward the next year's target.
- Removes the 10% penalty for failure to provide requested information but retains incentive payments for participation in data collection.
- Removes the global surgical payments provision.

Measure Development

- Increases annual funding for professional quality measure development from $10 million to $15 million per year from 2014-2018.

Timely Feedback and More Efficient Two-Way Communication

- Expands the scope of information CMS would provide through the physician feedback program (likely a web-portal).
- Enables professionals to submit other information (e.g., quality measures) to CMS through the web-portal to reduce the administrative burden on professionals.

Promoting Evidence-Based Care through Appropriate Use Criteria

- Redefines applicable imaging services as an advance diagnostic imaging service under section 1834(e)(1)(B) of the Social Security Act, for which there are one or more applicable appropriate use criteria and one or more qualified clinical decision support mechanisms that are free of charge.
- The Secretary may require that clinical decision support mechanisms are capable of providing aggregate feedback to ordering professionals.
- Exceptions to the requirement to consult with appropriate use criteria will be made for imaging services ordered in an emergency situation, imaging services paid under Part A, imaging services ordered by a professional for patients attributed to an eligible APM, or for ordering professionals who face significant hardship (e.g., lack of Internet access).
- Requires the Secretary to obtain input from stakeholders through an Advanced Notice of Proposed Rulemaking before establishing an appropriate use program for other Part B services.

- Requires GAO to make recommendations to Congress on other services that could benefit from use of clinical decision support mechanisms.

Expansion of Availability of Claims Data

- Allows Qualified Entities (QE) to provide or sell analyses to medical societies and hospital associations in addition to employers, insurers, and providers.
- When directly identified in a non-public analysis, providers will have an opportunity to review and submit corrections before the QE sells the analysis to other entities.
- Allows QEs to give providers, medical societies, and hospital associations access to claims data through a qualified data enclave (e.g., web-based portal). QEs must de-identify data, except for services rendered by the provider accessing the data enclave.
- MA encounter data will not be made available.

Transparency of Physician Medicare Data

- The Physician Compare website will indicate, where appropriate, that publicized information may not be representative of the eligible professionals entire patient population, variety of services furnished, or the health conditions of the individuals treated.