NEUROSURGERY PERSPECTIVE

The Good

- Repeals Medicare’s sustainable growth rate (SGR) payment formula.
- Beginning in 2024, physicians participating in advanced payment models (APMs) would receive a 2% annual update; those who do not would receive a 1% annual update.
- Consolidates existing Physician Quality Reporting System (PQRS), Electronic Health Records (EHR) Program and Value-Based Payment Modifier (VBPM) into a single new Value-Based Payment (VBP) program.
- Eliminates current quality-related penalties (PQRS = 2%; EHR 3-5%; VBM 1-2%) at the end of 2016 and these funds will now remain in physician payment pool of Medicare dollars ($10 billion from 2017-2023).
- Physicians who achieve a high enough composite quality score will receive bonus payments.
- Physicians who treat few Medicare patients, as well as those who receive a significant portion of their revenue from an advanced Alternative Payment Model (APM) would be excluded from the VBP program.
- Outcomes measures would be given greater weight than process measures.
- To prevent duplicative reporting, physicians who report quality measures through certified EHR systems would meet the meaningful use clinical quality measure component.
- Physicians can opt to assess their quality performance at the group (including “virtual” groups when the practice has fewer than 10 physicians) or individual level.
- Starting in 2014, group-level quality-reporting credit would be available for groups reporting to a qualified clinical data registry.
- Physicians participating in any Medicare APM will automatically receive half of the highest possible score and could achieve the highest possible score by engaging in additional clinical improvement activities.
- Confidential feedback on performance in the quality and resource use categories to professionals on a timely basis, such as quarterly. Feedback may be provided using multiple mechanisms, such as a web-based portal or qualified clinical data registries.
- Physicians who have a significant share of their revenues in an APM(s) that involves two-sided financial risk and a quality measurement component would receive a five percent bonus each year from 2016-2021.
- 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) would be phased-in over a two-year period (of course if you are getting a 20% cut, that should be in the “Ugly” category).
- Requires Medicare to share administrative claims data with qualified clinical data registries.

The Bad (or not quite good)

- The VBP program would assess physicians’ performance in the following categories: 1) Quality; 2) Resource Use; 3) Clinical Practice Improvement Activities; and 4) EHR Meaningful Use.
- Quality measures included in current PQRS would be used (although it appears that the current qualified clinical data registry program would remain in place, allowing neurosurgeons to participate through N3QOD).
- Resource use metrics used in the current law VBPM program and the methodology that is under development to identify resources associated with specific care episodes would be enhanced and used for the resource use category of the new VBP program.
- EHR meaningful use requirements, demonstrated by use of a certified system, would continue to apply as part of the new VBP program.
- For 2017, the funding available for VBP incentive payments would be equal to eight percent of the total estimated spending for VBP eligible professionals (note: 8% is the projected 2017 amount tied to performance under the current law incentive programs). The entire funding pool for a year would be paid out to eligible professionals based on their VBP composite score for a specified performance period, with those achieving the highest scores receiving the greatest incentive payment. The funding pool would be increased to nine percent in 2018 and ten percent in 2019. Starting 2020, the Secretary would have the authority to increase, but not lower, the funding pool.
- The APM revenue sharing methodology and risk methodology is not clear, but appears complex.
- The proposal would establish payment for one or more codes for complex chronic care management services, beginning in 2015 and payments for these codes would be budget-neutral within the physician fee schedule.
- Directs the Government Accountability Office (GAO) to study the AMA/Specialty Society Relative Value Scale Update Committee (RUC) processes for making recommendations on valuation of physician services.
- The proposal directs the Secretary of HHS to ensure that the global payment for the work component of surgical procedures accurately reflects the average number/type of visits following surgery (which will likely reduce neurosurgical procedure values).
- The proposal would implement a program that would require ordering professionals to consult with appropriate use criteria (AUC) for advanced imaging and electrocardiogram services. Prior authorization would apply to outlier professionals whose ordering is inconsistent as compared to their peers.
- Based on the experience with the imaging AUC program, the Secretary of HHS could expand the use of appropriate use criteria to other services (note: if this bill becomes law, neurosurgery may want to consider develop AUC – which we do not do at this time, favoring evidence-based guidelines instead).
- The proposal would allow those that currently receive Medicare data for public reporting purposes (qualified entities, “QEs”) to provide or sell non-public data analyses to physicians and other professionals to assist them in their quality improvement activities. The proposal would also allow QEs to provide or sell similar analyses to health insurers and employers meeting certain criteria.

**The Ugly**

- Freezes physician payments for 10-years, producing a cumulative gap of nearly 45% (note the Energy and Commerce bill provided a 0.5% update each year).
Physicians would be assessed and receive payment adjustments based on a composite score that encompasses all of the applicable composite categories and associated measures. A professional would get a score in each category, which would add up to a single composite score. These scores would reflect the differences in professionals’ performance and would be tied to VBP incentive payments. Weights for performance categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>PY 2017 Weight</th>
<th>PY 2018 Weight</th>
<th>PY 2019 Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60% total with neither category less than 15%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Resource Use</td>
<td></td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Clinical practice improvement activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>EHR meaningful use</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

VPM program is budget neutral – so there will be winners and losers. Payment increases provided to physicians with high performance scores would be offset by payment reductions to poor performing professionals.

The proposal would set a target for identifying and revaluing misvalued services. In each of 2016, 2017, and 2018, the target for identifying misvalued services is one percent of all expenditures under the physician fee schedule. If the target is met, that amount would be redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments for the year would be reduced by the difference between the target and the amount of misvalued services identified that year (note this is better than the Energy and Commerce Committee bill, which would remove 3% of fee schedule payments out of the pool of dollars available for physician payments). Neurosurgical services continue to be targeted for reductions as “overvalued”.
The Secretary of HHS (or CMS) would solicit information from selected professionals (unclear who these individuals will be) to assist in accurate valuation under the fee schedule. Professionals who submit the requested information may be compensated, while those who do not submit information would receive a ten percent payment reduction for all services in the subsequent year.

The proposal would require HHS to publish utilization and payment data for physician and other practitioners on the Physician Compare website.

**Missing from the Proposal**

Based on neurosurgery’s principles for SGR reform, the following important items are not part of this proposal:

- Private contracting on a case-by-case basis
- Medical liability reform
- Repeal of the Independent Payment Advisory Board (IPAB)

**BOTTOM LINE:** Below is a very general assessment of SGR replacement bills vs. neurosurgery’s top reform principles:

<table>
<thead>
<tr>
<th>Reform Principle</th>
<th>E&amp;C</th>
<th></th>
<th>W&amp;M/Finance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeal SGR</td>
<td>X</td>
<td>Yes</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5-year period of payment stability</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Payments based on MEI</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>No pay differentials for specialists &amp; PCPs</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Choice of payment models</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Viable fee-for-service option</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Private contracting</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Positive, not negative, incentives for QI</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Replace current PQRS, EHR, VBPM</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Quality measures developed by physicians</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Legal protections for physicians</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>IPAB Repeal</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Katie O. Orrico, Director
Washington Office
American Association of Neurological Surgeons/
Congress of Neurological Surgeons
725 15th Street, NW, Suite 500
Washington, DC 20005
Direct Dial: 202-446-2024
Fax: 202-628-5264
Cell: 703-362-4637
korrico@neurosurgery.org