REPRESENTATIVE ALLYSON Y. SCHWARTZ
13th District, Pennsylvania

REPRESENTATIVE JOE HECK, D.O.
3rd District, Nevada

MEDICARE PHYSICIAN PAYMENT INNOVATION ACT OF 2013

The Balanced Budget Act of 1997 created the sustainable growth rate formula (SGR) in an attempt to control spending in the Medicare program. For over a decade, 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, 2014, physicians face a scheduled reduction in Medicare payments of nearly 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 the SGR and create a clear pathway to new reimbursement models that will treat providers 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 2013 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.

SUMMARY OF PROVISIONS

1. REPEAL THE SUSTAINABLE GROWTH RATE PERMANENTLY.

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.

2. STABILIZE THE CURRENT PAYMENT SYSTEM.

This provision would maintain 2013 payment levels through December 31, 2014 in order to avert cuts to physician reimbursements scheduled for January 1, 2014. 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 2019.

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

At present, primary care services, preventive care services and care coordination services are undervalued. To address this problem, the Medicare Physician Payment Innovation Act would

implement temporary, four year differential updates to payments for physician services. For years 2015 to 2018, 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.

4. PROVIDE POSITIVE PAYMENT UPDATES FOR ALL PHYSICIANS.
Static payments and rising costs are threatening the viability of medical practices and discouraging investments in quality improvements. This legislation provides positive annual updates of .5 percent for all other physician services each year for four years.

5. AGGRESSIVELY TEST AND EVALUATE NEW PAYMENT AND DELIVERY MODELS.
Physicians and health systems across the country are actively changing the way they deliver care. In order to transform the health care delivery system, improve outcomes and contain the rising growth of costs, this legislation directs CMS to expand its current charge and identify, test and evaluate multiple widely applicable and comprehensive models. It also requires ongoing collaboration with state and national medical provider organizations, and directs the Government Accountability Office to conduct a meta-analysis of CMS's evaluations and report to Congress by April 1, 2017.

6. IDENTIFY BEST PRACTICES AND DEVELOP A MENU OF DELIVERY MODEL OPTIONS.
The SGR imposes a singular payment formula in an inappropriately wide array of health care settings. 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, 2017, the Centers for Medicare and Medicaid Services (CMS) must issue a menu health care delivery and payment model options based on an analysis of its relevant evaluations and input from the provider community.

7. PROVIDE ALTERNATIVE VALUE-DRIVEN FEE-FOR-SERVICE SYSTEM
This provision 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 modified fee-for-service option.

8. ESTABLISH A TRANSITION PERIOD.
The period of physician practice transformation will initially be resource intensive. In order to minimize disruption in the transition to new delivery models in 2019, fee-for-service payments will be continued at 2018 levels for one year. This legislation also 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.
Incentives for physicians to change their practice models will ensure a comprehensive transformation to coordinated care models, which are the future of the Medicare physician payment system. Beginning January 1, 2019, 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. Clinicians who choose to retain the current fee-for-service model will be

subject to reduced updates to both primary and non-primary care services. The legislation contains a limited exemption from negative fee-for-service updates for providers who are incapable of transitioning to an established model.

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 2024 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 2023 levels.