

CBO score expected before introduction  
estimate +/- \$128 billion (no extenders)

## SGR Repeal and Medicare Provider Payment Modernization Act

Section by Section

5 yr of QI extended

### Sec. 1. Short Title; Table of Contents

### Sec. 2. Repealing the Sustainable Growth Rate (SGR) and Improving Medicare Payment for Physicians' Services.

This section repeals the SGR to provide long-term stability to the Medicare physician fee schedule. It provides stable updates for five years and ensures no changes are made to the current payment system for four years. In 2018, it establishes a streamlined and improved incentive payment program that will focus the fee-for-service system on providing value and quality. The incentive payment program, referred to as the Merit-Based Incentive Payment System (MIPS), consolidates the three existing incentive programs, continuing the focus on quality, resource use, and meaningful electronic health record (EHR) use with which professionals are familiar, but in a cohesive program that avoids redundancies. Further, this section provides financial incentive(s) for professionals to participate in tests of alternative payment models (APMs).

#### Stabilizing Fee Updates

The flawed SGR mechanism is permanently repealed, averting a 23.7 percent SGR-induced cut scheduled for April 1, 2014. Professionals will receive an annual update of 0.5 percent in each of 2014 through 2018. The rates in 2018 will be maintained through 2023, while providing professionals with the opportunity to receive additional payment adjustments through the MIPS. In 2024 and subsequent years, professionals participating in APMs that meet certain criteria would receive annual updates of one percent, while all other professionals would receive annual updates of 0.5 percent.

The Medicare Payment Advisory Commission (MedPAC) is required to submit reports to Congress in 2018 evaluating the impact that the 2014-2018 updates on beneficiary access and quality of care, with recommendations regarding further updates. Further, MedPAC will submit reports to Congress in 2017 and 2021 that assess the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D. These reports recognize the critical role that professionals have in directing care and utilization by evaluating their impact on total program spending, including under the MIPS program.

#### Consolidating Current Law Programs into a unified MIPS

Payments to professionals will be adjusted based on performance in the unified MIPS starting in 2018. The MIPS streamlines and improves on the three distinct current law incentive programs:

- The Physician Quality Reporting System (PQRS) that incentivizes professionals to report on quality of care measures;
- The Value-Based Modifier (VBM) that adjusts payment based on quality and resource use in a budget-neutral manner; and

- Meaningful use of EHRs (EHR MU) that entails meeting certain requirements in the use of certified EHR systems.

#### Sunsetting Current Law Incentive Program Payment Implications

The payment implications associated with the current law incentive program penalties are sunset at the end of 2017, including the 2 percent penalty for failure to report PQRS quality measures and the 3 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR MU requirements. The money from penalties that would have been assessed would now remain in the physician fee schedule, significantly increasing total payments compared to the current law baseline.

#### Professionals to Whom MIPS Applies

The MIPS will apply to: doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in 2018. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2020, provided there are viable performance metrics available. Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from eligible APM(s) will be excluded from the MIPS.

#### MIPS Assessment Categories

The MIPS will assess the performance of eligible professionals in four categories: quality; resource use; EHR Meaningful Use; and clinical practice improvement activities.

1. **Quality.** Measures used for this performance category will be published annually in the final measures list developed under the methodology specified below. In addition to measures used in the existing quality performance programs (PQRS, VBM, EHR MU), the Secretary would solicit recommended measures and fund professional organizations and others to develop additional measures. Measures used by qualified clinical data registries may also be used to assess performance under this category.
2. **Resource Use.** The resource use category will include measures used in the current VBM program. The methodology that CMS is currently developing to identify resources associated with specific care episodes would be enhanced through public input and an additional process that directly engages professionals. The additional process allows professionals to report their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode). This additional process addresses concerns that algorithms and patient attribution rules fail to accurately link the cost of services to a professional. Resource use measurement would also reflect additional research and recommendations on how to improve risk adjustment methodologies to ensure that professionals are not penalized for serving sicker or more costly patients.
3. **Meaningful Use.** Current EHR Meaningful Use requirements, demonstrated by use of a certified system, will continue to apply in order to receive credit in this category. To

prevent duplicative reporting, professionals who report quality measures through certified EHR systems for the MIPS quality category are deemed to meet the meaningful use clinical quality measure component.

4. **Clinical Practice Improvement Activities.** Professionals will be assessed on their effort to engage in clinical practice improvement activities. Incorporation of this new component gives credit to professionals working to improve their practices and facilitates future participation in APMs. The menu of recognized activities will be established in collaboration with professionals. Activities must be applicable to all specialties and attainable for small practices and professionals in rural and underserved areas.

#### Annual List of Quality Measures Used in MIPS

Every year, the Secretary, through notice and comment rulemaking, will publish a list of quality measures to be used in the forthcoming MIPS performance period. Updates and modifications to the list of quality measures will also occur through this process. Eligible professionals will select which measures on the final list to report and be assessed on.

Eligible professional organizations and other relevant stakeholders will identify and submit quality measures to be considered for selection and to identify and submit updates to the measures already on the list. Measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by a consensus-based entity that holds a contract with the Centers for Medicare and Medicaid Services (CMS). Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity must be evidence-based.

To the extent practicable, quality measures selected for inclusion on the final list will address all five of the following quality domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. Before including a new measure in the final list, the Secretary will submit the measure for publication in an applicable specialty-appropriate peer-reviewed journal, including the method for developing and selecting the measure.

Qualified clinical data registry measures, many of which are maintained by physician specialty organizations, and existing quality measures will not be subject to these additional requirements and will be automatically included in the first program year's final list of quality measures. These measures will remain in the MIPS program unless they are removed under the rulemaking process.

#### Composite Performance Score

Professionals will receive a composite performance score of 0-100 based on their performance in each of the four performance categories listed above. Professionals will only be assessed on the categories, measures, and activities that apply to them. Scoring weights for performance categories, measures, and activities may be adjusted as necessary, to account for a professional's ability to successfully report on such category measure or activity and to ensure that individuals are measured on an equitable basis.

*Prepared by the House Committees on Energy & Commerce and Ways & Means and the Senate Committee on Finance Staff*

*February 6, 2014*

To incentivize improved performance, professionals will also receive credit for improvement from one year to the next in the determination of their quality and resource use performance category score and may receive credit for improvement in clinical practice improvement activities.

#### MIPS Payment Adjustment

Each eligible professional's composite score will be compared to a performance threshold. The performance threshold will be the mean or median of the composite performance scores for all MIPS eligible professionals during a period prior to the performance period. Professionals will know what composite score they must achieve to obtain incentive payments and avoid penalties at the beginning of each performance period.

Payment adjustments will follow a linear distribution. Eligible professionals whose composite performance scores fall above the threshold will receive positive payment adjustments and eligible professionals whose composite performance scores fall below the threshold will receive negative payment adjustments.

- Negative adjustments – Negative payment adjustments will be capped at four percent in 2018, five percent in 2019, seven percent in 2020, and nine percent in 2021. Eligible professionals whose composite performance score falls between 0 and  $\frac{1}{4}$  of the threshold will receive the maximum possible negative payment adjustment for the year. Professionals with composite performance scores closer to the threshold will receive proportionally smaller negative payment adjustments. These negative payment adjustments for eligible professionals whose composite performance scores fall below the threshold will fund positive payment adjustments to professionals with composite performance scores above the threshold.
- Zero adjustments – Eligible professionals whose composite performance score is at the threshold will not receive a MIPS payment adjustment.
- Positive adjustments – Eligible professionals whose composite performance scores are above the threshold will receive positive payment adjustments. Eligible professionals with higher performance scores will receive proportionally larger incentive payments up to a maximum of three times the annual cap for negative payment adjustments.
  - Additional Incentive Payment – An additional performance threshold for exceptional performance will be set at the 25<sup>th</sup> percentile of the range between the initial performance threshold and 100 (e.g., if the performance threshold is a score of 60, the additional performance threshold would be a score of 70) or the 25<sup>th</sup> percentile of actual composite performance scores for MIPS eligible professionals with composite scores at or above the initial performance threshold (i.e., 75 percent of professionals who receive a positive payment adjustment would receive an additional payment adjustment). Eligible professionals with composite scores above the additional performance threshold will receive an

additional incentive payment. Aggregate additional incentive payments will be capped at \$500 million per year for each of 2018 through 2023. Additional incentive payments will be allocated according to a linear distribution, with better performers receiving larger incentive payments. These payments will enable some professionals to receive incentive payments even if all professionals score above the initial threshold.

A professional's payment adjustment in one year will have no impact on their payment adjustment in a future year.

The Government Accountability Office (GAO) is required to evaluate the MIPS and issue reports in 2018 and 2021, including an assessment of the professional types, practice sizes, practice geography, and patient mix that are receiving MIPS payment increases and reductions.

#### Expanded Participation Options and Tools to Enable Success

Professionals will have the flexibility to participate in MIPS in a way that best fits their practice environment. These options include: use of EHRs, use of qualified clinical data registries maintained by physician specialty organizations, and the option to be assessed as a group, as a "virtual" group, or with an affiliated hospital or facility.

Technical assistance will be available to help practices with 15 or fewer professionals improve MIPS performance or transition to APMs. Priority will be given to practices with low MIPS scores and those in rural and underserved areas. Funding will be \$40 million annually from 2014 to 2018, with \$10 million reserved for practices in areas designated as health professional shortage areas or medically underserved areas.

Professionals will receive confidential feedback on performance in the quality and resource use categories at least quarterly, likely through a web-based portal. Professionals may also receive confidential feedback on performance through qualified clinical data registries.

#### Encouraging Participation in APMs

Professionals who receive a significant share of their revenues through an APM(s) that involves risk of financial losses and a quality measurement component will receive a five percent bonus each year from 2018-2023. A patient-centered medical home APM will be exempted from the downside financial risk requirement if proven to work in the Medicare population. Two tracks will be available for professionals to qualify for the bonus. The first option will be based on receiving a significant percent of Medicare revenue through an APM; the second will be based on receiving a significant percent of APM revenue combined from Medicare and other payers. The second option makes it possible for professionals to qualify for the bonus even if Medicare APM options are unavailable in their area. If no Medicaid APM is available in a state, a professional's Medicaid revenue will not be counted against the proportion of revenue in an APM. In states where Medicaid APMs are available, Medicaid medical homes will also be exempted from downside financial risk if they are proven to work in the Medicaid population.

Professionals who meet these criteria will be excluded from the MIPS assessment and most EHR

meaningful use requirements.

The bonus payment for APM participation encourages professionals to consider participation and testing of new APMs, recognizes that practice changes are needed to facilitate such participation, and promotes the alignment of incentives across payers.

To make the bonus opportunity available to the greatest number of professionals, the Secretary is specifically encouraged to test APMs relevant to specialty professionals, professionals in small practices, and those that align with private and state-based payer initiatives. Further, a Technical Advisory Committee will be established to consider physician-focused APM proposals. CMS would be required to provide a detailed response to TAC-recommended APMs. The section also requires HHS to identify potential fraud vulnerabilities in APMs.

### **Sec. 3. Priorities and Funding for Quality Measure Development**

#### Measure Development Plan

Gaps in quality measurement programs will be addressed to ensure meaningful measures on which to assess professionals and funding will be provided for measure development priorities. The Secretary, with stakeholder input, is required to develop and publish a plan for the development of quality measures for use in the MIPS and in APMs, taking into account how measures from the private sector and integrated delivery systems could be utilized in the Medicare program. The plan, which must be finalized by May 1, 2015, will prioritize outcome measures, patient experience measures, care coordination measures, and measures of appropriate use of services, and consider gaps in quality measurement and applicability of measures across health care settings. The Secretary will contract with entities, which could include physician organizations, to develop priority measures and focus on measures that can be reported through an EHR.

#### Annual Report

By May 1, 2016, and annually thereafter, the Secretary is required to report on the progress made in developing quality measures. The report will include descriptions of the number of measures developed, including the name and type of each measure. The report will also include descriptions of the measures under development, including an estimated timeline for completion of such measures, as well as quality areas being considered for future measure development.

#### Funding

Funding will be \$15 million annually in 2014 to 2018 for professional quality measure development. The funding will remain available through fiscal year 2021.

### **Sec. 4. Encouraging Care Management for Individuals with Chronic Care Needs**

In order to encourage the management of care for individuals with chronic conditions, at least one payment code for care management services will be established for professionals treating such individuals. Payment for such services will be made to professionals practicing in a patient-centered medical home or comparable specialty practice certified by an organization(s)

*Prepared by the House Committees on Energy & Commerce and Ways & Means and the Senate Committee on Finance Staff*

*February 6, 2014*

recognized by the Secretary. In order to prevent duplicative payments, only one professional or group practice will receive payment for these services provided to an individual during a specified period. Payment for these codes will be budget-neutral within the physician fee schedule. Finally, payments for chronic care management would not require that an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.

## **Sec. 5. Ensuring Accurate Valuation of Services Under the Physician Fee Schedule**

*No change*

### Collection of Information to Assist in Accurate Valuation of Services

The Secretary is permitted to collect information from professionals and other providers and suppliers to assist in accurate valuation of service-level payments under the fee schedule. Such information may include: practice expense inputs, time involved in furnishing services, cost and charge data, and other elements the Secretary believes can be used to improve the valuation of services. The information may be collected via such mechanisms as surveys, practice logs, facility records, electronic health records, etc. The Secretary may only use this information in valuing services through notice and comment rulemaking. Starting in 2014, \$2 million in annual funding is available to compensate professionals who submit the requested information.

### Potentially Misvalued Codes

The list of criteria the Secretary can use to identify potentially misvalued services is expanded to include codes: that account for a majority of spending under the physician fee schedule; with substantial changes in procedure time; for which there may be a change in the site of service or a significant difference in payment between sites of service; services that may have greater efficiencies when performed together; or, with high practice expenses or high cost supplies.

The legislation sets an annual target for identifying misvalued services of 0.5 percent of the estimated amount of fee schedule expenditures in 2015, 2016, 2017, and 2018. If the target is met, that amount is redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments for the year are reduced by the difference between the target and the amount of misvalued services identified in a given year. If the target is exceeded, the amount in excess of the target is credited toward the following year's target.

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) will be phased-in over a two-year period.

The Secretary is provided authority to smooth RVUs within a group of services, and GAO is required to study the AMA/Specialty Society Relative Value Scale Update Committee (RUC) processes for making recommendations on the valuation of physician services. The report is due no later than one year after enactment.

### Adjustment to Medicare Payment Localities in California

Beginning January 1, 2017, fee schedule areas used for payment in California will transition from county-based localities, which have not been updated in 16 years, to Metropolitan

Statistical Areas (MSAs), which are updated annually by the Office of Management and Budget (OMB) and used to organize and pay hospitals under the Medicare program. Payments for such areas shall transition over a six-year period. This modification would hold harmless professionals in certain transitional payment localities from negative payment adjustments.

## **Sec. 6. Promoting Evidence-Based Care**

### Selection of Appropriate Use Criteria

The Secretary is required to establish a program that promotes the use of appropriate use criteria (AUC) for advanced diagnostic imaging. In consultation with stakeholders, and no later than November 15, 2015, the Secretary will specify one or more AUC(s) from among those developed or endorsed by national professional medical specialty societies, taking into account whether such criteria have stakeholder consensus, are evidence-based, and are based on publicly available studies. The Secretary would not be permitted to develop or initiate the development of clinical practice guidelines or appropriate use criteria.

### Selection of Qualified Clinical Decision Support (CDS) Mechanisms

In consultation with stakeholders, and no later than April 1, 2016, the Secretary will identify and publish a list of qualified CDS mechanisms, at least one of which must be free of charge, that could be used by ordering professionals to consult with applicable appropriate use criteria. Such mechanisms may be included in or independent from certified EHR technology and must: make available the applicable AUC(s) and supporting documentation; indicate the AUC(s) being used when more than one is available; determine the extent to which an imaging order follows the AUC(s); provide documentation to the ordering professional that such consultation occurred; be updated to reflect revisions to the AUC(s); and meet applicable privacy and security standards. The mechanism may be required to provide feedback to the ordering professional regarding that professional's aggregate adherence to applicable AUC(s).

### Consultation with Qualified CDS Mechanisms

Beginning January 1, 2017, payment will only be made to the furnishing professional for an applicable advanced diagnostic imaging service if the claim for such service includes information: 1) showing that the ordering professional consulted with a qualified CDS mechanism; 2) as to whether the ordered service adheres to the applicable AUC(s); and 3) regarding the national provider identifier (NPI) of the ordering professional. The requirement to consult with AUC(s) does not apply to imaging services: ordered for an individual with an emergency medical condition as defined under EMTALA; paid under Part A; ordered by professionals for individuals attributed to a APM that meets certain criteria; or ordered by professionals who meet hardship criteria, such as lack of Internet access.

### Prior Authorization

Beginning with 2017, and in consultation with stakeholders, the Secretary will identify ordering professionals with low adherence to applicable AUC(s) ("outliers") based on two years of data. Beginning January 1, 2020, outlier physicians shall be subject to prior authorization for applicable imaging services. Not more than five percent of ordering physicians can be subject to

prior authorization. The legislation provides CMS with \$5 million in each of 2019, 2020, and 2021 to carry out the prior authorization program.

GAO is required to provide a report to Congress no later than 18 months after enactment of this legislation regarding other Part B services for which the use of clinical decision support mechanism would be appropriate, such as radiation therapy and clinical diagnostic laboratory services.

### **Sec. 7. Empowering Beneficiary Choices through Access to Information on Physician Services**

*Unchanged*

Not later than July 1, 2015, for physicians and July 1, 2016, for other professionals, in addition to the quality and resource use information that would be posted through the MIPS, the Secretary is required to publish utilization and payment data for professionals on the Physician Compare website. With emphasis on the services a professional most commonly furnishes, such information will include the number of services furnished and submitted charges and payments for such services and will be searchable by the eligible professional's name, provider type, specialty, location, and services furnished.

The website will indicate, where appropriate, that information may not be representative of the eligible professionals entire patient population, variety of services furnished, or the health conditions of the individuals treated. Professionals will to have an opportunity to review and correct this information prior to its posting on the website.

### **Sec. 8. Expanding Claims Data Availability to Improve Care**

#### Qualified Entities

Consistent with relevant privacy and security laws, entities that currently receive Medicare data for public reporting purposes (qualified entities, "QEs") will be permitted to provide or sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them in their quality improvement activities or in developing APMs. Any data or analyses must be de-identified, though the provider accessing the data or analysis can receive identifiable information on the services furnished to his or her patient. QEs will be permitted to provide or sell non-public analyses to health insurers (who provide claims data to the QE) and self-insured employers (only for purposes of providing health insurance to their employees or retirees). Providers identified in such analyses will have an opportunity to review and submit corrections before the QE provides or sells the analysis to other entities.

To ensure the privacy, security, and appropriate use of Medicare claims information, QEs must: have a data use agreement with providers and entities to which they provide data; and be subject to an assessment for breach of such agreement. Further, providers and entities receiving data and analyses are prohibited from re-disclosing them or using them for marketing.

QEs that provide or sell analyses or data shall provide an annual report to the Secretary that provides an accounting of: 1) the analyses provided or sold, including the number of analyses

and purchasers, the amount of fees received, and the topics and purposes of the analyses; and 2) a list entities that were provided or sold data, the uses of that data, and the fees received by the QE for such data. The claims data available to QEs will also include Medicaid/CHIP data.

#### Qualified Clinical Data Registries

Consistent with relevant privacy and security laws, the Secretary is required to make data available, for a fee that covers the cost of preparing the data, to requesting qualified clinical data registries to support quality improvement and patient safety activities. Providers identified in public reports will have an opportunity to review and submit corrections.

### **Sec. 9. Reducing Administrative Burden and Other Provisions**

#### Rule of Construction Regarding Standard of Care

Provides that the development, recognition, or implementation of any guideline or other standard under any Federal health care provision, including Medicare, cannot be construed to establish the standard of care or duty of care owed by a health care professional to a patient in any medical malpractice or medical product liability action or claim. This ensures that MIPS participation cannot be used in liability cases. This provision would not preempt any state or common law governing medical professional or medical product liability actions or claims.

#### Other Provisions

- Allows professionals who opt-out of Medicare to automatically renew at the end of each two-year cycle.
- Requires regular reporting of opt-out physician characteristics.
- Requires that Electronic Health Records (EHR) be interoperable by 2017 and prohibits providers from deliberately blocking information sharing with other EHR vendor products. New date  
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- Requires the Secretary to issue a report recommending how a permanent physician-hospital gainsharing program can best be established.
- Requires GAO to report on barriers to expanded use of telemedicine and remote patient monitoring.
- Requires the Secretary to publish information used to establish the multiple procedure payment reduction policy for imaging.

## **REPEALING AND REPLACING THE SGR**

- The Sustainable Growth Rate (SGR) formula is a budget cap passed into law in 1997 to control physician spending, but it has failed to work.
- Since 2003, Congress has spent nearly \$150 billion in short term patches to avoid unsustainable cuts imposed by the flawed SGR. The most recent patch will expire on March 31<sup>st</sup>.
- Building on bipartisan legislation unanimously reported out of the House Energy & Commerce and Ways & Means Committees, and reported out of the Senate Finance Committee, the unified legislation from the three committees repeals the SGR and transitions Medicare away from a volume-based system towards one based on value.

### **Repeals the SGR and provides stability and 5 years of payment updates**

- Repeals the SGR and replaces it with a system focused on quality, value, and accountability.
- Removes the imminent threat of draconian cuts to Medicare providers and ensures a 5-year period of annual updates of 0.5 percent to transition to the new system.

### **Improves the existing fee-for-service system by rewarding value over volume and ensuring payment accuracy**

- Consolidates the three existing quality programs into a streamlined and improved program that rewards providers who meet performance thresholds, improve care for seniors, and provide certainty for providers.
- Implements a process to improve payment accuracy for individual provider services.
- Incentivizes care coordination efforts for patients with chronic care needs.
- Introduces physician-developed clinical care guidelines to reduce inappropriate care that can harm patients and results in wasteful spending.
- Requires development of quality measures and ensures close collaboration with physicians and other stakeholders regarding the measures used in the performance program.

### **Incentivizes movement to alternative payment models (APMs)**

- Provides a 5 percent bonus to providers who receive a significant portion of their revenue from an APM or patient centered medical home (PCMH).
- Participants need to receive at least 25 percent of their Medicare revenue through an APM in 2018-2019. This threshold increases over time. The policy also incentivizes participation in private-payer APMs.
- Establishes a Technical Advisory Committee (TAC) to review and recommend physician-developed APMs based on criteria developed through an open comment process.

### **Expands the use of Medicare data for transparency and quality improvement**

- Posts quality and utilization data on the Physician Compare website to enable patients to make more informed decisions about their care.
- Allows qualified entities (QEs) to provide analysis and underlying data to providers for purposes of quality improvement, subject to relevant privacy and security laws.

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- Allows qualified clinical data registries to purchase claims data for purposes of quality improvement and patient safety.