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The Long, Winding Path To Medicare Physician Payment Reform

Law360, New York (March 07, 2014, 5:57 PM ET) -- During the current and previous Congress, lawmakers have consented on only a paucity of critical legislation facing this country. With respect to physician payment reform, however, legislators have made rare bipartisan overtures in an effort to change the way the services provided by health care professionals through the Medicare Part B program are reimbursed.

The effort is a rare glimmer of hope during a period of unprecedented political antipathy. At a time when ideological stances are more entrenched than ever, where nonregular order is the new normal, Republican and Democratic members of congressional committees with jurisdiction over Medicare policy have come together in a concerted and seemingly genuine move to permanently transform the Medicare physician payment system — from one that is inefficient and volumetric to one that hews more tightly to quality of care and better patient outcomes.

An Overview of the SGR Reform Process

Since 2011, the committees of jurisdiction — the Senate Committee on Finance, House Committee on Energy & Commerce and House Committee on Ways & Means — have focused on a legislative overhaul of Medicare payments to physicians. In particular, their efforts have focused on preventing cuts to physician payments by passing into law a permanent repeal and replacement of the sustainable growth rate formula, which is used to adjust payments to physicians who provide Medicare services, as opposed to annual, short-term patches or overrides.

To moderate Medicare spending for physician services, the SGR payment formula sets specified spending growth containment targets linked to growth in U.S. gross domestic product and updates physician payments based on the extent to which actual Medicare spending aligns with those targets.

Based on this, the SGR formula has mandated "negative updates" (i.e., cuts) to payments every year since 2002. However, every year since 2003, Congress has provided a legislative short-term override of those cuts. Moreover, because Congress has never paid for these overrides, the cost of a permanent fix increases every year.

As a result, it was estimated that Medicare payments to physicians could be cut by 24.4 percent beginning on Jan. 1, 2014, when this year's SGR override would have expired. In order to prevent the payment cut to physicians, before adjourning for 2013, Congress passed a new override that will expire on March 31, 2014.

The override included a 0.5 percent annual payment update through that period and also

reauthorized for at least three months Medicare and Medicaid "extenders" that were funded under the previous SGR override. If Congress does not act again, payments to physicians will be cut by approximately 24 percent on April 1, 2014.

Legislative Proposals

On July 31, 2013, the House Committee on Energy & Commerce by voice vote passed H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013. In early December, the House Committee on Ways & Means introduced a chairman amendment that made modifications to H.R. 2810. On Dec. 12, the Ways & Means Committee passed the revised H.R. 2810 unanimously.

In early December, the Senate Committee on Finance released S. 1871, the SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013. On Dec. 12, the Finance Committee passed the bill by voice vote. On Feb. 6, 2014, lawmakers in both chambers of Congress announced a bipartisan SGR reform deal that consolidates and unifies most language from H.R. 2810 and S. 1871 into H.R. 4015, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014.

On the whole, H.R. 4015 would repeal the current SGR methodology for determining physician payments. It would then maintain payment rates at the current level for the rest of 2014 and update annual payments by 0.5 percent from 2015 to 2018. Payment updates would remain at the 2018 level through 2023, but the amounts paid to individual providers would be subject to adjustments depending on whether the physician chose to participate in a merit-based incentive payment system ("MIPS") or an alternative payment model ("APM") program. For 2024 and subsequent years, provider payments through the MIPS program would be updated each year by 0.5 percent while provider pay through an APM would increase each year by 1 percent.

The MIPS consolidates the three existing quality incentive programs that are used to inform Medicare physician payments but “in a cohesive program that avoids redundancies.” The bill provides fairly strong financial incentives for professionals to participate in APMs. APMs may include, but are not limited to: patient-centered medical homes, specialty models, accountable care organizations ("ACOs") and payment bundling initiatives.

Under H.R. 4015, professionals will receive a composite performance score between zero and 100 based on their performance in four categories: quality, resource use, meaningful use of electronic health records and clinical practice improvement activities.

Each eligible professional's composite score will be compared to a performance threshold. The performance threshold will be the mean or median of the composite performance scores for all MIP-eligible professionals during a period prior to the performance period. According to where a professional scores, he or she will receive a negative, zero or positive payment adjustment. In addition, those with exceptional scores will be entitled to additional incentive payments.

H.R. 4015 also links professionals’ services to quality of care through other initiatives, including new payment codes for managing patients with chronic conditions, new authorities for the federal government to reign in misvalued payment codes and improper payment, closer consultation with appropriate use criteria for applicable imaging services and expanded access to information on physician services through the physician compare website. Additionally, the legislation opens up more Medicare claims data to public view and sets new requirements and deadlines for achieving interoperability of EHRs.

While H.R. 4015 harmonizes and resolves most of the differences in statutory construction between H.R. 2810 and S. 1871, the bill still does not achieve consensus on what Medicare and Medicaid extenders to reauthorize and does not include any fiscal offsets to pay for the legislation's cost.

As currently drafted, S. 1871 includes a large list of Medicare and Medicaid extenders. H.R. 2810 and H.R. 4015 do not address Medicare and Medicaid extenders. Congress needs to decisively answer which extenders, if any, should be reauthorized and if they should be reauthorized on a permanent or temporary basis.

Popular programs that have been reauthorized as part of past SGR overrides include primary care physician bonus payments, Medicare outpatient therapy caps and Medicare Advantage's Special Needs Plans. Senate Finance Committee leadership said that as the legislation is developed, extenders demonstrating value will be permanently authorized while others extenders will be authorized temporarily so that their value can be further assessed. At a Jan. 9, 2014, hearing of the House Energy & Commerce Subcommittee on Health, Subcommittee Chairman Joe Pitts expressed similar sentiments.

Sequestration and SGR Reform

Physician payment policy is also being tied to sequestration. Without getting into the fiscal and statutory complexities of sequestration, the budgetary mechanism, as amended under the Budget Control Act of 2011, mandates cuts of two percent for reimbursement to providers of Medicare Part B services, impacting a broad swathe of health care professionals, including physicians, drug manufacturers, hospitals and laboratories.

While the White House's Office of Management and Budget recently confirmed that sequestration of discretionary spending will not be triggered in fiscal year 2014, Medicare spending — because it lies largely in mandatory accounts — remains sequestered. In fact, recent law now extends Medicare sequestration past the regular sequester end point of 2021, through January 2024.

The extension of Medicare provider payment sequestration to 2024 may also provide a bellwether for whether Congress will patch or reform the SGR. Rather than append any Medicare-related provisions to the federal debt ceiling extension that passed in mid-February, Congress decided to approve it clean of any other policy riders. Instead, Congress quietly inserted an amendment into a bill on military pensions that used most of the $8 billion saved by extending Medicare sequestration. The bill then states that the remaining $2.3 billion in savings shall be used as an offset for Medicare physician payments.

It appears lawmakers with an interest in health care were keen on seizing those savings before they could be subsequently claimed for other purposes. The savings of $2.3 billion are almost exactly the amount needed to fund an SGR patch of about one month.

The Congressional Budget Office estimated that H.R. 2810 as amended by the House Ways & Means Committee would cost $121.1 billion from 2014-2023. CBO estimated that S.1871 would cost $148.6 billion over the same period. The CBO most recently estimated that H.R. 4015 will cost about $122 billion from 2014-2023. Considering that the cheapest SGR reform package costs about $121 billion at a minimum — meaning without extenders tacked on — the $2.3 billion offset would be more easily used to buy extra time vis-à-vis a short-term override rather than chiseling away at an overhaul that costs much more.

Paying for SGR Reform

Despite deepening consensus on the legislation's core framework, H.R. 4015 was not accompanied by any strategy for passing it into law. Yet in discussions with congressional staffers, there seems to be a growing preference for an eight- to nine-month SGR override that would be passed on or before March 31. This means that lawmakers would have until after the November midterm elections to mete out agreement over contentious offsets and resolve any additional obstacles to passage. Lawmakers, however, have not committed to this pathway and stakeholders across the health care spectrum generally oppose such an approach, favoring instead passage of an actual reform bill by the current March deadline.

Examining the list of possible SGR offsets only adds to the argument that Congress is not moving to pass a permanent reform package any time soon. For some time now, policymakers have been considering offsets proposed by the Obama administration, CBO and the Bipartisan Policy Center.

Yet many of the most salient and cost-effective "pay-fors" are simply not very viable in the current political climate. Take a CBO proposal to eliminate federal subsidies for use in the health insurance exchanges if an individual's income is over 300 percent of the federal poverty level — the Affordable Care Act currently sets the eligibility ceiling at 400 percent.

While this offset would save $109 billion over 10 years, many Democrats eager to prevent more piecemeal changes to the health care reform law will oppose the proposal, while beneficiary advocates will argue that it restricts coverage access for the middle class. Another option by hospital advocates, to increase some combination of cost-sharing across Medicare Parts A, B and D, and to limit "first dollar" supplemental coverage, would together more than cover the cost of SGR reform.

Yet influential groups like AARP and the Medicare Rights Center are pushing back on these proposals in equal measure. And if lawmakers were to use such offsets in an already contentious election year, beneficiaries may counter at the polls in November. All the more reason to assume Congress will seek the path of least resistance and pass an SGR override that extends into the postelection lame duck session.

On the other side of the spectrum, pharmaceutical manufacturers are staunchly opposing proposals to extend Medicare Part D drug rebates to low-income earners. This CBO proposal would reduce mandatory spending by $123 billion over 10 years, enough to entirely offset the cost of H.R. 4015.

A slightly more attractive option offered by the Bipartisan Policy Center would increase copayments on brand-name drugs and thus incent utilization of generics among low-income earners. But this option has concerned beneficiary advocates who worry it could price out poor individuals in need of brand-name drugs for certain medical reasons. Furthermore, the copayment option, currently scored at $29 billion, but combined with another copayment option would be worth around $80 billion, could become less cost-effective if lawmakers enact special safeguards to assure access to branded drugs when needed. The policy is also opposed by both brand-name drug manufacturers and many beneficiary groups.

Finally, lawmakers continue to seriously consider postacute care for potential savings. One well-recognized proposal from the Obama administration would adjust payment updates for certain postacute care providers. And a CBO proposal worth approximately $45 billion would bundle payments for inpatient care and 90 days of postacute care. In recent SGR overrides, Congress paid for the legislative patches by mandating cuts to acute-care providers, creating a sense that it is now postacute

care's turn to bear a preponderance of the cuts. Furthermore, postacute care and other long-term providers have been in general reaping higher profit margins than other provider sectors, making it more likely that Congress will view postacute care as fair game.

A Way Forward

Despite the pugilism over offsets, legislators should take an even-handed approach to paying for the legislation and seek a combination of cuts across the health care spectrum. In doing so, however, Congress must still emphasize beneficiary and patient access while targeting health care sectors that have boasted the thickest profit margins and that have been less impacted by previous legislative patches. These savings should be put towards SGR reform and not another patch. Congress could then add the $2.3 billion military pension offset to the reform measure. There is also a panoply of smaller, less-discussed "pay-fors" that can further smooth out an offset package.

At the same time, lawmakers should eschew sequestration, especially to offset future Medicare legislation. Sequester is a penny wise pound foolish strategy; it allows for no discretion in the short-term over cuts to programs that could potentially serve as investments over the long term.

Additionally, as argued by the Medicare Payment Advisory Commission, sequestration and the SGR are born from two entirely different statutory jurisdictions that cannot be neatly reconciled. While many policymakers are getting used to sequester as a long-term budgetary mechanism, it is a blunt tool that only obfuscates the path to SGR reform. Using savings from extended Medicare sequestration to fund more patches is like stealing from Peter to pay Paul; it makes Congress dependent on an inefficient fiscal mechanism to help extend — but not transform — an inefficient reimbursement formula.

SGR reform has repercussions that stretch beyond the immediate physician space. The SGR formula was originally crafted with the primary intent of increasing access to Medicare, something that is often forgotten in the winnowed focus on health care professionals. In addition, the formula was especially designed to keep Medicare spending growth per beneficiary relatively in line with national economic growth.

The SGR formula has unequivocally failed to achieve the latter and now runs the risk of jeopardizing the former. If Congress takes the path of least resistance and passes yet another patch rather than implementing a permanent solution, it will have dangerous consequences for American health care while exacerbating Medicare's fiscal insolvency. In addition, given the fact that SGR reform is likely the only Medicare reform vehicle lawmakers will advance in 2014, failure to pass it will further undermine confidence in Congress and its ability to responsibly tackle forthcoming health care policy challenges.

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