

April 3, 2013

To: Provider Community

From: Fred Upton, Chairman, Energy and Commerce Committee  
Dave Camp, Chairman, Committee on Ways and Means  
Joe Pitts, Chairman, Energy and Commerce Committee, Health Subcommittee  
Kevin Brady, Chairman, Committee on Ways and Means, Subcommittee on Health

Subject: Second Draft of Sustainable Growth Rate (SGR) Repeal and Reform Proposal – Request for Feedback

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Fixing the flawed SGR physician payment system is a top priority for the Committees on Energy and Commerce and Ways and Means. We recognize that the uncertainty over potentially devastating reimbursement cuts makes it difficult for practices to plan for the future. This uncertainty affects decisions to hire necessary staff and make investments in practice improvement.

On February 7, 2013, we requested stakeholder input on an overview of a permanent solution to the SGR. We appreciate the many thoughtful responses we received, as they have been instrumental in formulating the more detailed and refined proposal that is attached.

This latest proposal provides further clarity on the three individual phases of a proposal to repeal SGR and reward providers for high quality and efficient care in the fee for service (FFS) program, while allowing providers to actively participate in payment and delivery reform. Those responding to the first draft emphasized the need for a period of stable payments to provide predictability and allow time for alternate payment models (APMs) to evolve that are sustainable in the long-term. We built Phase I around a multi-year period of stable payment updates which will coincide with quality and efficiency measure development that will be used in FFS and will also be relevant to APMs.

Respondents to the first draft emphasized the critical need for evidence-based quality and efficiency measures. This proposal includes processes for determining quality and efficiency measures that focus on evidence while being flexible and specialty-specific. Respondents to the first draft stressed that specialty-specific registries provide a means to achieve and standardize measures and improve risk adjustment. This proposal recognizes the important role that these registries can play to facilitate quality improvement while minimizing provider participation burden. This proposal also addresses the respondent-stated need for timely performance feedback to allow providers to identify improvement opportunities and optimize incentive payments. Respondent input highlighted the importance of risk-adjusting performance on quality and efficiency measures.

APMs are of significant interest to respondents and they are addressed in greater detail. Based on respondent input, we envision a system where providers have the flexibility to participate in the payment and delivery model that best fits their practice. The overarching goal is to reward

providers for delivering high quality, efficient health care, whether in a FFS system or in an alternative payment model program.

The Committees appreciate the provider interest in medical liability reform, repeal of the Independent Payment Advisory Board, private contracting/balance billing, and hospital-physician gainsharing arrangements. We look forward to a constructive dialogue regarding policies that can improve the practice environment and enhance provider focus on patient care.

Designing a system that is inclusive of all specialties and practice types presents a great challenge, and this draft makes a concerted effort to avoid a “one size fits all” approach in favor of a versatile and inclusive process that provides for the maximum amount of individual choice. The Committees request your feedback on this more detailed proposal. We ask that you respond to the specific questions embedded in the proposal document as part of your feedback. Please submit written comments to the SGR comments mailbox at [sgrcomments@mail.house.gov](mailto:sgrcomments@mail.house.gov) by April 15, 2013. The Committees look forward to continuing a dialogue as we work toward a system that will benefit patients, providers, and the Medicare program.

## Overview of SGR Repeal and Reform Proposal

### Second Iteration

The following summary is a second, more detailed iteration of the proposal to repeal the SGR and reform Medicare physician payments.

#### **Section 1: Goals of Reform**

- Repealing the SGR, eliminating the 24.4 percent across-the-board cut slated for 2014 and any future SGR cuts;
- Establishing a period of stable payments, enabling providers to prepare for payment changes;
- Engaging the provider community in efforts to improve, reform, and update reimbursement systems;
- Empowering providers and other relevant stakeholders to determine the measures of quality and efficiency that are meaningful for Medicare beneficiaries;
- Establishing a more reasonable timeframe for developing measures that promote value;
- Prompting the Centers for Medicare and Medicaid Services (CMS) to provide timely feedback, enabling providers to make adjustments to improve patient care and optimize their incentive payments;
- Providing options that enable providers to select the Medicare payment system—whether performance based fee-for-service or an alternative model—that best fits their practice situation; and
- Aiming to improve the provider practice environment by reducing practice costs and administrative burden—freeing up time to focus on patient care, not administrative paperwork.

#### **Section 2: Proposal**

##### **A. Phase I: Stable, Predictable Updates**

SGR will be repealed so that it will not determine the payment update in any future year. Providers will receive stable, predictable fee schedule updates that are set in statute for a period of time sufficient to support the policy objectives contained within the proposal. These updates will apply to all providers. This will allow providers the time to develop quality and efficiency measures as well as clinical improvement activities that are the key to Phase II and Phase III. This stable period will also afford providers time to assess the applicability of private sector and Medicare alternative payment models.

##### **B. Phase II: Portion of Payment Based on Quality through Update Incentive Program (UIP)**

In Phase II, provider payment rates will be based, in part, on the quality of care provided to beneficiaries. A provider's payment rate will consist of a base rate and a variable rate tied to

performance. Providers will have three ways to receive credit that will determine their variable, performance-based rate:

- Score on quality measures relative to their peers;
- Significant improvement in their own quality score from the previous year;
- Executing clinical improvement activities.

Quality measures are to be risk-adjusted as to the severity of illness so that providers are not penalized for treating sicker or more complicated patients.

Providers can choose whether the assessment of their quality occurs at the individual or group practice level.

The Secretary will minimize the participation burden on providers by:

- Identifying and streamlining administrative requirements;
- Facilitating measure reporting through electronic health records (EHRs), patient registries, and other reliable data sources that providers trust;
- Working with provider organizations to align the UIP with current Medicare incentive payment programs such as PQRS; and
- Aligning the UIP with private payer initiatives, which would provide a more comprehensive picture of performance to providers and patients.

The Secretary will ensure that providers have the ability to optimize their incentive payments by:

- Providing timely feedback that enables providers to assess their quality score relative to their peers during the performance period;
- Affording providers the opportunity to review their results before they are used to determine UIP payments; and
- Providing for reconsideration and an appeal process so that providers can contest an UIP determination

During the Phase I period of stability, the Secretary will work with provider organizations to establish the quality measures and clinical improvement activities on which provider performance will be assessed in Phase II.

- The Secretary shall request that providers submit quality measures that are relevant to their practice and meaningful for beneficiaries for inclusion in the UIP. A quality measure is a metric that assesses the relationship of a provider's care to a desired care process or health outcome. The Secretary will establish measures that apply to all providers using the following process:
  - The Secretary is required to adopt measures endorsed by consensus-based organizations, such as the National Quality Forum (NQF).
  - The Secretary is required to adopt measures that are not endorsed by a consensus-based organization that conform to certain requirements spelled out in statute. Requirements could include that measures:

- Meaningfully differentiate performance
    - Address at least one of the following domains: clinical care, safety, care coordination, and patient and caregiver experience.
  - The Secretary is authorized to adopt additional measures that are needed to fill gaps to ensure there are measures for all providers.
- Phase II quality measures are also likely to be used to assess quality in alternate payment models.
- The Secretary shall request that providers submit clinical practice improvement activities. A clinical practice improvement activity is an activity that improves care delivery and that, when effectively executed, is likely to result in improved health outcomes. Using the activities identified by providers, the Secretary will determine a menu of activities from which providers can select. The menu is to include activities relevant to all providers and it must consist of, at a minimum, the following categories:
  - Provision of care consistent with specialty-specific evidence-based guidelines or application of decision support tools;
  - Improved care organization or coordination and delivery;
  - Targeted utilization of patient registries for chronic conditions;
  - Enhanced access to comprehensive and timely care that is delivered in the least intensive and most appropriate setting based on patient needs;
  - Reporting and collection of clinical data to optimally manage care and prevent unnecessary hospitalizations and emergency department visits; and
  - Collection of feedback from beneficiaries on their care experience.

In addition to receiving UIP credit for executing activities, these activities are intended to enhance provider readiness for alternate payment models.

Measures and clinical practice improvement activities shall go through an annual process to update and improve upon value of care for the benefit of both providers and patients. This provides an opportunity to add new measures and eliminate outdated or ineffective measures by the same process used to identify the initial set of measures.

The Secretary shall convene an expert panel to advise on the establishment and maintenance of the UIP.

The Secretary shall establish an alternative, yet similar program to the extent that the Phase II incentive program does not apply to non-physician providers. The Secretary shall consult with these providers when establishing such a program.

Questions for Phase II:

- ✓ How should the Secretary address specialties that have not established sufficient quality measures?
- ✓ Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

- ✓ Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?
- ✓ Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?

### **C. Phase III: Reward for Efficient Resource Use**

In Phase III, provider payment rates will continue to be based, in part, on risk-adjusted measures of the quality of care delivered. Providers who meet a minimum quality score threshold will also have an opportunity to earn additional incentive payments based on efficient use of health care resources. Provider efficiency will be assessed using a risk-adjusted relative ranking system that also takes geographic differences into account. The Secretary will consider both episode-based and per capita measurements for provider costs of care. Providers can choose whether the assessment of their performance—on quality and efficiency—occurs at the individual or group practice level.

During Phase II, the Secretary will solicit physician organization input on how to assess efficiency in Phase III. The Secretary will continue to consult physician organizations on the efficiency measures on an on-going basis.

#### Questions for Phase III:

- ✓ How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?
- ✓ Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?

### **D. Provider Opt-Out for Alternate Payment Model (APM) Adoption**

Providers can choose to participate in an APM at any time. Services that are provided in a payment model that has been assessed and approved by the Secretary will be exempt from the UIP and will be reimbursed according to the payment arrangements of the model.

#### Questions for APM Adoption:

- ✓ What do you believe will be necessary to support provider participation in new payment models?
- ✓ What is a reasonable time frame for CMS to approve and adopt APMs?
- ✓ Should providers be able to participate in more than one payment model?

### **E. Reports on Improved Provider Fee Schedule and Alternate Payment Models**

Periodically, the Secretary of HHS, the Comptroller General of the United States and the Medicare Payment Advisory Commission shall submit to Congress a report analyzing the extent to which such update incentive program is successfully satisfying performance objectives and the status of APM development.

## **F. Improvements upon Current Law**

This proposal attempts to improve current law by repealing SGR, establishing measures of care that are meaningful to patients and providers, and allowing providers to participate in payment and delivery reform efforts. It is prudent to consider other policies that reducing the administrative burden on providers and generally improve the practice environment.

### Questions for Current Law Improvements:

- ✓ What improvements upon current law do you believe will be required to support alternate payment model adoption?
- ✓ What improvements upon current law will help ease the administrative burden upon medical providers and allow more time caring for Medicare beneficiaries?
- ✓ What improvements upon current law would support the provision of quality health care delivery for Medicare beneficiaries?