

# **Summary of the Patients First Act, H.R. 9693**

## **Title I – Strengthening Reimbursement and Patient Access**

- Beginning in 2027, sets annual Medicare physician payment updates at the Medicare Economic Index (MEI) minus 1 percentage point for most physicians and MEI minus 0.5 percentage points for Qualified Participants in alternative payment models (APMs).
- The MEI-linked updates will be permanent, not temporary, and will be built into the baseline.
- Sets a floor and ceiling on the updates so that if MEI is low for a year, the update cannot be less than 25% of full MEI and if it is unusually high for a year, the update cannot be more than 75% of MEI.
- Requires a report to Congress on the adequacy of the new payment updates that assesses its impact on system capacity, timely beneficiary access to services, and consolidation of independent practices.
- Uses new money to extend 1.00 work GPCI floor for an additional 5 years, from 2027 through 2031, and increase it to 1.025, leading to a 2.5% increase in the work relative values for all localities that are subject to this floor. Also provides a 2.0% increase in the work GPCI for all other localities through 2031. These increases are applied any year in the 5-year window that inflation is above 2%. It is expected to not only increase Medicare payment rates but to help physicians whose compensation is tied to the work relative values.

### **Hybrid Payments for Primary Care Demonstration**

- Establishes a 5-year demonstration program from 2027 through 2031 for primary care physicians with hybrid per-member-per-month (PMPM) and traditional payments that is funded with new money.
- Similar to other demonstration projects it will run for a finite period. This project will not negatively impact any other specialties.
- The PMPM payments will not require any patient cost-sharing and will be designed to include care management services, behavioral health integration, office and telehealth visits, and follow-up care communications. Primary care physicians can still submit claims for all other services not included in the PMPM payment.
- The demonstration program is only available to primary care physicians in independent practice.
- The bill text explicitly states that the funding for the demonstration is exempt from budget neutrality.

## **Title II – POINTS (Patient Outcome Improvement National Tabulation System)**

- Over a 5-year transition period, replaces the Merit-based Incentive Payment System (MIPS) with a new quality measure program that is intended to be driven by specialty societies, physicians and other health professionals, not the government.
- Significantly reduces MIPS penalties to a maximum of 2% annually during 5-year transition to POINTS. Increases maximum penalties by one percent annually up to a maximum of 5% thereafter, down from payment adjustments of +/- 9% per year under MIPS.
- Eliminates the Promoting Interoperability category of MIPS (formerly Meaningful Use).
- Eliminates the MACRA requirement that cost measures account for a majority of Medicare spending under the physician fee schedule to enable more flexibility in cost measure design.
- Establishes a new Quality Care Reform Task Force comprised by a clinician majority to recommend all of the measures to be used in the POINTS program.
- POINTS will have three categories of measures focused on quality (65%), resource use (20%), and a new care efficiency category (15%).
- The care efficiency category aims to give physicians credit for Medicare savings they achieve, for example, by reducing medication burden or preventing complications from patients' chronic diseases.

- Measures approved by a majority of the Task Force are recommended to CMS. The Secretary must publish responses to all recommended metrics and submit progress reports to Congress on what is being implemented within 120 days.
- Measures approved by a supermajority (75%) of the Task Force are required to be fast tracked along a special implementation pathway.
- Metrics are required to conform with relevant clinical guidelines and encompass input from the relevant specialty and subspecialty that will practice under said metric, with a guaranteed representative on the Task Force that will be chosen by the relevant specialty/subspecialty society.
- To encourage reporting on new measures with substantive changes or no benchmark, requires CMS to score as pay-for-reporting (full points). Metrics for non-patient facing providers must consider the circumstances of their practice.
- Requires metrics to align across categories and directly relate to either an episode of care or across a continuum of care.
- Creates a permanent new bonus performance program in POINTS solely for independent physicians and small practices.
- Requires that new metrics must be able to be submitted through EHR technology, administrative or billing claims or through a data registry, including a Qualified Clinical Data Registry.
- Gives special consideration to metrics developed by Clinician Led or Qualified Clinical Data Registries.
- Directs a greater share of positive POINTS adjustments to physicians in independent and small practices by limiting positive POINTS payment adjustments for non-independent physicians to 50 percent.
- Starting in 2032, prohibits CMS from imposing penalties on physicians for any performance year that they have not received at least three timely quarterly performance feedback reports.
- Allows clinician-led data registries access to CMS claims data to inform their work.
- Establishes a pathway for clinician-led clinical data registries that are established and operated by physician professional societies to be approved for 3-year periods as an optional reporting pathway for physicians to report their quality metrics and satisfy the requirements under POINTS.
- Authorizes HHS to fund contracts with the clinician-led data registries for development and testing of metrics, measuring performance, and determining whether MIPS/POINTS eligible professionals meet program criteria.
- Clarifies ownership and IP rights for metrics and services developed by CLDR/QCDRs for the purpose of POINTS.

### **Modification of Appropriate Use Criteria Data Collection**

- Modifies the Medicare Appropriate Use Criteria (AUC) program with certain changes aimed at reducing burden and barriers, including accommodations for small practices and exemptions, including for emergency medical conditions.

### **Title III - APM Improvement**

- Lowers barriers to APM participation by freezing participation thresholds to reach QP status at 50% for three years instead of 75% as required by MACRA.
- Allows HHS the flexibility to set lower thresholds.
- Requires GAO and MedPAC report on barriers to specialist participation in APMs with recommendations to reduce these barriers.
- Requires the Secretary to use notice-and-comment rulemaking: when determining that a CMMI model would meet the statutory criteria for expansion; before terminating or modifying an expanded CMMI model ahead of its scheduled termination date; and for any mandatory model.

- Requires each CMMI report to Congress submitted in 2027 or later to describe any savings generated by each model tested.

#### **Title IV – Physician Payment Improvements**

Includes text of H.R. 8163, the "Provider Reimbursement Stability Act," to reform budget neutrality policies by correcting for misestimates of utilization, raising the annual limit, and requiring regular updates to direct practice expenses:

- Raises the budget neutrality threshold that triggers conversion factor cuts from \$20 million (unchanged since 1994) to \$57.64 million in 2028, and indexes it to cumulative MEI growth every five years starting in 2033.
- Creates a correction process for utilization misestimates: beginning in 2029, CMS must compare its estimated utilization against actual utilization for certain new separately payable services and reconcile the difference (positive or negative) through a prospective conversion factor adjustment.
  - The correction is applied on a two-year lag (once actual utilization data is available) in the fee schedule for the "assumption correction period" (e.g., a 2029 misestimate is corrected in the 2031 fee schedule).
  - Reconciliation is triggered only when the gap between estimated and actual expenditures exceeds 0.1% of total PFS spending for the year; if CMS overestimated utilization the adjustment is negative, and if it underestimated, positive.
  - Exempts these utilization corrections from budget neutrality, so fixing CMS's estimating errors does not trigger offsetting cuts elsewhere in the fee schedule.
- Requires CMS to update the direct cost inputs behind practice expense RVUs (clinical staff wages, supply prices, equipment prices) at least every five years, updating all categories together and in consultation with physician specialty societies.
- Caps year-to-year conversion factor variance from budget neutrality adjustments at 2.5%, beginning in 2027, while preserving the underlying budget neutrality requirement.