

**Medicare Physician Payment Reforms and Their Impact on Practices
Leadership Day on Capitol Hill
May 21-22, 2013
Background**

Where Things Stand

Over the past decade, one of the most vexing problems that Congress has failed to solve has been how to reform the flawed Medicare physician payment formula known as the Sustainable Growth Rate (SGR). Unless Congress intercedes, physicians are again facing scheduled cuts of nearly 25 percent on January 1, 2014. Although a vast majority of Congress understands the need to eliminate this flawed formula, they have failed to advance any agreement resolving the issue, largely due to the high cost of repealing the SGR. The Congressional Budget Office (CBO) recently reduced the estimated cost of repealing the formula to just under \$150 billion, a considerable drop from previous estimates, which was welcomed news in this tight fiscal environment.

From the outset of this new Congress, which began in January, there are some signs of hope from congressional leaders that they will introduce and attempt to advance a comprehensive SGR reform proposal this year. What form that proposal will take remains to be seen but we have seen early movement by the key committees of jurisdiction in the House, those being Energy & Commerce and Ways & Means, on a draft GOP joint committee proposal as well as recently-introduced legislation by Reps. Schwartz (D-PA) and Heck (R-NV). The Energy & Commerce Committee also held a [hearing](#) earlier this year to engage key stakeholder groups in the formulation of ideas about new payment systems, which is encouraging. The outlook in the United States Senate is more uncertain, as the Senate Finance Committee has not yet produced a draft SGR reform proposal of its own and has not held any hearings on the issue for a considerable period of time. We remain guarded but hopeful that this year Congress will succeed in passing comprehensive legislation to repeal the SGR and move toward new valued-based models of care.

The enactment and on-going implementation of the Affordable Care Act (ACA) has resulted in positive changes in Medicare and Medicaid payments for physicians providing primary care services. In 2011, the ACA began providing a 10 percent bonus payment for five years on select primary care services furnished by primary care physicians. ACP estimates that this bonus has resulted in a typical office-based, general internist who qualifies for the bonus getting approximately \$8,000 in Medicare revenue each year through 2015, depending on their mix of services. In 2013, the ACA also began increasing Medicaid payment rates for certain primary care services to at least the level of Medicare through 2014. More detail about the status of these, and other, key provisions in the ACA can be found in the background, *The Affordable Care Act at Age Three*.

The background information below outlines details surrounding the various SGR proposals in development, how ACP has sought to influence those proposals, and where we have succeeded in making advancements in payment reform over the past year.

Background

REPEALING MEDICARE'S SUSTAINABLE GROWTH RATE

The SGR was enacted by Congress in 1997 as part of the Balanced Budget Act to control spending on physician services. This outdated formula determines payments to physicians for the services they provide under Medicare. For the past several years, this formula has threatened to enact steep payment cuts to physicians at the end of each year that would harm all physicians, particularly those who practice in primary care. The threat of sharp payment cuts to physicians looming every year makes it difficult, if not impossible, for physicians to budget for overhead expenses or to invest in the capability to enhance care coordination to improve the quality of care they provide to their patients. At the final hour, before SGR cuts are scheduled to take effect, Congress typically steps in to avert the cuts, although on several occasions in recent years Congress has allowed the scheduled SGR cut to go into effect, and then days or weeks later enacted legislation to retroactively reverse the cut and restore payments to physicians.

SGR REFORM PROPOSALS IN CONGRESS

House Energy and Commerce and Ways and Means Proposal

In February of this year, the Chairmen of the House Committees on Energy and Commerce and Ways and Means released a draft joint GOP proposal to repeal the SGR. It includes a temporary period of predictable payment rates for physicians, reforms Medicare's fee-for-service system to reflect the quality and efficiency of care provided, and provides options for physicians to transform their practices into new models of care. It was released as a framework, without legislative text, and physician organizations were asked to comment. ACP provided the committees with substantial feedback on their initial framework, the details of which can be found [here](#). On April 3rd, the committees released a second iteration of their framework proposal, again without legislative text, that provided additional clarity on the three phases of their proposal. The plan includes the following elements (*as prepared by the Energy and Commerce and Ways and Means Committee*):

- It would repeal the SGR, eliminating the 24.4 percent across-the-board cut slated for 2014 and any future SGR cuts
- Establish a period of stable payments, enabling physicians to prepare for payment changes
- Engage the physician community in efforts to improve, reform, and update reimbursement systems
- Provide options that enable physicians to select the Medicare payment system – whether performance-based fee-for-service or an alternative model — that best fits their practice situation
- Aim to improve the physician practice environment by reducing practice costs and administrative burdens

ACP again provided feedback on this second iteration, which can be found [here](#).

We are pleased to see that the basic framework is largely consistent with ACP policy in that it:

- Eliminates the SGR as a factor in determining payment updates.
- Provides for a period of stable, predictable fee schedule updates during a transition period to value-based payment and delivery models
- During a transition period, allows physicians the time to assess the applicability of private sector and Medicare alternative payment models.
- Allows physicians to begin qualifying for higher updates for participating in approved performance measurement/reporting/improvement programs or other quality improvement programs, or for participating in new payments models like Patient-Centered Medical Homes or Accountable Care Organizations, with some flexibility for individual practice needs.

ACP made several recommendations for improving the draft, however:

- The current draft does not specify for how long “stable” updates would be in effect or the amount of the updates. ACP recommends that there be a period of at least five years where positive updates would be provided to all physicians, with the opportunity for physicians to qualify for additional updates for participating in approved quality improvement or value-based payment models.
- The current draft does not provide higher updates for undervalued evaluation and management services. As noted in our comments, we continue to believe that such incentives are critical to improving care coordination and addressing historical payment inequities that contribute to severe shortages in internal medicine, family medicine, internal medicine subspecialties, neurology, and other fields that principally provide evaluation and management services.
- We recommended that to ensure a level playing field, no specialty should be exempted from having its performance measured or held to a higher or lower standard than any other.
- We recommended harmonization and improvements in the current measures used to assess physician performance in the PQRS, e-RX and meaningful use programs; re-consideration of the current penalties if most physicians, because of limitations in the existing reporting programs themselves, are unable to report successfully on the measures; opportunities for physicians to review and appeal adverse determinations based on performance

measurement programs; improved data sharing with physicians; and other steps to prevent unintended adverse consequences from performance measures.

We continue to work closely with the committees as they transform their framework proposal into legislation, which we understand could come before the full House for a vote before the August recess.

The Medicare Physician Payment Innovation Act of 2013

ACP's ideas for SGR reform were incorporated in bipartisan legislation H.R. 574, *the Medicare Physician Payment Innovation Act*, which was introduced on February 6th, by Representatives Allyson Schwartz (D-PA) and Joe Heck (R-NV). ACP has endorsed H.R. 574, which would eliminate the SGR once and for all and transition to better payment and delivery systems that are aligned with value. Specifically, this legislation would repeal the SGR formula, provide more than 5 years of stable physician payments, with positive increases for all physician services, and higher payments for primary care, preventive and care coordination services, and establishes a process for practices to transition to new, more effective, models of care by 2019.

Reps. Schwartz and Heck introduced similar legislation, H.R. 5707, last year that unfortunately did not advance before the end of the 112th Congress, which rendered it inactive. With the dawning of the 113th Congress in January, H.R. 5707 was modified and re-introduced as H.R. 574. The changes reflected in H.R. 574, not previously found in H.R. 5707, include removal of the Overseas Contingency Operations (OCO) funds as a "pay-for" in repealing the SGR, which proved too controversial, and other technical changes.

Details on H.R. 574 are provided below:

- **Permanent Repeal of the Sustainable Growth Rate:** This legislation permanently repeals the SGR formula by eliminating the \$300 billion debt to the Medicare program, restores stability and fiscal transparency to the payment system, and sets out a clear path to comprehensive payment reform.
- **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, this legislation would freeze 2013 physician payment levels through Dec. 31, 2014. Thereafter, a five year transition period would replace cuts that threaten access to care with positive and predictable updates to all physicians.
- **Provide Positive Updates for All Physicians:** It would provide positive annual updates of 0.5 percent for all physician services each year for four years starting in 2015.
- **Institute Interim Measures to Ensure Access to Care Coordination and Primary Care Services:** It would provide a 2.5 percent increase in payments for primary care, preventative and care coordination services from 2015 to 2018. Physicians would qualify for this increase in payments if 60 percent of their Medicare allowable charges are for primary care, preventive, and care coordination services.
- **Aggressively Test and Evaluate New Payment and Delivery Models:** Ongoing demonstration projects under CMS will inform the development of payment models to replace the SGR. This legislation directs CMS to identify, test, and evaluate multiple care models that can be successfully replicated in more than one geographic region. 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.
- **Identify Best Practices and Develop a Menu of Delivery Model Options:** By Oct. 1, 2017, 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 physician organizations. These models will have demonstrated success in containing costs while improving quality.
- **Establish a Transition Period:** Physician will have until 2019 to transition to new CMS-approved models. In order to minimize disruption in the transition to new delivery models, fee for service payments in 2019 will be continued at 2018 payment levels.
- **Establish an Alternative Fee-For-Service System:** The legislation provides 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.

- **Reward Clinicians for High-Quality, High-Value Care While Dis-incentivizing Fragmented, Volume Driven Care:** Beginning Jan. 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 rather than participating in one of the new CMS approved coordinated care system or a new alternative fee for service models will be subject to disincentives in the form of reduced updates to both primary and non-primary care services. The goal of the bill is for there to be enough validated models, with enough positive payment incentives, so that just about all physicians will have a model that will work for them, so the penalties need not apply. It will be important for Congress to hold CMS accountable to ensuring that a viable model is available for all physicians in all specialties, so that physicians are not subject to penalties because the agency was unable to develop an appropriate and workable model for them. It also is important to recognize that the penalties, should they go into effect for some physicians, are far smaller than the scheduled SGR cut of more than a quarter of total payments that will be prevented by the *Medicare Physician Payment Innovation Act*.

REVISED CBO SCORE LOWERS COST OF SGR REPEAL

A major impediment to SGR reform has been the high cost of complete repeal of this formula. In 2012, the cost of repeal was estimated at \$244 billion, a huge outlay at a time when Congress focused on reducing spending and decreasing budget deficits. In February of this year, CBO issued a revised estimate for the cost of SGR repeal due to lower than expected growth in Medicare spending. CBO's new estimate for full repeal now stands at \$138 billion, a significant reduction from 2012 estimates. While \$138 billion is still a significant cost, this reduction in the cost may improve the likelihood of enactment of SGR repeal, especially in this very tight budget environment.

IMPACT OF MEDICARE PHYSICIAN PAYMENT CUTS THROUGH SEQUESTRATION

The Budget Control Act (BCA), which became law in 2011, mandates billions of dollars in automatic across-the-board cuts (called sequestration) across all federal agencies, half on domestic programs and half on defense. Under sequestration, almost all federal programs are subject to a specific percentage cut. Medicare payments to physicians, hospitals, graduate medical education programs, and other providers will be cut by 2 percent. While the sequester cuts officially took effect on March 1, the 2 percent Medicare cut to providers applies to payments for all Medicare services rendered on or after April 1, as announced by CMS on March 8. To understand more about the impact of the 2 percent sequester cuts on your practice, please see [here](#).

ACP remains opposed to the across-the-board cuts in health programs and payments to providers and has [commented](#) numerous times to Congress urging them to stop these cuts and enact alternative policies that address the true underlying causes of rising health costs. To read more about ACP's views on the sequester cuts, please see the backgrounder, *Understanding the Current Fiscal Environment*.

ACP'S ADVOCACY EFFORTS PAY OFF FOR PRACTICES!

ACP, in collaboration with allied organizations, has been very successful over the past year [in advancing reforms](#) that are intended to improve your practice environment. Through advocacy with Congress and especially with federal health agencies, we want you to be aware of the progress that has been made on your behalf to not only increase physician payments but to make your professional life easier. While we have more work to do, advocacy does make a difference, which is why your participation in advocacy and Leadership Day is so important.

For more information on ACP's positions on payment and delivery system reforms, please visit the Advocacy section of ACP Online, http://www.acponline.org/advocacy/where_we_stand/physician_payment.html.