# Health Policy and Legislation Alert

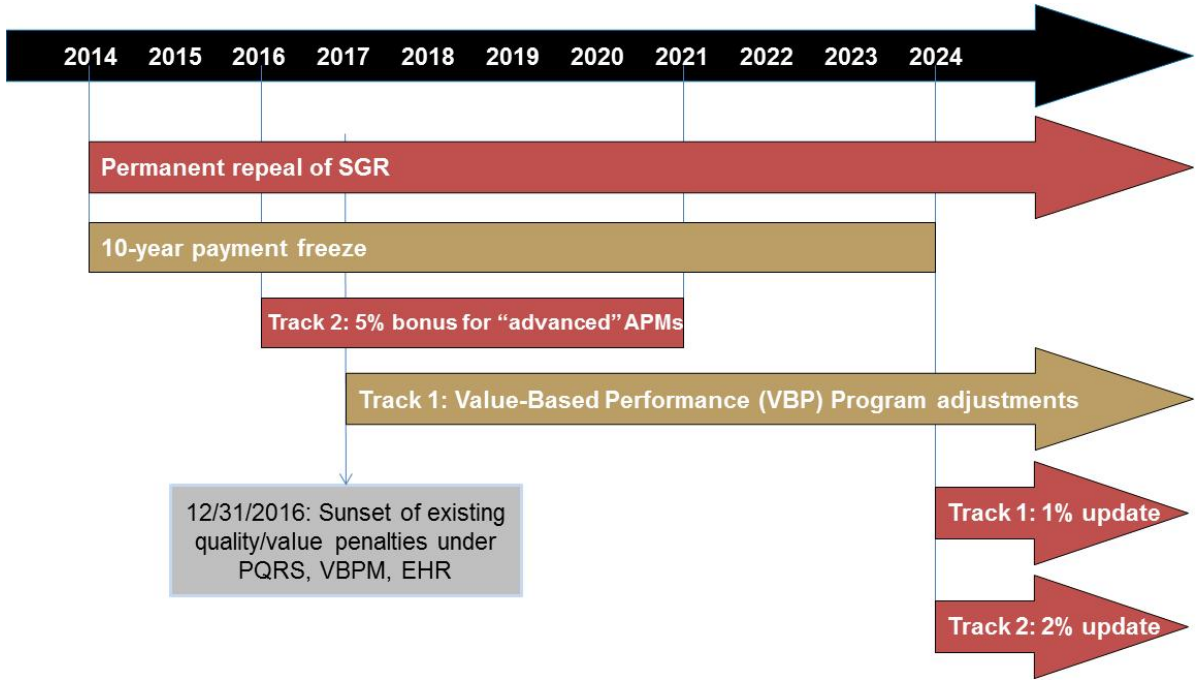
**November 4, 2013**

## Senate Finance And House Ways & Means Committees Release Bicameral, Bipartisan Proposal To Reform Physician Payment System

On October 30, 2013, the Senate Finance Committee and the House Ways & Means Committee released a bicameral, bipartisan discussion draft outlining a proposal to permanently repeal the sustainable growth rate (SGR) mechanism and reform the physician payment system. In addition to payment system reform, the draft proposal makes a number of other payment policy changes impacting care coordination and valuation of services, and would expand access to and transparency of Medicare data. The Congressional Budget Office has scored repeal of the SGR at $139.1 billion over 10 years. The draft does not include any potential offsets to this cost, nor does it include other Medicare extenders that may be part of the final package.

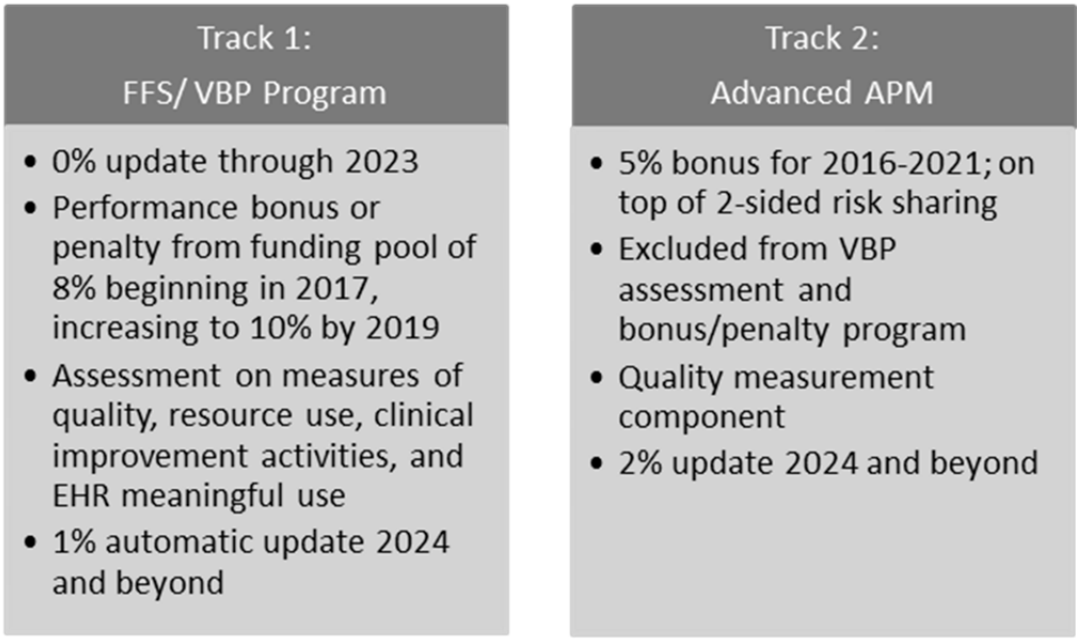
### SGR Repeal and Reform

The proposal would eliminate the SGR, and freeze physician payments at current levels for 10 years (2014-2023). The proposal would also reform the current physician payment system by combining and strengthening existing quality and value incentive programs and encouraging physicians to participate in alternative payment models (APMs). The proposal would create two tracks for physicians and other professionals traditionally paid under the physician fee schedule: "Track 1," a mandatory value-based performance (VBP) program; and "Track 2," a bonus program for risk-sharing APMs. The new system would be phased in over a number of years.



On the first track, physicians and groups would continue to be paid under the physician fee schedule, and payments would be subject to performance adjustments under a new Value Based Performance (VBP) Program that combines the existing incentive/penalty programs (i.e., the Physician Quality Reporting System (PQRS), the value-based payment modifier (VBPM) and the electronic health record (EHR) incentive program). On the second track are "advanced" APMs which are exempt from the new VBP program and are eligible for a 5% annual bonus from 2016 to 2021.




**Track 1: Physician Fee Schedule w/ Value-Based Performance (VBP) Program**

Beginning in 2017, fee schedule payments would be adjusted based on a single, budget-neutral incentive payment program. The payment pool would be 8% of total estimated spending for VBP eligible professionals for 2017, 9% for 2018, and 10% for 2019, and the Secretary would have the authority to increase (but not decrease) the amount of funding beginning in 2020. In contrast to existing penalty/incentive programs, all amounts withheld through penalties would be re-distributed to high-performers.

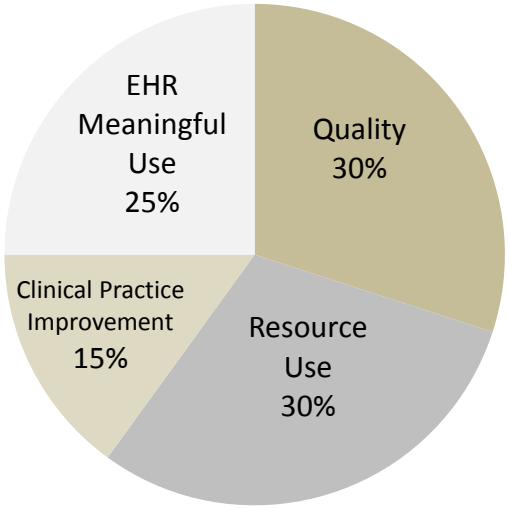
The program would exclude: (1) professionals who treat few Medicare patients; and (2) professionals in "advanced" APMs who receive a significant portion of their revenue from an APM. The program would assess performance based on *quality, resource use, clinical practice improvement activities, and EHR meaningful use*.

- *Quality* – The program would use PQRS and other measures developed through an annual recommendation process. This category would account for 15-45% of the total score for 2017 and 2018, and 30% beginning in 2019.

- *Resource use* **–** The program would use the same cost/efficiency metrics as currently used in the value-based payment modifier (VBPM) program. This category would be weighted as 15-45% of the total score for 2017 and 2018, and 30% beginning in 2019.
- *Clinical practice improvement activities* – The program would also score professionals based on their completion of clinical improvement activities. This category would account for 15% of the total composite score.
- *EHR meaningful use* – The program would use existing requirements for meaningful use of a certified EHR. This category would account for 25% of the total composite score.

**Weighting for VBP Program Composite Score (2019)**




Professionals would be scored in each category, and receive one composite score. The composite score would dictate the amount of the upward or downward adjustment. Professionals can opt to assess their quality performance at the group level, but the proposal would allow the Secretary to permit group assessments for other categories as well.

### Track 2: "Advanced" Alternative Payment Models

From 2016 to 2021, a 5% bonus will be available for professionals where (1) the professionals receive a "significant share" of revenues through APMs, (2) the APMs involve two-sided financial risk and (3) the APMs have a quality measurement component. The proposal specifies various percentage thresholds a professional's APM revenue must meet in order to be considered a "significant share." For 2018 through 2021, professionals may choose from one of two thresholds – Option 1, a threshold that considers only Medicare revenue; or Option 2, a threshold that considers all payer revenue.

| **Percentage of revenue that must be earned through APM to be considered an "advanced" APM** | | |
|---|---|---|
| **2016-2017** | **Option 1: Medicare threshold** | **Option 2: All-payer threshold** |
| 25% Medicare | 2018-2019: 50% Medicare | 2018-2019: 50% all-payer, including 25% Medicare |
| | 2020-2021: 75% Medicare | 2020-2021: 75% all-payer, including 25% Medicare |

Professionals in advanced APMs would be excluded from the VBP composite assessment. The proposal also encourages the Secretary to test APMs for specialist professionals and those that align with private and state-based payer initiatives.

## Other Part B Payment and Related Policies

### Coordinated Care Codes

The proposal also would establish payment codes for complex care management services beginning in 2015. The proposal notes that these payments could be available to professionals practicing in a patient-centered medical home or a certified specialty practice.

### Mis-valued Services

The proposal would require the Secretary to identify and revalue mis-valued services, and would set a 1% target for identifying over-valued services. If this target is met, amounts taken away from over-valued services would be redistributed in a budget-neutral manner within the fee schedule. The proposal notes that an estimated $3 billion in reduced expenditures would be redistributed to other fee schedule services. If the target is not met, fee schedule payments would be reduced by the difference between the target and the amount of mis-valued services identified that year.

### Medicare Data

The proposal calls for an expansion of the Qualified Entity (QE) program to allow QEs that currently receive Medicare data for public performance reports to provide or sell Medicare data analyses to downstream users for non-public purposes. The proposal also calls for the Department of Health and Human Services to publish utilization and payment data for physicians on the Physician Compare website.

## Contact Information

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