Bipartisan Medicare Physician Payment Legislation

This bipartisan legislation takes important steps to transform the Medicare physician payment system in a number of important ways. First and foremost, the bill repeals the flawed sustainable growth rate system and replaces it with a fair and stable system of payments. Instead of looming annual cuts, physicians will be rewarded for the quality of care they provide to Medicare beneficiaries. The legislation also includes new transparency and collaboration requirements to solicit input from expert medical organizations and other groups on the development and selection of quality measures. The bipartisan bill also provides additional avenues for development of new payment and care delivery models.

Repeal Flawed Medicare Sustainable Growth Rate Formula

For the past decade, Congress had needed to override the SGR formula to undo deep cuts caused by flaws in the formula. This legislation permanently repeals the current Medicare SGR mechanism that places a global cap on Medicare spending on provider services.

Period of Stability

The legislation provides an annual statutory update of 0.5% per year for 2014 through 2018. During this time, the current law payment incentives, such as the Physician Quality Reporting Program (PQRS) and the Electronic Health Record (EHR) Incentive Program will continue. During this time, quality measure development will continue to ensure robust availability of measures for rewarding provider performance. Providers will also have the option of using current delivery system reform avenues as well as a new Alternative Payment Models (APM) process to put forward and test new models of care delivery and improvement.

Rewarding Performance

Beginning in 2019, providers will receive an annual update of 0.5%. However, physicians practicing in fee-for-service will receive an additional update adjustment based on quality performance under a new Update Incentive Program (UIP). Performance under the UIP will be assessed based on quality measures and clinical practice improvement activities. These measures and activities may be those currently in use or new measures. Providers and other stakeholders shall be included in the development and selection of measures used in the UIP. Provider performance will be assessed among peer cohorts of like providers providing like services. High performing providers (those that achieve above a threshold) will have the opportunity to earn a 1% bonus payment based on previous performance, while low performing providers (those that are below a threshold) will see a 1% reduction in payments.

Providers who do not report any quality information will receive the current law 2% reduction in payment under PQRS, an additional 3% reduction under UIP. Other incentive programs in title XVIII remain in place.

Alternative Payment Models (APMs)

Development of new models of care is already underway; many of these new models show great promise for care coordination, keeping people healthy, and encouraging collaboration and shared accountability across the care continuum. This legislation establishes an additional avenue for the development, testing, and approval of APMs beginning in 2015. Under this new process, providers and other stakeholders may submit proposals for new models to an independent entity that will review
proposals and make recommendations to the Secretary for models to move forward as either a
demonstration or as a permanent program. The independent entity will report at least quarterly on
models received and recommendations. Models that are adopted as demonstrations are evaluated by
an independent third party for success on improving care or reducing (or not increasing) costs.

Supporting Care Coordination and Medical Homes

To support care coordination and development of patient centered medical homes, the legislation
establishes new payment codes for complex chronic care management for providers treating individuals
with complex chronic conditions. The legislation also ensures that Medicare payment is available for
care coordination services performed by physicians who: are certified as a Level III Medical Home by the
National Committee on Quality Assurance; are recognized as a patient-centered specialty practice by the
National Committee on Quality Assurance; have received equivalent certification, or meet other
comparable qualifications.

Expanded Data Availability for Care Improvement

To expand the availability of Medicare data for providers to use in developing new models of care and
improving quality and patient care, the legislation expands access to Medicare data for certain certified
entities. The legislation eliminates the roadblocks that prevented these entities from sharing data
directly with providers to facilitate the development of alternative payment models and care
improvement.

Improving Payment Accuracy

A lack of accurate and meaningful data on costs has hampered the ability of Medicare to review the
accuracy of payments for services and identify which services are improperly valued. The legislation
would ensure that providers could be compensated for the cost of submitting such data. The legislation
also directs Medicare to identify improperly valued services under the fee schedule that would result in
a net reduction of one percent of the projected amount of expenditures for a year during 2016 through 2018.

Rule of Construction Regarding Standards of Care

This legislation provides that the development, recognition, or implementation of any guideline or other
standard under any Federal health care provision under the ACA, Medicare, and Medicaid shall not be
construed to establish the standard of care or duty of care owed by a health care provider to a patient in
any medical malpractice or medical product liability action or claim.