IR Economics: Overcoming Challenges and Delivering Quality Care

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Goals

- Give an overview of the political climate on Capitol Hill as it relates to health care policy
- Describe some of the economic and political challenges you will be faced with over the next few years

Objectives

- Describe the challenges facing the health care community in relation to the SGR
- Describe the economic and political challenges facing IR
- Identify the provisions of the Affordable Care Act (ACA) which could affect you and your practice
- Formulate a plan to address those concerns
- Prepare to handle the many policy challenges facing IR in this political climate

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Overview

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US Congress

- Only 60 laws passed so far this year in Congress
- Government Shutdown
- Debt Ceiling
- Sequestration

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So how does Congress really work?

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What's behind the Curtain?

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Who Runs Congress?






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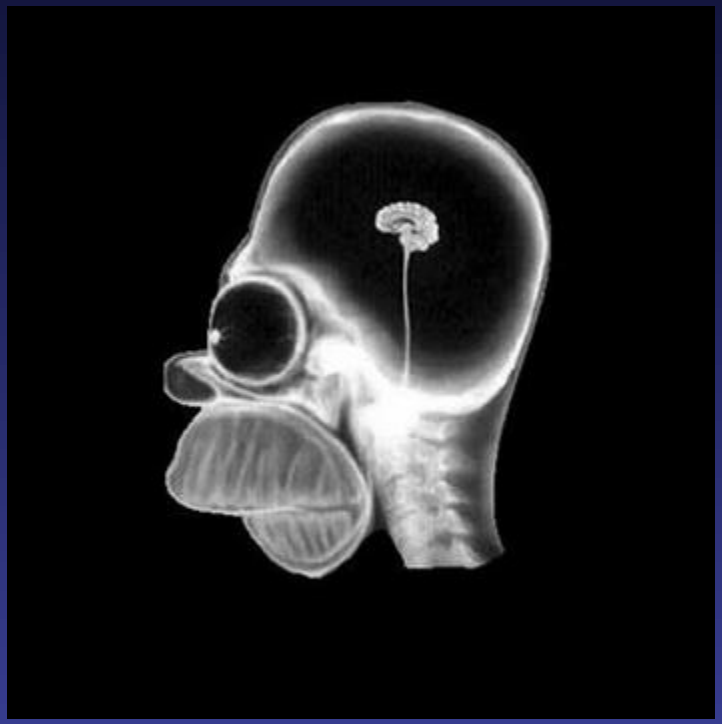
Congress and Imaging



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Imaging

- Overutilization of imaging services has driven up the cost of healthcare
- Numerous cuts to the reimbursement of imaging services
- Statistics don’t back up Congressional assertions

Imaging

- Since 2003 Medicare spending for scans has not increased
- Imaging is the slowest growing service over the past 10 years according to the Health Care Cost Institute

Interventional Radiology

- SIR has made it a priority to speak to lawmakers
- Interventional radiology is not diagnostic radiology
- IRs are clinicians
- Identify IRs as physicians who use imaging as guidance

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Interventional Radiology

- Awareness
- SIR Value Task Force
- Safer, cheaper, better, faster
- Branding Campaign
- Agile, modern

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Congressional Issues

- What does this all mean?
- Walk through of the major issues facing physicians
- Where do things stand?
- What can you do to prepare

Affordable Care Act

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ACA

- Patient Protection and Affordable Care Act signed into law March 23, 2010
- Most comprehensive reform of United States health care policy since the creation of Medicare and Medicaid
- Not without controversy
- Numerous constitutional challenges to the law since its passage

ACA

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ACA Provisions 2010

- Changes in Medicare Provider Rates
- Qualifying Therapeutic Discovery Project Credit
- Medicaid and CHIP Payment Advisory Commission
- Comparative Effectiveness Research
- Prevention and Public Health Fund

ACA Provisions 2010

- Review of Health Plan Premium Increases
- Temporary Reinsurance Program for Retiree Coverage
- Temporary Pre-existing Condition Insurance Plan
- Adult Dependent Coverage to Age 26
- Consumer Protections in Insurance
- Insurance Plan Appeals Process
- Coverage of Preventive Benefits

ACA Provisions 2010

- Funding for Community Health Centers
- Funding for National Health Service Corps
- National Prevention, Health Promotion and Public Health Council
- Health Care Workforce Commission
- .Medicaid Community-Based Services
- Consumer Website
- Tax on Indoor Tanning Services

ACA Provisions 2011

- Medicare Beneficiary Drug Rebate
- Small Business Tax Credits
- Medicaid Drug Rebate Increases
- Generic Biologic Drugs
- Expansion of 340B Drug Discount Program
- Coordinating Care for Dual Eligibles
- New Requirements on Non-profit Hospitals
- Optional Medicaid for Childless Adults

ACA Provisions 2011

- Minimum Medical Loss Ratio for Insurers
- Closing the Medicare Drug Coverage Gap
- Medicare Payments for Primary Care
- Additional Medicare Prevention Benefits
- Center for Medicare and Medicaid Innovation
- Medicare Premiums for Higher-Income Beneficiaries
- Medicare Advantage Payment Changes
- Medicaid Health Homes

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ACA Provisions 2011

- Chronic Disease Prevention in Medicaid
- National Quality Strategy
- Changes to Tax-Free Savings Accounts
- Grants to Establish Wellness Programs
- Teaching Health Centers
- Medical Malpractice Grants
- Funding for Health Insurance Exchanges
- Nutritional Labeling

ACA Provisions 2011

- Medicaid Payments for Hospital-Acquired Infections
- Graduate Medical Education reforms
- Medicare Independent Payment Advisory Board
- Medicaid Long-Term Care Services

ACA Provisions 2012

- Medicare ACOs
- Uniform Coverage Summaries for Consumers
- Medicare Advantage Plan Payments
- Medicare Independence at Home Demonstration
- Additional Medicare Provider Payment Changes
- Fraud and Abuse Prevention
- Annual Fees on the Pharmaceutical Industry
- Medicaid Payment Demonstration Projects
- Data Collection to Reduce Health Care Disparities
- Medicare Value-Based Purchasing
- Reduced Medicare Payments for Hospital Readmissions

ACA Provisions 2013

- State Decision Regarding Exchanges
- Medicare Bundled Payment Pilot Program
- Medicaid Coverage of Preventive Services
- Medicaid Payments for Primary Care
- Itemized Deductions for Medical Expenses
- Flexible Spending Account Limits
- Medicare Tax Increase
- Employer Retiree Drug Coverage Subsidy

ACA Provisions 2013

- Tax on Medical Devices
- Financial Disclosure
- CO-OP Health Insurance Plans
- Extension of CHIP
- Medicare Disproportionate Share Hospital Payments
- Medicaid Disproportionate Share Hospital Payments

ACA Provisions 2014 - 2018

- Expanded Medicaid Coverage
- Presumptive Eligibility for Medicaid
- Individual Mandate
- Health Insurance Exchanges
- Health Insurance Premium and Cost Sharing Subsidies
- Guaranteed Availability of Insurance
- No Annual Limits on Coverage
- Essential Health Benefits
- Multi-State Health Plans

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ACA Provisions 2014 - 2018

- Basic Health Plan
- Employer Mandate (One Year Delay)
- Medicare Advantage Plan Loss Ratios
- Wellness Programs in Insurance
- Fees on Health Insurance Sector
- Medicare Payments for Hospital-Acquired Infections
- Increase Federal Match for CHIP (2015)
- Health Care Choice Compacts (2016)
- Tax on High-Cost Insurance (2018)

ACA

- Each and every person in this room is affected by the ACA
- For clarity, we will focus on the ones with the biggest impact on IR
- Brief Overview of provisions in the ACA

Jon Stewart

"I'm going to try to download every movie ever made and you are going to try to sign up for Obamacare, and we'll see which happens first."

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Federal Exchange

- Early problems included:
  - Slow (or nonexistent) access to web site
  - Inability to set up an account
  - Inability to access plans or accurate premium quotes
  - Inability of insurers to identify their new customers
  - Multiple enrollment/disenrollment reported to insurers
  - Inability of insurers and navigators to access website

Open Enrollment Deadline

- **October 1, 2013**—Open enrollment began on Exchanges. Consumers use online portal to enter information used for eligibility determinations for premium tax credits and Medicaid/CHIP eligibility; shop for health plans. Major web site problems: *"Trying not to make this a 'third world' experience."*
- **January 1, 2014**—Health care coverage for enrollees in Qualified Health Plans (QHPs) on Exchanges set to begin.

Open Enrollment Deadline

- **March 31, 2014**—Open enrollment period scheduled to close for 2014 plan year.
- **April 1, 2014 - December 31, 2014**—Special enrollment period commences for consumers that failed to enroll during open enrollment, but eligible to enroll for QHP insurance coverage for 2014 due to "qualifying life event" like a job loss, birth, or divorce

Physician Sunshine Act

- New federal transparency requirements (ACA §6002):
  - Applicable drug and device manufacturers report payments or other transfers of value to physicians and teaching hospitals.
  - Applicable drug and device manufacturers and group purchasing organizations (GPOs) report information regarding physician ownership or investment interests and payments or other transfers of value provided to such physicians.

Physician Sunshine Timeline

- **Mar. 23, 2010**
- "Physician Sunshine" requirements enacted as part of health care reform
- **Dec. 14, 2011**
- Proposed Rule released
- **Feb. 1, 2012**
- Final Rule released
- **August 1, 2013**

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Physician Sunshine Timeline

- Beginning of data collection
- **Mar. 31, 2014**
- First reporting deadline (For subsequent years, 90th day of calendar year)
- **Sept. 30, 2014**
- Public reporting of data (For subsequent years, June 30th)

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Physician Sunshine

- Information submitted to include:
  - Applicable manufacturer/GPO name;
  - Covered recipient's or physician owner's name and address;
  - For physicians only: NPI; specialty; and state professional license number;
  - Amount, date, form, and nature of payment/ transfer or value in U.S. dollars;
  - Name of associated covered drug, device, biological, or medical supply if any;

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Physician Sunshine

- Name of entity that received the payment/transfer of value, if not provided to the covered recipient directly;
  - Whether the payment/transfer of value was provided to a physician holding ownership or investment interests in the applicable manufacturer;
  - Whether the payment/transfer of value should be granted delay in publication; and
  - Additional context for payment or other transfer of value.

45 Day Review

- Applicable manufacturers, GPOs, covered recipients and physician owners/investors must have opportunity to review data submitted for at least 45 days prior to publication (actually will be at least 60 days prior to publication).
- For covered recipients and physician owners/ investors, they may register with CMS in early 2014 to receive notifications and agency will notify them through public postings and CMS listserves.

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45 Day Review

- Applicable manufacturers/GPOs and covered recipients and physician owners or investors may log into secure website to view information pertaining only to them and review data submitted by or about them for previous reporting year.

45 Day Review

- During 45-day review and correction period, covered recipients and physician owners/ investors can dispute reported information, and CMS will notify applicable manufacturers/GPOs so parties can resolve dispute during review and correction period.
- After 45-day review and correction period, applicable manufacturers/GPOs have additional 15 days to correct information before the information is made public.

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45 Day Review

- If dispute not resolved by 15 days after review and correction period, reported information will appear on public database and will be flagged as contested.
- Information corrected after 60-day period for current and previous year will be updated at least once a year.

ACA Your Practice and Employees

SIR members are small employers too!

Important provisions related to employer-provided coverage

- Penalty for not providing health care coverage
- Tax credit to help small firms afford health care

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Penalties for Not Providing Coverage

- Businesses are subject to monthly penalty if:
  - Not providing "affordable and adequate" heath insurance
    - » Required contribution exceeds 9.5% of employee's required contribution
    - » Plan covers less than 60% of total allowed costs
    - » Penalty comes out to roughly $2,000 per employee
  - It is a "large employer": greater than 50 full-time employees (30 hours per week)
  - Have at least 1 full-time employee receiving a health insurance premium credit in the individual insurance exchange market

- Originally set to begin January 2014. Obama Administration delayed implementation until January 2015

Tax Credits for Small Business

Small Business Employer Health Care Tax Credit

- IR Practices may be eligible for a credit of 50% of costs of providing health insurance if
  1) Small businesses with less than 25 full-time employees
  2) Employees' average wages less than $50,000
  3) Employer must pay at least 50% of health care premiums
- Credit worth up to 50% of your contribution (35% for tax-exempt employees)
- Less than 4% of businesses in 2010 filed a claim

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PQRS

- Physician Quality Reporting Initiative
- Extends program through 2014
- Payments for 2012 – 2014 equal to 0.5 percent
- Eligible Professionals who do not report quality data measures will be penalized 1.5 percent for 2015 and 2 percent for 2016
- Must have participated by October 15 to avoid 2015 penalty
- Must report 3 individual or 1 group measure

PQRS

- 4 Ways to Report
- 1) To CMS on their Medicare Part B claims

  2) To a qualified Physician Quality Reporting registry

  3) To CMS via a qualified electronic health record (EHR) product

  4) To a qualified Physician Quality Reporting EHR data submission vendor

Equipment Utilization Rate

- 2011 Physician Fee Schedule set the utilization assumption rate for advanced diagnostic imaging equipment at 75%
- Stands at 75% today
- Advanced diagnostic imaging defined as equipment costing over $1 million
- Includes MRI, CT
- Higher the utilization rate, the lower the reimbursement

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Taxes

- For individuals making $200,000 per year or families making $250,000
- Increase in the Medicare payroll tax of 0.9%
- Increase in investment income tax of 3.8%

Physician Disclosure Requirements

- The ACA imposes a disclosure requirement on physicians who self refer MRI, CT, PET and other designated health services
- Requires that the referring physician provide written notice to the patient that he or she may receive the same services from another physician
- Within a 25 mile radius

Mis-valued Codes

- Allows the Secretary to review and identify codes that could potentially be “misvalued” and subsequently change their relative value
- Some criteria of a misvalued code:
- Codes that have grown the most
- Codes that have experienced substantial changes in practice expense
- Codes the Secretary deems inappropriate

Independent Payment Advisory Board

- IPAB
- 15 member panel made up of health care experts, only a minority of which can be health care providers
- Can not be practicing physicians
- If Medicare grows too quickly (exceeds specific spending targets), panel is tasked with making binding recommendations to reduce spending
- Triggered by a 1% increase over CPI

IPAB

- Proposal sent to Congress. If Congress does not approve it must come up with alternative
- Can be overturned by a super majority vote of the Senate
- If Congress fails to act, Secretary must impose recommendations

Accountable Care Organization

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ACOs

- An ACO is a network of doctors and hospitals that share the responsibility of providing coordinated health care to patients
- Goal of an ACO is to reduce health care costs by encouraging health care providers to form these coordinated networks which keep costs down
- ACOs make providers jointly accountable for the health of their patients and offer them financial incentives for quality care coordination and efficiency of practice

ACOs

- As part of the ACA , each ACO has to manage the health care needs of a minimum of 5,000 Medicare benificiaries for at least three years
- 4 million beneficiaries are now enrolled in an ACO
- An estimated 14% of the U.S population is being served by an ACO

ACOs

- When ACOs succeed in delivering quality care and spending health care dollars wisely, they share in the savings
- ACOs are set up as risk vs reward programs
- Different ACO programs such as the “Pioneer Program” for high performing health systems receive greater financial reward in exchange for greater financial risk
- Some programs offer little or no risk at all

ACOs

- Types of ACO programs
  - 1) Medicare Shared Savings Program
  - 2) Advance Payment ACO Program
  - 3) Pioneer ACA Model

ACOs

- How does it work? How will I get paid?
- ACOs still follow the fee-for-service payment model but create savings incentives by offering bonuses for keeping costs down
- Providers have to meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases
- Patients stay healthy. You get paid more

Value Based Modifier

- CMS will submit payments to physicians based on the quality of care furnished and the cost of that care under the physician fee schedule
- The VBM program will begin in 2015 for some providers and apply to all providers in 2017
- Physicians in a groups of 100 or more eligible professionals who submit claims under a single tax identification number will be subject to the rule in 2015 based on their performance in 2013

Value Based Modifier

- All other physicians will be impacted by the rule in 2017
- In 2013 groups of 100 or more eligible professionals will need to self nominate and choose one of the following 3 reporting methods:
  - Web interface
  - Registry
  - Quality measurers from administrative claims
  - 1 percent penalty for non compliance

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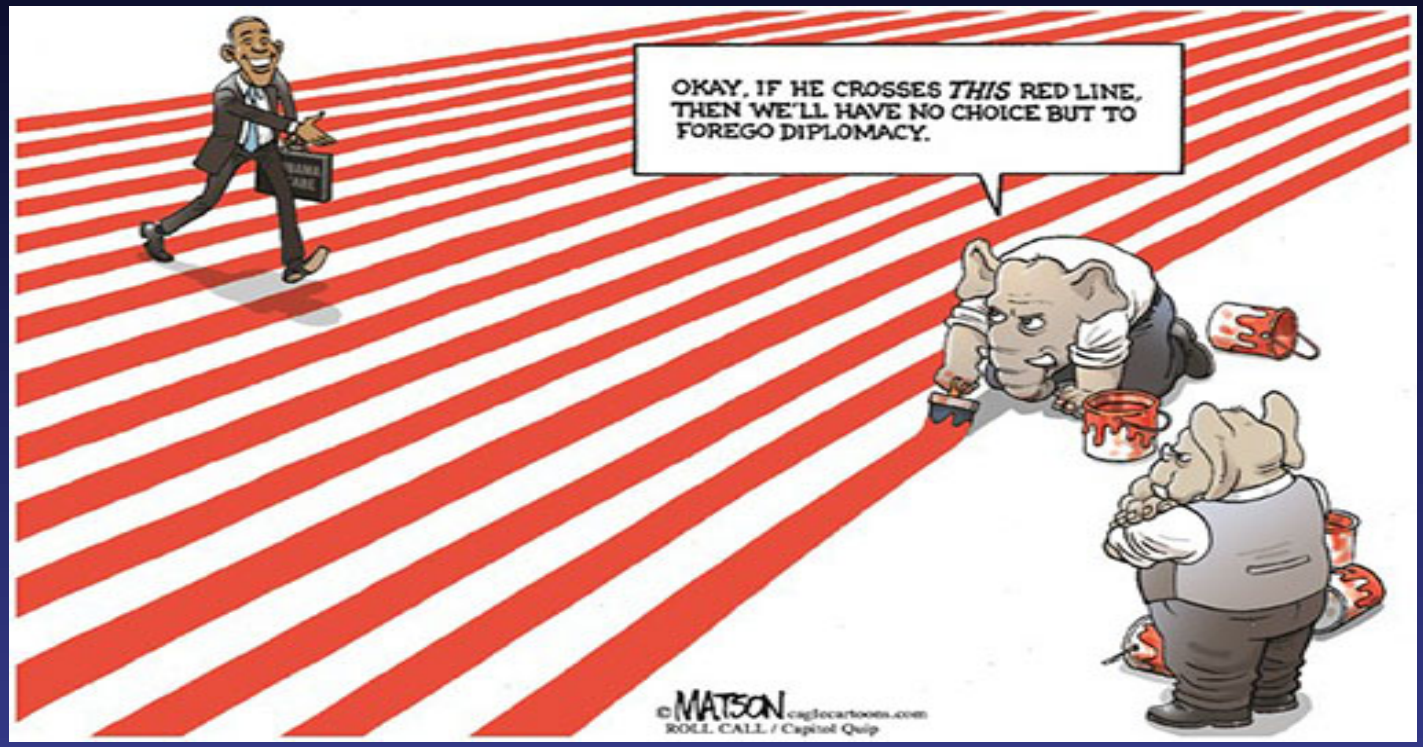
Congressional Issues



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Drug Shortages

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Drug Shortages

- Drug Shortage
- S. 296 Preserving Access to Life-Savings Medication Act
  - Requires drug companies from notifying the FDA of potential drug shortages
  - Establishes a system which allows the Secretary and drug companies to collaborate and work together in order to address the issue

Drug Shortages

- Energy and Commerce Drug Shortage Bill
  - Requires drug companies to issue 6 month notice of a potential drug shortage
  - Allows the Secretary to maintain an up to date list of drugs that are verified to be in shortage
  - Allows the FDA expedited review of manufacturing process
  - Requires an annual report of the state of drug shortages

Drug Shortages

- FDA Safety and Innovation Act
- Requires manufacturer of a drug that is life-supporting, life-sustaining, or "intended for use in the prevention or treatment of a debilitating disease or condition" submit a notice to the FDA of a discontinuation or interruption of the manufacture of the drug that could lead to a "meaningful disruption" to the supply of the drug.
- The notice must be submitted at least 6 months prior to the discontinuation or interruption or "as soon as practicable."

Drug Shortages

- The requirement that the FDA submit an annual report to Congress detailing the manufacturers reporting potential drug shortages and the communications concerning the FDAs actions to prevent drug shortages.
- The establishment of a drug shortage list.

Drug Shortages

- The establishment of a task force to “develop and implement a strategic plan” to enhance the FDA’s ability to prevent and mitigate drug shortages.
- The requirement to conduct a study that examines the cause of drug shortages and formulates recommendations on the prevention and alleviation of such shortages.

Drug Shortages

- The bills have helped
- Amount of new drug shortages has decreased from a high of 267 in 2011 to less than 100 as of today
- Active drug shortages still a problem
- As of the third quarter of this year there were 302 drug shortages, an increase from 2012
- Biggest issue is manufacturing quality

Medical Malpractice

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Medical Malpractice

- Medical Malpractice reforms
  - Cap on non-economic damages
  - Limitations on punitive damage awards
  - Allows for the introduction of collateral source evidence
  - Sets the statute of limitations limits
  - Failure to follow national guidelines not grounds for a lawsuit

Multiple Procedure Payment Reduction

- The 2011 Physician Fee Schedule increased the payment reduction for the technical component of certain single session imaging services to consecutive body areas to 50%
- Applies to reimbursement for multiple diagnostic imaging services administered by the same physicians, to the same patient, at the same session
- Previous number 25%
- The 2012 PFS applied a 25% discount to the same services to the professional component

MPPR

- HR 846 “The Diagnostic Imaging Services Access Protection Act”
  - Would repeal the payment reduction to the professional component of Medicare reimbursement for multiple diagnostic imaging services administered by the same physicians, to the same patient, at the same session
  - CT, MRI, Ultrasound
  - Payment reduction is currently at 25%

MPPR

- Mandates CMS to disclose specific data that was used to come in assessing their values
- Currently has 160 co-sponsors
- Currently sitting in committee

Stark Law

- Introduced by Rep. Pete Stark (D-CA)
- Prohibits physicians from making a self referral for certain designated health services to an entity from which the physician has a financial interest
- Not to be confused with the anti-kick back statute
- Stark deals with physician referrals. Anti-kickback deals with anyone doing business with a federal health care program

Stark Law

- 3 Key Questions
  - 1) Does this involve a referral of a Medicare or Medicaid patient by a physician or an immediate family member of the physician?
  - 2) Is the referral for a designated health service?
  - 3) Is there a financial relationship of any kind between the referring physician or family member and the entity to which the patient is being referred ?

Stark Self Referral

- HR. 2914 "The Promoting Integrity in Medicare Act"
  - Stark Law bars physicians from referring patients for certain designated services to facilities in which they have a financial interest
  - In-office ancillary exception provides a loophole to this rule
  - HR 2914 would remove advanced diagnostic imaging services, and radiation therapy from a list of accepted services from which physicians can self refer

Relative Value Update Committee

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RUC

- Advisory panel established by the AMA in 1991
- Consists of 29 elected members
- Meets twice a year
- Tasked with making recommendations as to how specific procedures should be valued and reimbursed
- Recommendations go to the Center for Medicare and Medicaid Services (CMS)
- Typically over a 90 percent acceptance rate

Sustainable Growth Rate (SGR)

- Created in 1997 through the Balanced Budget Act of 1997
- Statutory formula which determines Medicare Part B reimbursement rates
- Formula was established to attempt to constrain growth in Medicare spending
- The law mandated that the total spending for physician reimbursement could not exceed the total growth rate of the U.S. economy

SGR

Sustainable Growth Rate

$$SGR = b \times R$$

$$= b \times \frac{\text{Earnings}}{\text{Equity}}$$

$$= b \times \frac{\text{Assets}}{\text{Equity}} \times \frac{\text{Earnings}}{\text{Assets}}$$

$$= b \times \frac{\text{Equity} + \text{Debt}}{\text{Equity}} \times \frac{\text{Earnings}}{\text{Sales}} \times \frac{\text{Sales}}{\text{Assets}}$$

$$= \underset{A}{b} \times \underbrace{\left(1 + \frac{\text{Debt}}{\text{Equity}}\right)}_{B} \times \underbrace{\frac{\text{Earnings}}{\text{Sales}}}_{C} \times \underbrace{\frac{\text{Sales}}{\text{Assets}}}_{D}$$

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SGR

- Based on the statutory mandate that Medicare costs not exceed the total growth of the economy
- SGR has had to be cut every years since 2002
- Permanent fix too costly
- Temporary patches have cost the government close to $150 billion over the past 10 years

CBO and the SGR

- Estimated cost to permanently repeal the SGR is $135 billion
- Congress wants to take advantage of this window of opportunity
- Has made efforts over the past year to formulate a plan to repeal and replace the SGR

SGR

- CMS projects physician payments will drop 24.4% in 2014 without fixing the SGR.
- Cost of 10-yr SGR freeze currently is $139 billion over 10 years (about $100 billion less than previous estimates), while one-year patch would cost about $18 billion.
- Even if the House and the Senate can agree on offsets to match the cost, SGR formula must be replaced.

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Energy and Commerce SGR bill

- Provide positive payment updates of 0.5 % for years 2013 – 2018
- Beginning in 2019, quality update incentive program would be implemented
- Program would establish peer cohort system whereby physicians would be graded according to their peers

Hunger Games

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Energy and Commerce SGR Bill

- Quality Update Incentive Program (QUIP)
  - Before 2019, Stakeholders submit to HHS quality measures and clinical practice improvement activities applicable to specific peer group.
  - HHS solicits input and publishes final set before performance period used to measure performance for purposes of determining payment adjustment.
  - Each provider self-selects peer group and submits data on measures and clinical practice improvement activities.

Energy and Commerce SGR Bill

- Quality Update Incentive Program (QUIP)
  - Payment adjustment determined based on performance relative to thresholds.
    - Providers above top threshold get +1% adjustment.
    - Providers below bottom threshold get -1% adjustment.
    - Providers between thresholds get no adjustment.
  - Unless participating in APM, failure to report would result in -5% reduction to Medicare payments.
  - Keep in mind QUIP adjustments would be on top of other adjustments (e.g., meaningful use).

Energy and Commerce SGR Bill

- Alternative Payment Model (APM)
  - Starting in 2019, physicians can choose to be paid under alternative payment model.
  - Providers would submit proposed models to HHS.
  - Models can first be tested and evaluated through demonstration or incorporated into Medicare program without testing based on strength of evidence that model would reduce spending or improve care quality.
- CBO scored bill as costing $175.5 billion

Senate Finance SGR

- Senate Finance / Ways and Means SGR Proposal released October 30
- Applies 10 year payment freeze through 2023
- Seeks to move away from the current volume-based payment system and towards one that rewards quality, efficiency, and innovation

Senate Finance SGR

- Permanently repeal the current SGR system
- Provide zero percent update through 2023
- Beyond 2023, providers participating in an advanced APM would receive annual updates of 2 percent, while others would receive an annual update of 1 percent
- Physicians and other health care professionals to earn performance-based incentive payments through a compulsory budget-neutral incentive payment program called the value-based performance payment program

Senate Finance SGR

- Under the VBP program, the following current law payment penalties would cease at the end of 2016
  - Failure to successfully report on quality measures (PQRS) (2 percent penalty)
  - Budget neutral payment adjustment based on quality and resource use (Value-based modifier)
  - Failure to demonstrate meaningful use of certified EHR technology (3 – 5 percent penalty)
  - Money earned from these programs would remain in the physician payment pool

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Senate Finance SGR

- VBP program would apply to physicians beginning with payment in year 2017
- VBP program would apply to physician assistants, nurse practitioners, and clinical specialists beginning with payment in year 2018
- All others will begin receiving payments in 2019

Senate Finance SGR

- VBP program would asses provider performance in the following categories:
  - 1) Quality
  - 2) Resource Use
  - 3) Clinical Practice Improvement Activities
  - 4) EHR Meaningful Use

Quality Measures

- Secretary would solicit recommended measures for inclusion annually, and funding would be provided to develop additional measures
- Professionals would be given credit for attainment and achievement, with higher overall weight given to outcome measures
- To prevent duplicative reporting, professionals who report quality measures through certified EHR systems would meet the meaningful use clinical quality measures component

Resource Use

- Resource use metrics used in the current law VBM program and the methodology that is under development to indentify resources associated with specific care episodes would be enhanced and used for the resource use category
- The proposal would establish a process to involve professionals in furthering the measurement of resource use through identifying episodes of care and require them to indicate their specific role in treating the beneficiary
- Payment reduced for those who do who do not provide the information.

Clinical Practice Improvement Activities

- Will prepare professionals to transition to an advanced APM through a collaborative process with professionals and other stakeholders
- Specific activities from which professionals can select would fall under the following sub-categories

Clinical Practice Improvement Activities

- Expanded practice areas, such as same-day appointments for urgent needs and after hours access to clinician advice
- Population management
- Care Coordination
- Beneficiary engagement
- Participation in any Medicare APM

EHR Meaningful Use

- Professionals 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 professional's performance and would be tied to VBP incentive payments.

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SGR – Alternative Payment Models

- Professionals who have a significant share of their revenues in an APM that involves two-sided financial risk and a quality measurement component would receive a five percent bonus each year from 2016-2021.
- The revenue threshold would be 25 percent of Medicare revenue for 2016-2017.
- For 2018-2021, professionals could choose from a Medicare revenue only option or a combination of Medicare and non-Medicare revenue.
- Professionals who meet these criteria would be exempt from the VBM payment system.

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Encouraging Care Coordination

- Proposal would establish payment for one or more codes for complex chronic care management services, beginning in 2015
- Payments for these codes could be made to professionals practicing in a patient- centered medical home or comparable specialty practice certified by an organization recognized by the Secretary who are providing care management services.

Accurate Valuation of Services

- Proposal would set a target for identifying and revaluing misvalued services
- From 2016-2018, the target for identifying misvalued services is one percent of the estimated amount of expenditures under the physician fee schedule
- Secretary would solicit information from selected professionals to assist in accurate valuation under the fee schedule. Professionals who submit the requested information may be compensated, while those who don't may see a ten deduction in payment in any given year.

Appropriate Use Criteria

- Proposal would implement a program that would require ordering professionals to consult with appropriate use criteria for advanced imaging services.
- Secretary would specify appropriate use criteria from among those developed or endorsed by national professional medical specialty socities or other organizations.
- Payment would not be made for the advanced imaging service if consultation with appropriate use criteria did not occur.

Expanding Use of Medicare Data

- Proposal would allow those that currently receive Medicare data for public reporting purposes to provide or sell non-public data analyses to physicians and other professionals to assist them in their quality improvement activities

Transparency of Medicare Data

- Proposal would require HHS to publish utilization and payment data for physician and other practitoners on the Physician Compare website.
- Professionals would have the opportunity to review and correct their information prior to its posting on the website.

Next Steps

- Become involved in the quality reform efforts
- Establish and report quality measures
- Participate in PQRS
- Become involved with and report on clinical registries
- Respond to surveys collecting data
- Report outcomes data

Next Steps

- Make sure you are up to date with electronic health records standards
- Participate in alternate payment systems (ACOs)
- Participate in the use of structured reporting
- Engage in clinical practice activity improvements

See you next Session

SOCIETY OF INTERVENTIONAL RADIOLOGY

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