BAUCUS MEDICARE PACKAGE
Summary of Likely Physician/Clinician-Related Provisions
June 2, 2008

Update

- Blocks SGR cuts through December 31, 2009 (18-month fix)
- Provides 0.5% positive update for 2009
- Repeals 2013 PAQI fund to offset costs of fix and PQRI extension (see below)
- Deposits excess 10-year savings into 2014 Medicare Improvement Fund that will be accessed to block “cliffs” in 2010 and subsequent years

Quality

- Extends PQRI until January 1, 2011 (2-year extension)
- Increases PQRI bonus to 2.0% for 2009 and 2010
- Requires, except in limited circumstances, that PQRI measures be endorsed by a consensus-based entity identified by the Secretary
  - Provides substantial funding to that entity for measure endorsement
  - Requires stakeholders have the opportunity to provide input in measure development and adoption
- Requires Secretary to accept aggregated data from group practices addressing a subset of PQRI measures targeting high-cost, chronic conditions
- Incorporates changes from MMSEA 2007, including the use of condition-specific measure sets reported on consecutive claims and the use of registries to report on behalf of eligible providers
- Permits audiologists to participate in PQRI
- Requires Secretary to provide confidential feedback to providers regarding their resource use
- Requires Secretary to submit a plan to Congress regarding transition to a value-based purchasing program for physicians

E-Prescribing

- Provides positive incentives for practitioners who use a qualified e-prescribing systems in 2009 through 2013
  - Positive incentives are 2% for 2009 and 2010, 1% for 2011 and 2012, and 0.5% for 2013
- Requires practitioners to use qualified e-prescribing system in 2011 and beyond
  - Mandate enforced by reductions in payments to those who fail to e-prescribe
  - Reductions are 1% for 2011, 1.5% for 2012, and 2% for 2013 and beyond
- Positive incentives and reductions apply to all allowable Medicare charges
• Limits the application of financial incentives to those for whom encounters related to prescribing comprise 10% or more of their Medicare billing (using denominator codes for PQRI e-Rx measure)
• Secretary may provide hardship exception to those who are unable to use qualified e-prescribing system
• At first, e-prescribing will be determined using PQRI e-Rx measure, which specifies the characteristics of a qualified e-prescribing system
  o Allows the Secretary, if practicable, to eventually use Part D data to determine e-prescribing practices

**Primary Care and Work Values**

• Increases funding and expands authority for the Medical Home Demonstration Project established in TRHCA 2006 (funding level TBD)
  o Authorizes the Secretary to expand the duration and scope of the demonstration if certain quality and/or savings targets are achieved
  o Waives application of administrative obstacles to launching the demonstration
• Reapplies budget neutrality adjustment for recent RVU changes to the conversion factor, rather than work RVUs, effective 2009
• Effective 2011, focuses Physician Shortage Area (PSA) bonus on primary care physicians providing primary care services
  o Requires the Secretary to identify, through rulemaking, which payment codes qualify as primary care services
  o Defines primary care physician as one for whom primary care services account for a certain percentage (or more) of their Medicare allowable charges
  o Existing PSA bonus would not be renewed. New bonus would be permanent.

**Imaging**

• Requires facilities performing advanced diagnostic imaging services (MRI, CT, and nuclear/PET) to be accredited by January 1, 2012, in order to be eligible for the technical component of Medicare payment for imaging studies
  o Requires the Secretary to designate, by January 1, 2010, accrediting organizations for these purposes
  o Requires GAO study of implementation of the accreditation requirement
• Establishes, by January 1, 2010, a two-year, voluntary demonstration program to test the use of appropriateness criteria for advanced diagnostic imaging services
  o Requires that appropriateness criteria be developed by medical specialty societies in accordance with appropriateness principles developed by a consensus organization such as the AQA
  o Authorizes two means of collecting data regarding compliance with appropriateness criteria: (1) point of order; and (2) point of service
o Point of order model provides referring physician with real-time feedback on the appropriateness of imaging study ordered
o Point of service model collects data from physician performing the imaging study that will be aggregated and analyzed by the Secretary
o The use of prior authorization is prohibited

Extenders

- Extends the 1.0 floor on the work GPCI through December 31, 2009 (18 month extension)
- Extends the exceptions process for therapy caps through December 31, 2009
- Extends the grandfather of certain pathology contracts through December 31, 2009
- Makes permanent the MMSEA 2007 provision accommodating billing arrangements for physicians ordered to active duty in the armed services

Other

- Reverses the CMS payment rule for teaching anesthesiologists so that they receive 100% of payment for cases involving residents or student nurse anesthetists
  o Ensures comparable treatment of certified registered nurse anesthetists
  o Both changes consistent with (and in no way change) existing state standards for anesthesia training programs and scope of practice for affected providers
- Establishes Medicare coverage and payment for kidney disease patient education services furnished by qualified practitioners
  o This provision is part of a broader package of ESRD reforms that requires the establishment of a fully bundled payment system for ESRD services by 2011
- Requires Medicare coverage of cardiac and pulmonary rehabilitation programs
- Allows for separate billing of speech-language pathology services