

MEDICARE PHYSICIAN PAYMENT INNOVATION ACT OF 2012

INTRODUCTION

The Balanced Budget Act of 1997 created the sustainable growth rate formula (SGR) in an attempt to control spending in the Medicare program. For ten years, this payment formula has consistently produced unrealistic expenditure targets, which subsequently trigger untenable reductions in payment rates. Annual Congressional overrides of these scheduled cuts have averted immediate crises in access to physician services for Medicare beneficiaries. Failing to repeal the SGR has exacerbated a longer-term crisis in Medicare financing. On January 1, 2013, physicians face a scheduled reduction in Medicare payments of more than 30 percent.

The current approach to payment levels based on overall physician expenditure targets, which punishes individual physicians for systemic dysfunction, is the wrong approach to reducing costs. The existing fee-for-service model, particularly with the threat of SGR cuts, rewards overutilization as clinicians seek to compensate for insufficient payments. It is time to end SGR and create a clear pathway to new reimbursement models that will treat physicians fairly, improve patient outcomes, and reduce costs in Medicare by changing the way we pay physicians to incentivize timely, evidence-based, coordinated care for Medicare beneficiaries. Payment reforms that reimburse clinicians on the basis of efficiency, quality and patient outcomes are essential to slowing the rate of growth in health care spending while ensuring access to services.

The Medicare Physician Payment Innovation Act of 2012 fully repeals the SGR, stabilizes current payment rates to ensure beneficiary access in the near-term, eliminates scheduled SGR cuts, creates positive incentives for undervalued primary, preventive and coordinated care services, and sets out a clear path toward comprehensive payment reform.

MEDICARE PHYSICIAN PAYMENT INNOVATION ACT OF 2012

SUMMARY OF PROVISIONS

1. REPEAL THE SUSTAINABLE GROWTH RATE PERMANENTLY.

The existing Medicare physician payment system is unsustainable and the SGR must be repealed immediately. Real progress toward a quality-based, fiscally sound payment system cannot begin without eliminating the uncertainty and instability resulting from the SGR that has persisted for a decade.

This legislation permanently repeals the “sustainable growth rate” (SGR) formula. By eliminating the \$300 billion debt to the Medicare program, this provision restores stability and fiscal transparency to the payment system, and sets out a clear path to comprehensive payment reform. The cost of repeal is fully offset using the savings from the reduction in military operations in Iraq and Afghanistan.

2. STABILIZE THE CURRENT PAYMENT SYSTEM.

First and foremost, Congress must take action to avert cuts exceeding 30 percent to physician reimbursements scheduled for January 1, 2013 and stabilize the current payment system.

In order to ensure a workable transformation of the Medicare payment system over the long-term and provide short-term stability in the Medicare program, 2012 payment levels would be maintained through December 31, 2013. Thereafter, a five-year transition period would replace scheduled cuts that threaten access to care with positive and predictable updates to all physicians, while gradually modifying the current physician payment formula, before new payment systems are fully implemented in 2018.

3. PROVIDE POSITIVE PAYMENT UPDATES FOR ALL PHYSICIANS.

Despite the steady increase in the cost of providing patient care, physician payments have remained virtually static for over a decade. Static payments and rising costs are threatening the viability of medical practices and discouraging investments in quality improvements, leading the large cohort of practicing physicians over 55 years of age to weigh retirement or no longer accept Medicare patients.

This legislation provides positive annual updates of .5 percent for all physician services each year for four years.

4. INSTITUTE INTERIM MEASURES TO ENSURE ACCESS TO CARE COORDINATION AND PRIMARY CARE SERVICES.

At present, more than 1.3 million Medicare beneficiaries have difficulty finding a primary care physician. A major factor in the supply of these physicians is the undervaluation of primary care services, preventive care and care coordination services. Nonprocedural services associated with prevention, evaluation, diagnosis and management, which constitute the majority of primary care services, are undervalued under the current system, while care coordination is rarely reimbursed at all. During the transition period to more coordinated, patient-centered delivery models, short-term measures to attract and retain primary care physicians and other clinicians who are involved in care coordination are needed to ensure beneficiary access to such care.

The Medicare Physician Payment Innovation Act would implement temporary, four year differential updates to payments for physician services. For years 2014 to 2017, the bill provides an annual increase of 2.5 percent for primary care, preventive and care coordination services provided by clinicians for whom 60 percent of their Medicare allowable charges are for those same services. This would direct the differential to physicians who are principally providing comprehensive prevention, care coordination and preventive services to their patients. This short-term measure addresses the undervaluation of primary care, preventive and care coordination services.

5. AGGRESSIVELY TEST AND EVALUATE NEW PAYMENT AND DELIVERY MODELS.

Building on initiatives by physicians, employers, and payors in the private sector, the Centers for Medicare and Medicaid Services (CMS) are currently engaged in a number of initiatives to test new health care delivery and payment models intended to reduce costs while improving quality. Physicians and health systems across the country are actively pursuing innovative changes to the way they deliver care. These ongoing activities in both the public and private sector have the potential to transform the health care delivery system, improve outcomes and contain the rising growth of costs.

Ongoing demonstration projects under CMS will inform the development of payment models to replace the SGR. This legislation directs CMS to expand upon its current charge and identify, test and evaluate multiple models that can be successfully replicated in more than one geographic region taking into account the need to identify workable options for both primary care providers and specialists. In addition to the quality and spending components, the Secretary's evaluation of models would include an estimate of the per-physician cost of implementation.

Recognizing that such evaluations cannot be successful without the input of those on the front lines of patient care, the legislation requires ongoing collaboration with state and national physician membership organizations, many of which are leading the effort to develop, disseminate and evaluate new payment models. It provides for assessment of private payor models that have demonstrated success in achieving high-quality care at lower cost for potential inclusion in payment options made available under Medicare.

This legislation also directs the Government Accountability Office to conduct a meta-analysis of CMS's evaluations and report to Congress by April 1, 2016 on these initiatives to date and provide recommendations to the agency to address any problem areas identified in the report.

6. IDENTIFY BEST PRACTICES AND DEVELOP A MENU OF DELIVERY MODEL OPTIONS.

Under the existing Medicare Physician Payment System, the SGR imposes a singular payment formula in a wide array of health care settings, irrespective of the physician's practice model, specialty or role within the community's larger health care system. Comprehensive reforms to the payment system must provide flexibility and multiple options with various levels of risk and integration to ensure maximum participation and successful implementation of new payment models in diverse practice settings and geographic regions.

By October 1, 2016, the Centers for Medicare and Medicaid Services (CMS) must issue a menu of no fewer than four health care delivery and payment model options based on an analysis of its relevant evaluations and input from the provider community. CMS will also have the option of selecting models under development outside the agency, including models from the private sector, that have demonstrated success in containing costs while improving quality. In addition, CMS must publicly release guidance to clinicians as to best practices for transitioning from their current practice model to new models based on factors including practice size, specialty mix, health care infrastructure in the region, demographics, case mix and variations in cost of living.

7. PROVIDE ALTERNATIVE VALUE-DRIVEN FEE-FOR-SERVICE SYSTEM

Recognizing that the ability to transition into new payment models will vary by specialty and practice-type, the legislation provides two options for physicians with a demonstrated commitment to quality and efficiency, who are not able to participate in one of the other CMS-approved payment and delivery models described above, to participate in a new alternative fee-for-service system that would include incentives for care coordination, management of high-risk patients, and other policy objectives to improve the quality and reduce costs. Qualifying physicians must fall into one of the following categories:

Clinicians who adhere to a comprehensive list of cost, quality and outcome measures, developed in conjunction with medical societies. Such measures include meaningful use standards, participation in the Physician Quality Reporting System (PQRS) and successful participation in an approved Maintenance of Certification (MOC) program, which may include quality registries; or,

Exceptional clinicians as demonstrated by achievements in the areas of cost, quality and outcomes as assessed by the Value-Based Modifier relative to their peers. This group includes those in the top quartile within their geographic fee schedule area. These providers would also be required to meet meaningful use standards for electronic medical records.

8. ESTABLISH A TRANSITION PERIOD.

While delivery system reforms offer providers the opportunity to reap benefits in the long-term, the period of physician practice transformation will initially be time and resource intensive for many. Sufficient time will be necessary to allow clinicians to evaluate the appropriateness of the new models for implementation in their own practices and seek external guidance as needed.

In order to minimize disruption in the transition to new delivery models in 2018, fee-for-service payments will be continued at 2017 levels for one year. Recognizing the unique challenges facing solo and small group clinicians seeking to transform established business models, this legislation provides funding for existing Regional Extension Centers to provide guidance to physicians on alternative health care delivery model options and best practices for practice transition.

9. REWARD CLINICIANS FOR HIGH-QUALITY, HIGH-VALUE CARE WHILE DISINCENTIVIZING FRAGMENTED, VOLUME-DRIVEN CARE.

Coordinated care models are the future of the Medicare physician payment system and widespread adoption will be central to the success of cost-containment through delivery system reforms. Incentives for physicians to change their practice models will ensure a comprehensive transformation of the current delivery system. While financial incentives among the various approved models will vary, resistance to change cannot be rewarded. A straight fee-for-service system updated annually on the basis of overall spending relative to an expenditure target, however designed, cannot substitute for fundamental delivery system reforms.

Beginning, January 1, 2018, physicians practicing within a CMS-approved health care delivery model will continue to receive stable reimbursements consistent with their specified payment system, with opportunities to earn higher reimbursements for achieving gains in quality, effectiveness and cost of patient-centered care. Many of the CMS-approved models are expected to break down the Medicare payment silos between Medicare Part B (physician services) and Part A (hospital services), such as by allowing clinicians and hospitals to share in savings from reducing preventable admissions. For those practicing in CMS-designated coordinated care models with underlying fee-for-service payments, the fee-for-service component (only) will continue to be reimbursed at 2017 levels through 2021, while the other components would be established and updated based on their own underlying methodology.

Clinicians who choose to retain the current fee for-service-model, rather than participating in one of the new CMS-approved coordinated care payment and delivery models or the new alternative fee-for-service system described above, will be subject to disincentives in the form of reduced updates to both primary and non-primary care services. Annual updates in years 2019 to 2022 for those in this category will be: -2% in 2019, -3% in 2020, -4% in 2021 and -5% in 2022.

The legislation contains a limited exemption from negative fee-for-service updates to be granted annually by CMS on a case-by-case basis for providers who, after demonstrating a good faith effort, are deemed incapable of transitioning to an established model.

By offering clinicians multiple options to participate in the new CMS-approved payment models or alternative fee-for-service system developed with physician input, with a limited hardship exemption, the legislation ensures that clinicians need not be subject to disincentives unless they choose to remain in the traditional fee-for-service system.

10. ENSURE LONG TERM STABILITY IN THE MEDICARE PHYSICIAN PAYMENT SYSTEM.

Predictable updates that accurately reflect the cost and value of providing health care services in coordinated care models while containing health care spending will be essential to a sustainable payment system over the long-term.

This legislation directs the Secretary beginning in 2023 to update payments under coordinated care models between one percent and the Medicare Economic Index (MEI) annually based on beneficiary access to health care services, provider participation in CMMI models and the overall rate of growth in spending in the Medicare program – to include both Part A and Part B combined.

Payments in the straight fee-for-service model will be permanently frozen at 2022 levels.