

Patients First Act Section by Section

Title I – Strengthening Reimbursement and Patient Access

- **Section 101. Modifying the Conversion Factor**
 - Replaces the existing growth rate an inflationary based update of the MEI number with one point subtracted, or MEI -1;
 - Maintains the split conversion factor for APM and grows that conversion factor at an additional .5 percentage points annually to incentivize value-based care;
 - Includes guardrails on the MEI-1 calculation so that the adjustment cannot exceed .75 of total MEI or fall below .25 of MEI in any given year;
 - Adds additional annual reporting requirements to Congress on the adequacy of the MEI -1 number on system capacity, access of timely services for beneficiaries and consolidation of independent practice.
- **Section 102. Hybrid Payment Model for Primary Care**
 - Creates a new five-year demonstration project where CMS would be tasked with establishing a hybrid payment structure, blending traditional FFS with per-member-per-month (PMPM) capitated payments for primary care providers;
 - Requires elimination of cost sharing for beneficiaries for the PMPM payments;
 - PMPM Bundle Includes:
 - Care Management Services
 - Behavioral health integration
 - Office Based E&M Services including telehealth
 - Care follow up/wrap around communications
 - Participating practitioners can still bill the fee schedule for services not included in the PMPM.
 - Restricts access to the demonstration project to only independent clinicians.
- **Section 103. Work Geographic Floor Adjustment for High Inflationary Years**
 - For a five-year period, for years in which the MEI index is above 2% (defined as high inflationary). Requires the Secretary to adjust the Work Geographic Index floor by and additional .025 for rural GPCIs or by .02 for all other GPCIs.
 - This builds an additional bulwark for practices in years where there is high inflation to help better match payment to compensate for these pressures on practices.
 - Requires additional transparency at the Medicare Administrative Contractor level to publish the adjusted Work RVU on a quarterly basis.

Title II – POINTS

- **Section 201. POINTS Implementation**
 - Rebrands the FFS QPP program to replace MIPS after the five-year transition period as the Patient Outcome Improvement National Tabulation System (POINTS)
- **Section 202. Payment Reform**
 - Establishes three performance categories for metric development under POINTS, maintaining the Quality and Resource Use from MIPS and creates a Care Efficiency Category that is further defined as metrics that measure:

- Reductions in avoidable hospitalizations
 - Reductions in medication burden where clinically appropriate
 - Reductions in complications of chronic disease
 - Referral patterns to the lowest cost clinically appropriate care setting
- Clarifies that all POINTS Metrics must have been recommended by the Task Force to be enforceable.
- Upon enactment, enables the CMS to engage in pay for testing for new or substantially changed metrics to establish thresholds and encourage the utilization of novel metrics in the program.
- Sets the category weighing for POINTS at 65% Quality, 20% Resource Use and 15% Care Efficiency to generate a clinicians score during a given performance year.
- Eliminates MACRA requirement that cost measures be tied to at least half of physicians to enable more flexibility and targeting.
- **Section 203. Quality Reform Task Force**
 - Requires CMS to establish new Quality Care Reform Task Force to develop and implement new QPP reporting metrics for the POINTS System
 - Task Force will be led by CMS Administrator or their designee, CMS/HHS able to make appointments to the task force. Rotating slots will be available for relevant medical professionals to be appointed by professional medical societies during consideration of metrics in their field of practice;
 - Stipulates that the Task Force must be composed of a majority of medical clinicians. In turn, each metric must be approved by a majority vote of the Task Force;
 - Metrics are required to conform with relevant clinical guidelines and encompass input from the relevant specialty and subspecialty that will practice under said metric.
 - Requires that new metrics must be able to be submitted through EHR technology, administrative or billing claims or through a data registry to reduce clinician burden.
 - Metrics for non-patient facing providers must consider the circumstances of their practice.
 - Also requires metrics to align across categories and directly relate to either an episode of care or across a continuum of care.
 - Gives special consideration to metrics developed by Clinician Led or Qualified Clinical Data Registries.
 - Requires the Secretary to publish responses to recommended metrics and submit reports to Congress on what is being implemented.
 - Creates a special pathway for a presumption of inclusion for metrics developed and recommended by a 75% vote of the Task Force.
- **Section 204. Modification of MIPS Payment Adjustments**
 - Reduces payment penalties in MIPS from +/- 9% to +/-2% during the transition period of the rework of metrics and establishment of POINTS to reduce fiscal burden on providers.

- After commencing POINTS, the Secretary will bring the penalty/bonus cone up from +/-2% to +/-5% over a period of four years. The 5% maximum penalty structure is far less rigid and onerous than the 9% under MIPS for smaller and independent practices.
- Requires quarterly feedback to providers and exempts them from penalties if CMS fails to do so in a timely manner for a given performance year.
- Creates a bonus program for high performing independent practitioners based on the MACRA Exceptional Performance Bonus program.
- Sets a limit on POINTS bonus payouts for non-independent providers at 50% of the total adjustment and redistributes the delta to independent providers.
- **Section 205. Approval for Clinician Lead or Qualified Clinical Data Registries**
 - Sets up a pathway for CLDRs to receive approval from CMS to operate for three years at a time should they meet the statutory requirements. And renew for unlimited three year periods.
 - After approval CLDR/QCDRs would have the ability to:
 - Serve as an optional pathway for physicians to report their quality metrics and satisfy the requirements under POINTS;
 - Develop and use their own quality measures, including, but not limited to efficiency, outcome, and patient-reported measures;
 - Define data collection methodologies aligned with clinical workflows.
 - Clarifies that the Secretary may contract with CLDR/QCDRs as necessary to assist in:
 - Development and testing of metrics;
 - Measuring performance activities;
 - Determining whether a MIPS/POINTS eligible professional meets such criteria.
- **Section 206. Access to Claims Data**
 - Creates a mechanism for CLDR/QCDRs to receive access to claims level data from CMS for research, quality of care measurement, and reporting.
- **Section 207. Modification of Appropriate Use Criteria Data Collection**
 - Reduces burden and barriers in the Medicare Appropriate Use Criteria (AUC) program
 - The AUC program is an evidence-based tool that helps ensure only necessary advanced imaging services are ordered for patients.
- **Section 208. Rules of Construction**
 - Clarifies ownership and IP rights for metrics and services developed by CLDR/QCDRs for the purpose of POINTS.

Title III – APM Improvement

- **Section 301. Qualifying APM Participant Threshold Freeze**
 - Freeze current APM participation thresholds for three years;
 - Provide the Secretary with additional flexibility to further reduce thresholds if necessary to drive participation into new models.

- **Section 302. CMMI Model Requirements**
 - Statutory requirement for formal notice and comment period for all mandatory models and if a model is being ended early or materially changed.
- **Section 303. Report on Barriers to Participation in Value-Based Payment Models**
 - Requires GAO/CMMI/MedPAC report to Congress on existing barriers to specialty participation in value-based models and give specific recommendation to reduce them.

Title IV – Physician Payment Improvements

- **Section 401. Updating the Budget Neutrality Threshold**
 - Strikes current \$20 million threshold and inserts \$57.64 million and indexing it to MEI every 5 years.
- **Section 402. Budget Neutrality Corrections**
 - Requires retroactive adjustments in the conversion factor based on utilization estimates to reconcile differences.
- **Section 403. Timely Updates to Practice Expense RVU Inputs**
 - Requires that once every 5 years the Secretary shall update the direct cost calculations and valuations in consultation with the relevant stakeholders.
- **Section 404. Limitation on year to year Conversion Factory Variance**
 - Limits year to year variance of the conversion factor outside of other existing provisions of law to 2.5%.

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