HHS | Hart Health Strategies Inc.

Sustainable Growth Rate (SGR) Repeal and Replace: Comparison of 2014 and 2015 Legislation

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
SGR Repeal and Annual Updates		
General	Permanently repeals the SGR update mechanism, provides stable annual updates of 0.5% for five years (2014 through 2018), and ensures no changes are made to the current payment system for four years Professionals will receive an annual update of 0.5% in each of the years 2014 through 2018. The rates in 2018 will be maintained through 2023, while providing professionals with the opportunity to receive additional payment adjustments through the Merit-Based Incentive Payment System (MIPS). In 2024 and subsequent years, professionals participating in alternative payment models (APMs) that meet certain criteria would receive annual updates of 1.0%, while all other professionals would receive annual updates of 0.5%. Requires Medicare Payment Advisory Commission (MedPAC) to submit report to Congress in 2018 evaluating the impact that the 2014-2018 updates have on beneficiary access and quality of care, with recommendations regarding further updates. MedPAC also must submit reports in 2017 and 2021 that assess the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D.	Does the same, but modifies timeline: stable annual update of 0.5% will be offered from 2015 through 2019. Maintains stable rate through 2025, with opportunity for additional adjustments through the Merit-Based Incentive Payment System (MIPS). Starting in 2026, those participating in alternative payment models (APMs) would receive annual updates of 1.0%, while all other professionals would receive annual updates of 0.5%. Also pushes back timeline for the first Medicare Payment Advisory Commission (MedPAC) report by a year (2019); maintains timeline for additional reports that assess the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D.
Merit-Based Incentive Payment System		
Consolidating Current Programs	Payments to professionals will be adjusted based on performance in the unified MIPS starting in 2018. Consolidates the three existing programs: Physician Quality Reporting System (PQRS), Value-Modifier (VBM), and Meaningful Use (MU).	Same, but adjusts timeline so that performance-based payments begin in 2019.
Sunsetting Current Law Payment Penalties	Sunsets penalties associated with these three programs at the end of 2017, including the 2.0% penalty for failure to report PQRS quality measures, the up to 4.0% penalty under the VBM, and the 3.0% (increasing to 5.0% in 2019) penalty for failure to meet electronic health record (EHR) MU requirements. The money from penalties that would have been collected would now remain in the physician fee schedule,	Same, but penalties sunset at end of 2018

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	significantly increasing total payments compared to the current law baseline.	
Eligible Professionals	MIPS will apply to: doctors of medicine or osteopathy, 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 beginning in 2019. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2021, provided there are viable performance metrics available. Qualifying APM participants (described below) and partial qualifying APM participants (described below) who do not report measure data are not eligible for MIPS. However, a partial qualifying APM participant who reports applicable measure data and activities described under this section is eligible. Also excluded from MIPS are professionals who do not exceed a low-volume threshold selected by the Secretary, which may include one or more or a combination of: a minimum number of treated beneficiaries; a minimum number of items/services furnished to such beneficiaries; or a minimum amount of Medicare Part B allowed charges billed.	Same, but moves up implementation dates by a year.
Performance Assessment Categories	MIPs will rely on four categories to assess performance: 1. **Quality**. Quality measures will be published annually in a final measures list developed under the methodology specified below. In addition to measures used in existing quality programs, the Secretary will solicit newly recommended measures and fund professional organizations and others to develop additional measures. Measures used by qualified clinical data registries (QCDRs) may also be used to assess performance under this category. 2. **Resource Use**. Will include measures used in the current VBM program. The Centers for Medicare and Medicaid Services (CMS)	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	will continue to develop a methodology to measure resources associated with specific care episodes, but will rely more heavily on public input and an additional process that directly engages professionals and allows them to report their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode) to address current concerns about patient attribution. These measures will also incorporate ongoing work to improve risk adjustment methodologies. 3. **Meaningful Use**. Current EHR MU requirements, including use of a certified system, will continue to apply in order to receive credit in this category. To prevent duplicative reporting, professionals who report quality measures through certified EHR systems for the MIPS quality category are deemed to meet the meaningful use clinical quality measure component. 4. **Clinical Practice Improvement Activities**. Gives credit to professionals working to improve their practices through clinical practice improvement activities, which should facilitate future participation in APMs. The menu of recognized activities will be established in collaboration with professionals, but must at least include the following subcategories: – Expanded practice access (e.g., same day appointments for urgent needs and after hours access to clinician advice). – Population management (e.g. monitoring health conditions of individuals to provide timely health care interventions or participation in a QCDR). – Care coordination (e.g., timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth) – Beneficiary engagement (e.g., establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training,	

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	and using shared decision making mechanisms). – Patient safety and practice assessment (e.g., use of clinical or surgical checklists and practice assessments related to maintaining certification). – Participation in an alternative payment model (APM). In defining Clinical Practice Improvement Activities, the Secretary must solicit recommendations for additional activities and related criteria. The Secretary may contract with entities to assist with such activities and to determine whether an EP meets the applicable criteria. The Secretary must give consideration to small practices (those with 15 or fewer professionals) and those in rural or health professional shortage areas.	
Annual Selection of Quality Measures	Similar to the current process, the Secretary, through annual rulemaking, will publish by November 1 (prior to the performance year) a list of eligible quality measures to be used in the forthcoming MIPS performance period. Leading up to a rulemaking, the public will continue to have the opportunity to submit measures for consideration. In addition to measures used in existing quality programs, the Secretary will solicit newly recommended measures and fund professional organizations and others to develop additional measures. Measures may be submitted for consideration regardless of whether such measures were previously published in a proposed rule or endorsed by the National Quality Forum (NQF). Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity must be evidence-based. To the extent practicable, quality measures selected for inclusion on the final list will address all five of the following quality domains: clinical care, safety, care coordination, patient and caregiver experience, and	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	population health and prevention. Before including a new measure in the final list, the Secretary will submit the measure for publication in an applicable specialty appropriate peer-reviewed journal, including the method for developing and selecting the measure. Measures used by QCDRs may also be used to assess performance under this category. However, QCDR measures and existing quality measures will not be subject to the publication requirement and will be automatically included in the first program year's final list of quality measures. These measures will remain in the MIPS program unless they are removed under the rulemaking process.	
Funding for Quality Measure Development	Funding will be provided for measure development gaps and priorities. The Secretary, with stakeholder input, is required to develop and publish a plan for the development of quality measures for use in the MIPS and in APMs, taking into account how measures from the private sector and integrated delivery systems could be utilized in the Medicare program. The plan, which must be finalized by May 1, 2015, will prioritize outcome measures, patient experience measures, care coordination measures, and measures of appropriate use of services, and consider gaps in quality measurement and applicability of measures across health care settings. The Secretary will contract with entities with quality measure development expertise to develop priority measures and focus on measures that can be e-specified and are supported by clinical practice guidelines. By May 1, 2016, and annually thereafter, the Secretary must report on the progress made in developing quality measures, including descriptions of measures under development and quality areas being considered for future measure development. Funding will be $15 million annually in 2014 to 2018 for professional quality measure development. The funding will remain available through	Same, but all dates pushed back one year.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	fiscal year 2021.	
Performance Period	The performance period must begin and end prior to the beginning of a year for which a performance-based incentive payment will apply (no length specified), and must be as close as possible to such year.	Same.
Performance Standards and Scoring	In setting performance standards for measures and activities, the Secretary must take into account historical performance standards, improvement rates, and the opportunity for continued improvement. Professionals will receive a composite performance score of 0-100 based on their performance in each of the four performance categories listed above. Professionals will only be assessed on the categories, measures, and activities that apply to them. Weights would be assigned to each performance category and each underlying measure or clinical practice improvement activity as follows: • 30% for the quality performance category (and notes that multiple-payer quality data may be included in the analysis); • 30% for the resource use performance category (except for year 1 and 2 of the program when such weight must be 10% and 15%, respectively, with commensurate increases in the weight for quality to 50% and 45% in years 1 and 2, respectively); • 25% for the EHR meaningful use performance category. If EHR adoption reaches 75%, the weight for the EHR meaningful use performance category may be reduced to as low as 15%, with compensating adjustments made to other category weights; and • 15% for the clinical practice improvement performance category. Secretary must adjust weights if there are not sufficient measures and clinical practice improvement activities applicable available to each type of eligible professional (EP) involved. To create an incentive to report, EPs who fail to report on an applicable	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	measure or activity that is required to be reported by the professional, the EP shall be treated as achieving the lowest potential score applicable to such measure or activity. For the Clinical Practice Improvement Activities category score, EPs need not perform activities in each of the subcategories to achieve the highest potential score for this performance category. Also, EPs who participate in an APM are eligible to earn a minimum score of ½ of the highest potential score for this performance category. EPs in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, are eligible for the highest potential score.	
MIPS Payment Adjustment	Each EP's composite score will be compared to a performance threshold, which will be the mean or median of the composite performance scores for all MIPS EPs during a period prior to the performance period (details to be determined by the Secretary). Professionals will know what composite score they must achieve to obtain incentive payments and avoid penalties at the beginning of each performance period. Payment adjustments will follow a linear distribution. EPs whose composite performance scores fall above the threshold will receive positive payment adjustments and EPs whose composite performance scores fall below the threshold will receive negative payment adjustments. • **Negative adjustments**. Capped at 4.0% in 2018, 5.0% in 2019, 7.0% in 2020, and 9.0% in 2021. EPs whose composite performance score falls between 0 and 1/4 of the threshold will receive the maximum possible penalty for the year. EPs with composite performance scores closer to the threshold will receive proportionally smaller negative payment adjustments. These negative adjustments will fund positive payment adjustments to those with scores above the threshold,	Same, but implementation years are pushed back a year.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	• **Zero adjustments**. EPs whose composite performance score is at the threshold will not receive a MIPS payment adjustment. • **Positive adjustments**. EPs whose composite performance scores are above the threshold will receive positive payment adjustments. EPs with higher performance scores will receive proportionally larger incentive payments up to a maximum of three times the annual cap for negative payment adjustments. ○ ***Additional Incentive Payment***. Provides an additional funding pool of $500 million per year for 2018 through 2023 to reward exceptional performance. These payments will enable some professionals to receive incentive payments even if all professionals score above the initial threshold. The threshold for awarding these additional amounts could be set at either the 25th percentile of the range of possible composite performance scores (e.g., if the performance threshold is a score of 60, the additional performance threshold would be a score of 70) or at the 25th percentile of the actual composite performance scores for a prior period (i.e., 75% of professionals who receive a positive payment adjustment would receive an additional payment adjustment). EPs with scores above this threshold will receive an additional incentive payment, which will be allocated according to a linear distribution, with better performers receiving larger incentive payments. A professional's payment adjustment in one year will have no impact on their payment adjustment in a future year. Beginning with the second year to which the MIPS applies, in addition to the achievement of a threshold (see below), the scores from both the quality and resource use measure categories must take into account improvement if sufficient data to measure is available. For the other performance categories, the Secretary *may* take into account	Additional incentive payment funding pool applies from 2019-2024.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	improvement (although the Secretary may assign a higher weighting score to achievement vs. improvement). The GAO is required to evaluate the MIPS and issue a report in 2018, including an assessment of the professional types, practice sizes, practice geography, and patient mix that are receiving MIPS payment increases and reductions.	 GAO report must be issued by 2021.
Public Reporting	Secretary must publicly report EPs' composite scores and scores for each performance category on the Physician Compare website and may report scores for each underlying measure or activity. Must also report the names of EPs in an eligible APM and, if feasible, performance in such models. Must include a disclaimer, where appropriate, that this data "may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated." EPs must be given an opportunity to review/submit corrections to data prior to its being made public. The Secretary must also periodically post on the Physician Compare website aggregate data, including the range of composite scores for all eligible professionals and the range of the performance with respect to each performance category.	Same.
Technical Assistance	$40 million annually from 2014 to 2018 to help practices with 15 or fewer professionals improve MIPS performance or transition to APMs. $10 million of this funding is reserved for practices in areas designated as health professional shortage areas or medically underserved areas. Priority, in general, will be given to practices with low MIPS scores and those in rural and underserved areas.	Total funding reduced to $20 million and would apply from 2016 to 2020. Priority given to (but no specific portion reserved for) practices located in rural areas, health professional shortage areas, medically underserved areas, and practices with low composite scores.
Confidential Feedback	Professionals will receive confidential performance feedback related to the quality and resource use categories at least quarterly, likely through a web-based portal. Professionals may also receive confidential	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	feedback on performance through QCDRs.	
Other Provisions	The Secretary shall encourage the use of QCDRs and certified EHRs.	Same.
	The Secretary shall also account for risk factors in regards to both measures and performance methodologies used under MIPS.	Same.
	EPs will have the option to be assessed as a group or as a "virtual" group.	Same.
	The Secretary may use measures used for other payment systems (e.g. inpatient hospital measures) for purposes of the quality and resource use categories, but may not use hospital outpatient department measures, except in the case of emergency physicians.	Same, but exception for use of hospital outpatient measures was broadened to include not only emergency physicians, but also items/services provided by radiologists, and anesthesiologists.
	Multiple provisions to encourage collaboration with physicians and other stakeholders to improve resource use measurement for both the MIPS and APMs. This includes the development of care episodes, patient condition groups and classification codes, as well as patient relationship categories and codes to improve attribution of patients to physicians. Physicians and other applicable practitioners will be required to include these new codes on their claims on or after January 1, 2017, so that the Secretary can better analyze resource use. Relevant stakeholders will be given the opportunity to provide input throughout this process.	Same, but implementation date for reporting of new codes pushed back to January 1, 2018.

Encouraging Participation in Alternative Payment Models (APMs)

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
Qualifying APM Participants	Professionals who receive a significant share of their revenues through APMs that involve risk of financial losses and a quality measurement component will receive a 5.0% percent bonus each year from 2018-2023. Two tracks will be available for professionals to qualify for the bonus: 1. Based on receiving a significant percent of Medicare revenue through an APM. 2. Based on receiving a significant percent of APM revenue	Same, but dates pushed back one year so that APM bonus applies each year from 2019-2024.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	combined from Medicare and other payers. A "significant percent" is defined as follows: • For 2018 and 2019, at least 25% of Medicare payments from an APM. • For 2020 and 2021, at least 50% of Medicare payments or at least 50% of total payments (with at least 25% of Medicare payments) from an APM. • For 2022 and beyond, at least 75% of Medicare payments or at least 75% of total payments (with at least 25% of Medicare payments) from an APM. These determinations will be made based on covered professional services furnished by such professional during the most recent period for which data are available, which may be less than a full year. Payments made by the Secretaries of Defense/Veterans Affairs are not counted as part of the total payments. Medicaid payments are also not counted in states in which no medical home or Medicaid APM is available. Eligible APMs must involve the use of certified EHR technology and quality measures comparable to those used by Medicare. The Secretary may, as appropriate, base determination of whether an EP is a qualifying or partially qualifying APM participant by using counts of patients in lieu of using payments and using the same or similar percentage criteria.	The dates included in the definition of a "qualifying" APM participant are also pushed back a year.
Partially Qualifying APM Participants	EPs participating in an APM who meet somewhat lower payment thresholds than those for a qualifying APM participant are not eligible for additional payments available to qualifying APMs, but may be eligible for the MIPS if they report applicable measure data and activities (see above). These partially qualifying APM participants are defined as:	Same, but dates pushed back a year.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	• For 2018-2019, at least 20% of Medicare payments. • For 2020-2021, at least 40% of Medicare payments or at least 40% of total payments (with at least 20% of Medicare payments). • For 2022 and beyond, at least 50% of Medicare payments or at least 50% of total payments (with at least 20% of Medicare payments).	
Submission and Review of Physician-Focused Payment Models	Establish, upon enactment, a Physician-Focused Payment Model Technical Advisory Committee composed of 11 federally appointed national experts in physician-focused payment models and related delivery of care. Members would have 3 year staggered terms. No more than 5 members shall be providers and no member may be a federal employee. By November 1, 2016, Secretary must through Request For Information (RFI) and rulemaking, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making recommendations. MedPAC may also submit comments during this period. On an ongoing basis, the public may submit to the Committee proposals for physician-focused payment models that meet the established criteria. The Committee will review these models and make recommendations to the Secretary as to whether they meet the criteria. The Secretary's detailed response must be posted publicly. Language also included to specifically encourage the development and testing of models that focus on: • Non-primary care services; • Smaller practices (15 or fewer professionals); • Risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates,	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	hospital readmissions rates, and other relevant measures; • Medicaid/CHIP; and • Other public, private, and state-based payment models.	
Other Provisions	• Not later than 2 years after enactment, Secretary must present recommendations to Congress on ways to reduce potential fraud vulnerabilities in APMs. • By July 1, 2015, Secretary must submit a study to Congress on integrating APMs into the Medicare Advantage payment system, including the feasibility of a value-modifier.	Same, but pushes implementation date back a year.

Encouraging Care Management for Individuals with Chronic Care Needs

General	Directs the Secretary to establish one or more HCPCS codes for chronic care management (CCM) services and to make payments to applicable providers for services furnished on or after January 1, 2015. Applicable providers are defined as a physician, physician assistant or nurse practitioner, clinical nurse specialist, or certified nurse midwife who furnishes services as part of a patient-centered medical home or a comparable specialty practice.	Revised language states that the Secretary, as deemed appropriate, shall make payment for CCM services furnished on or after January 1, 2015, by a physician, physician assistant or nurse practitioner, clinical nurse specialist, or certified nurse midwife. Language about providing services as part of a patient-centered medical home was removed. CMS is also directed to conduct an education and outreach campaign to inform physicians about the benefits of CCM services, and encourage those with chronic care needs to receive such services. **NOTE**: *CMS finalized payment for CCM codes as part of the 2015 MPFS Final Rule, effective January 1, 2015.*
	In order to prevent duplicative payments, only one professional or group practice will receive payment for these services provided to an individual during a specified period. Payment for these codes will be budget-neutral within the physician fee schedule. Payments for chronic care management would not require that an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.	Same, but language about budget neutrality was removed.
	Secretary must submit report to Congress by December 31, 2017 on the use of chronic care management services by individuals living in rural	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	areas and by racial and ethnic minority populations.	

Transparency/Empowering Beneficiary Choices through Access to Information on Physician Services

General	Not later than July 1, 2015, for physicians and July 1, 2016, for other professionals, in addition to the quality and resource use information that would be posted through the MIPS, the Secretary is required to publish utilization and payment data for professionals on the Physician Compare website. With emphasis on the services a professional most commonly furnishes, such information will include the number of services furnished, as well as submitted charges and payments for such services. It will be searchable by the EP's name, provider type, specialty, location, and services furnished. The website will indicate, where appropriate, a disclaimer that information may not be representative of the EPs entire patient population, variety of services furnished, or the health conditions of the individuals treated. Professionals will continue to have an opportunity to review and correct this information prior to its posting on the website.	Minor revision to state that on an annual basis, beginning with 2015, the Secretary is required to publish utilization and payment data for both physicians and other professionals, as appropriate. The Secretary will integrate this information on the Physician Compare website starting in 2016. This version also clarifies that information made available under this section shall be similar to, and released in a similar manner as, the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File released with respect to 2012. The disclaimer language no longer appears in this section nor does the language giving professionals an opportunity to review this data.

Expanding Claims Data Availability to Improve Care

Qualified Entities	Consistent with relevant privacy and security laws, entities that currently receive Medicare data for public reporting purposes (known as qualified entities or "QEs") will be permitted to provide or sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them in their quality improvement activities or in developing APMs. Any data or analyses must be de-identified, though the provider accessing the data or analysis can receive identifiable information on the services furnished to his or her patient. QEs will be permitted to provide or sell non-public analyses	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	to health insurers (who provide claims data to the QE) and self-insured employers (only for purposes of providing health insurance to their employees or retirees). Providers identified in such analyses will have an opportunity to review and submit corrections before the QE provides or sells the analysis to other entities. To ensure the privacy, security, and appropriate use of Medicare claims information, QEs must: have a data use agreement with providers and entities to which they provide data; and be subject to an assessment for breach of such agreement. Further, providers and entities receiving data and analyses are prohibited from re-disclosing them or using them for marketing. QEs that provide or sell analyses or data shall provide an annual report to the Secretary that provides an accounting of: 1. The analyses provided or sold, including the number of analyses and purchasers, the amount of fees received, and the topics and purposes of the analyses; and 2. A list of entities that were provided or sold data, the uses of that data, and the fees received by the QE for such data. The claims data available to QEs will also include Medicaid/CHIP data.	
Qualified Clinical Data Registries	Consistent with relevant privacy and security laws, the Secretary is required to make data available to QCDRs to support quality improvement and patient safety activities. The Secretary may charge a fee that covers the cost of preparing the data.	Same.
Reducing Administrative Burden and Other Provisions		
General	Provides that the development, recognition, or implementation of any guideline or other standard under any Federal health care provision, including Medicare, cannot be construed to establish the standard of care or duty of care owed by a health care professional to a patient in any medical malpractice or medical product liability action or claim. This	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470
	ensures that MIPS participation cannot be used in liability cases. This provision would not preempt any state or common law governing medical professional or medical product liability actions or claims.	
Other Provisions		
Medicare Opt-Out	Allows professionals who opt-out of Medicare to automatically renew at the end of each two-year cycle. Requires regular public reporting of opt-out physician characteristics.	Same
EHR Interoperability	Requires that EHRs be interoperable by 2017 and prohibits providers from deliberately blocking information sharing with other EHR vendor products.	Moves date back to 2018.
Gainsharing	Requires the Secretary to issue a report recommending how a permanent physician-hospital gainsharing program can best be established.	Same.
Telemedicine	Requires GAO to report on barriers to expanded use of telemedicine and remote patient monitoring.	Same.
Remote Patient Monitoring	Requires Comptroller General to study remote patient monitoring technology in the private health insurance market, including dissemination and financial incentives, and barriers to adoption in the Medicare Program, among other things.	Same.
Multiple Procedure Payment Reduction	Requires the Secretary to publish information used to establish the multiple procedure payment reduction policy for imaging.	Language not included at bill introduction.