POWERS

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ATTORNEYS AT LAW

MEMORANDUM

To: **ASTS; c/o Kim Gifford**

From: **Peggy Tighe, Peter Thomas, Theresa Morgan, Sara Rosta and Brian Goss**

Date: **February 10, 2014**

Re: **Lawmakers Release Details of SGR Agreement; Remain Quiet on Offsets**

On Thursday, February 6, a bipartisan, bicameral agreement was reached by leaders of three key Congressional committees to repeal the Sustainable Growth Rate (SGR) portion of the Medicare physician payment formula and create a new quality measurement system for physicians and others paid under the formula. Congress delayed the formula's required cuts over the past 12 years through short-term legislative patches, but this is the first time a permanent fix to the physician fee schedule has progressed this far. The legislation, H.R. 4015 and S. 2000, was introduced in the House and Senate by the committee chairmen and ranking members of the Senate Finance, House Energy and Commerce, and House Ways and Means committees. A section-by-section summary of the bill can be found here.

POLITICS/TIMING

The legislative agreement is merely the first part of a legislative package to stop the Medicare physician payment cuts. Congressional committee staffers have already begun discussions and will spend the next several weeks prior to the expiration of the current SGR "patch" working on the "pay-fors" for the SGR repeal and quality program. "Pay-fors" are also known as "offsets" and they consist of Medicare policy proposals that save the government money over a ten-year period. These savings will be applied against the additional spending necessary to fix the fee schedule, resulting in a budget neutral bill.

Congressional leaders have determined that they will need to find cuts totaling approximately $150 billion to pay for the SGR repeal, physician incentives, and other policy issues expected to be tied to the legislation. The cost to repeal the SGR represents the bulk of the cost, most recently estimated by the Congressional Budget Office (CBO) at approximately$126 billion over 10 years. The most recent physician fee schedule patch, set to expire on March 31, prevented a 24 percent cut that would have gone into effect earlier this year. The committees must work with the House and Senate leadership to determine the legislative vehicle and timing for passage of any complete deal. The American Medical Association (AMA) circulated a sign-on letter for medical specialty associations supporting the legislation shortly after the deal's release.

RECENT DEVELOPMENTS

Several days prior to the announcement that a deal was reached, a table of pay-for options was circulated that is best described by committee staff as the "kitchen sink" of possible options to offset the cost of the SGR repeal. It is by no means a definitive list, but gives an indication of the types of cuts that staff may be reviewing as pay-fors. These proposals include policies that impact beneficiary cost-sharing and reimbursement of multiple providers.

This past Friday, two days after the deal was finalized, House Republican leaders announced that they plan to include a 9-month SGR patch in legislation regarding the debt ceiling. The AMA responded with a strongly worded press release opposing another patch and calling for a permanent repeal. The announcement followed a determination by Treasury Secretary Lew that the debt ceiling would be reached by February 27, 2014, more than a month before the current patch's expiration. It remains unclear at this time if this action is intended to encourage committee negotiators to move quickly to complete the pay-for portion of the deal or if it is a placeholder in case agreement is not reached on a full repeal complete with pay-fors. Most recent information from Capitol Hill suggests the strategy to include a 9-month SGR proposal in the debt ceiling legislation is very much in flux.

KEY PROVISIONS – PAYMENT AND QUALITY

The agreement reached last week provides a 0.5 percent annual update for professionals paid under the Medicare physician payment formula starting in 2014 through 2018, with 2018 rates maintained through 2023. The bill directs the Secretary of the Department of Health and Human Services (HHS) to develop a new methodology for assessing the annual performance of each professional within a new Merit-Based Incentive Payment System (MIPS). The bill allots $15 million annually from 2014 to 2018 to the Centers for Medicare and Medicaid Services (CMS) to develop quality measures. Quality measures would be published by the HHS Secretary and eligible professionals, and other relevant stakeholders, would submit quality measures for HHS consideration. Annually, HHS would be required to publish, with public notice and comment, a list of quality measures to be included in MIPS.

Eligible professionals could participate in MIPS through several options: Electronic Health Records (EHRs), qualified clinical data registries of physician specialty organizations, and group assessment—whether a "virtual" group or a group affiliated with a hospital or facility. Professionals would be required to report quality measures and would be eligible for incentive payments through MIPS. The start date for MIPS, cited above, is several years later than several of the legislative proposals preceding the deal. Eligible professionals would be assessed under MIPS in four categories:

1) Quality:
2) Resource use:
3) EHR Meaningful Use; and,
4) Clinical practice improvement activities.

MIPS would apply not only to physicians, but also to a range of medical professionals including 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. MIPS would be expanded to other professionals paid under the Physician Fee Schedule beginning in 2020, if performance metrics are available for those specialties. Qualified clinical data registry measures and existing quality measures would not be subject to these additional requirements and would be automatically included in the first program year's final list of quality measures. These measures would remain in the MIPS program unless they are removed under the rulemaking process.

CHRONIC CARE

We expect that Senator Wyden (R-OR), who will replace former Senate Finance Chairman Baucus in that role, was responsible for new language in the legislation creating a payment code for care

management services for professionals treating individuals with chronic conditions in certain certified and recognized patient-centered medical homes or comparable specialty practices. An annual wellness visit or an initial preventive physician examination would not be required as a condition of payment.

SCORING/INCENTIVE PAYMENTS

Eligible professionals would be evaluated using a composite score of 0-100 on the four performance categories, with adjustments made to accurately effect measurement and improvements over time. The legislation adds a new component to improve professionals' ability to gain incentives through clinical practice improvement and those working toward APMs. Professionals would collaborate with HHS to create the list of activities, applicable to all specialties and achievable by small practices and professionals in rural and underserved areas. Composite scores would be compared to a performance threshold published at the beginning of the performance period.

Negative payment adjustments would 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 is at the threshold would not receive a MIPS payment adjustment (i.e., a bonus) and those above the threshold would receive positive payment adjustments. An additional threshold for exceptional performance will be set at the 25th percentile of the range between the initial performance threshold and 100. Aggregate additional incentive payments are capped at $500 million per year for 2018 through 2023.

EXISTING QUALITY MEASUREMENT PROGRAMS

The legislation consolidates under MIPS three existing incentive programs: the Physician Quality Reporting System (PQRS); the Value-Based Modifier; and the Meaningful Use of Electronic Health Records (EHR). Each program would sunset by the end of 2017, with planned PQRS and EHR penalties transferred to the physician payment pool.

TECHNICAL ASSISTANCE

In response to the medical community's ardent request, the legislation also provides $40 million annually in technical assistance from 2014-2018 for practices with 15 or fewer professionals in efforts to improve MIPS performance or transition to Alternative Payment Models (APMs), with preference to practices with low MIPS scores and those in rural and underserved areas. $10 million will be reserved for practices in health professional shortage areas (HPSAs) or medically underserved areas (MUAs). Confidential feedback on performance quality will be available for eligible professionals and those in qualified clinical data registries.

ALTERNATIVE PAYMENT MODELS

Providers participating in APMs, such as medical homes or accountable care organizations, will receive a five percent bonus each year from 2018-2023 and be exempt from the MIPS quality requirements. In 2024 and thereafter, professionals meeting certain APM criteria would receive annual updates of one percent, while all other professionals would receive annual updates of 0.5 percent. Only those professionals receiving a significant share of their revenues through an APM(s) that involve risk of financial losses and a quality measurement component will be permitted to participate in the APM exclusion from MIPS. Patient-centered medical homes will be exempt from the downside financial risk requirement only if their model is proven to work in the Medicare population. Providers can choose to receive bonuses based on receiving a significant percentage of:

1) Medicare revenue through an APM or,
2) APM revenue combined from Medicare and other payers.

Where no APM is currently available, the program would not count Medicaid revenue against the proportion of revenue in an APM.

By November 1, 2015, the HHS Secretary is tasked with establishing a measure development plan to prioritize outcomes, patient experience, care coordination, and appropriate use of services, with consideration given to gaps in quality measurement and application of measures across health care settings. The Secretary is given the authority to contract with entities, including physician organizations, to develop priority measures and focus on measures reported through EHRs. The bill also directs the Comptroller General to appoint 11 members to a Technical Advisory Committee (TAC) to use the criteria to evaluate and make recommendations on physician-focused APM proposals. On an ongoing basis, stakeholders can submit proposals to the committee for models which they believe meet the criteria.

QUALIFIED CLINICAL DATA REGISTRIES

To protect and encourage the use of physician clinical registries, the legislation creates a process by which HHS will certify "qualified clinical data registry measures." QCDR measures will not be subject to the additional MIPS requirements but instead will automatically be included in the Secretary's list of quality measures for the first year and can only be removed through a rulemaking process.

MISVALUED SERVICES

To ensure accurate valuation of services under the fee schedule, the Secretary is permitted to collect information such as practice expense inputs, time involved in furnishing services, cost and charge data, as well as information from eligible professionals, other providers, and suppliers. Further, the list of criteria to help identify "misvalued" services has been expanded to focus on codes with higher practice expense, high cost, substantial differentials in pay, significant payment differences between sites of service, substantial changes in procedure time, and where efficiencies can be created when services are performed together. Annual funding of $2 million will be available in 2014 to compensate professionals submitting the requested information.

The legislation also establishes an annual target for identifying misvalued services of 0.5 percent of the estimated amount of fee schedule expenditures in each year from 2015-2018. If the target is met, that amount would be redistributed in a budget-neutral manner within the physician fee schedule. If the estimation of misvalued services does not reach the target in any given year, fee schedule payments would be reduced. After 2015, if the estimate exceeds 20 percent or more from the previous year, CMS will impose a 2-year phased in reduction. When the target is exceeded, the amount over the target is credited toward the following year's target. The Secretary is given authority to "smooth" RVUs within a group of services. The legislation also requires GAO to produce a study one year after enactment regarding the AMA/Specialty Society Relative Value Scale Update Committee (RUC) process that makes recommendations on the valuation of physician services. The legislation also includes new fee schedule rules to transition California from county-based localities to annually updated metropolitan statistical areas (MSAs).

APPROPRIATE USE CRITERIA/PRIOR AUTHORIZATION

The legislation requires the HHS Secretary to promote the use of appropriate use criteria (AUC) for **advanced diagnostic imaging** in consultation with stakeholders, and developed or endorsed only

by national professional medical specialty societies. The criteria must be evidence-based, developed with stakeholder consensus, and based on publicly available studies. No later than November 15, 2015, the Secretary will specify one or more AUC(s) but in no case would the Secretary be permitted to develop or initiate the development of clinical practice guidelines or appropriate use criteria.

By April 1, 2016, in consultation with stakeholders, the Secretary would identify and publish a list of Qualified Clinical Decision Support (CDS) mechanisms, at least one of which must be free of charge. The mechanisms would be used by ordering professionals to consult with applicable appropriate use criteria, must meet specific rules and standards outlined in the legislation, and may be required to provide feedback to ordering professionals. On January 1, 2017, only furnishing professionals would be paid for such services if the claim shows consultation of the CDS, adheres to the AUC, and includes the ordering professional's national provider identifier (NPI). The provision would not apply to services ordered for an emergency medical condition as defined by EMTALA, paid under Part A, for certain patients in APMs, or by professionals who meet hardship criteria, such as lack of Internet access.

The Secretary would begin establishment of Prior Authorization requirements in 2017, in consultation with stakeholders, for ordering professionals with low adherence to applicable AUC(s) ("outliers") within a two-year timeframe. Outlier physicians shall be subject to prior authorization for applicable imaging services beginning in 2020 with no more than five percent of ordering physicians subject to prior authorization. $5 million in 2019, 2020, and 2021 would be allocated to CMS to carry out the program and GAO would report to Congress on other Part B services for which CDS could be appropriate, such as radiation therapy and clinical diagnostic laboratory services.

TRANSPARENCY PROVISIONS

The legislation institutes several provisions to "empower beneficiary choices through access to information on physician services" beyond what would be published through the MIPS program. Such efforts would include publication of searchable utilization and payment data for professionals on the Physician Compare website. The Secretary would establish a process by which professionals could review and correct this information before it is posted on the website. Qualified entities (QEs), organizations that currently receive Medicare data for public reporting, may, under certain specified conditions, provide or sell non-public analyses and claims data to certain providers for quality improvement or APM purposes. Qualified Clinical Data Registries would also have access to the data under certain conditions and providers identified in the public reports would be permitted to review and submit corrections.

OTHER PROVISIONS

As originally passed in the Energy and Commerce version of the legislation, a provision was included to prohibit information obtained through the new law to be construed as the establishment of a duty or standard of care for participating health care professionals in any medical malpractice or medical product liability action or claim. The provision would not preempt any other state law. The legislation would also allow professionals who opt out of Medicare to renew their eligibility automatically at the end of each two-year cycle and would require regular reporting on physicians who opt out. It would also require EHR interoperability by 2017 and GAO to issue reports on 1) a gainsharing program as well as 2) barriers to expanded use of telemedicine and remote patient monitoring.