CONGRESS WILL NOT REPEAL THE SUSTAINABLE GROWTH RATE

Tired of waiting for SGR repeal? No worries, despite the flurry of activity in Congress last year and the ongoing public discussion it will not happen. Revision of the conversion factor for the Medicare physician fee schedule as determined by the SGR formula has been a priority for our national societies since 2002 when we first experienced a reduction in Medicare reimbursement for our services. Since that time, the US House of Representatives, the Senate and the White House have frequently committed verbally to passage of a permanent repeal of the SGR formula. Despite these commitments and the efforts of many of our medical societies there has been no relief through six different Congresses and two Presidential agendas covering twelve years. Important policy makers involved in this long drama have included the Administration, MedPAC, the Congressional Doctors Caucus and the three Congressional committees that oversee Medicare: the House Energy and Commerce Committee, House Committee on Ways and Means, and the Senate Finance Committee. While the focus of our medical societies has been on repeal of the SGR formula, annual legislation over the last decade has been gradually shaping a reimbursement system that meets the federal priority of increasing the Administration’s control of healthcare expenditures.

Legislative History

One of the best chances for SGR repeal to occur was in 2005 when the Senate majority leader was a physician and a bipartisan bill, The Preserving Patient Access to Physicians Act of 2005, was introduced by Senators Jon Kyl and Debbie Stabenow. The bill was strongly criticized by Senate leadership and was never brought up for a Senate vote. The primary criticism of the bill was the impact on the federal budget. The Congressional
Budget Office views the cumulative payments received by physicians in excess of those mandated by the SGR over the last decade as a loan that must be repaid. In its view, to eliminate the SGR without some form of loan repayment or “offsets” means that federal accountants must recognize a major financial deficit and, in the current climate, that creates a significant political problem.

Several pieces of legislation that would repeal the SGR have been introduced since 2005 and all have failed. Last year there was a major focus on this issue resulting in bipartisan, bicameral legislation which was evolving with great expectations in the medical community. The stunning collapse of this bill at the last minute raises the question of whether this was a manifestation of the toxic political climate in Washington or is there more to this issue under the surface? It is notable that despite the public profile of this effort, the bill was given only a 15% chance of being enacted by experienced observers. What happened and why will there be no legislative repeal of the SGR in future? Looking back over the past nine years, each iteration of SGR repeal legislation has been offered with no offsets and has been sunk by the PAYGO rules. Why, after all the time and effort these committees put into constructing a bipartisan bicameral bill and the fate of previous legislation fresh in the mind, was it brought forward with no proposals on financial offsets?

Over the last decade Congress has passed several pieces of legislation that, when combined, have reshaped the clinical practice environment. The initial SGR legislation was implemented to control the rising federal expenditures on healthcare. It has failed to do that and Congress realized it needed to develop a payment policy framework that does establish control. The legislative foundation for that framework has been built piece by piece culminating in the major restructuring of Medicare that occurred in the Patient Protection and Affordable Care Act (ACA). The enactment of the ACA produced the most significant legislative change to the American healthcare system since the establishment of the Medicare and Medicaid programs. The politics surrounding the passage of that legislation are instructive.

January 2009, appeared to offer renewed hope for an appropriate physician compensation plan. A new President promising bipartisanship, constructive change and reform of the health care system entered office. Early in 2009, both Senate Majority Leader Harry Reid and Senate Finance Chairman Max Baucus publicly promised the AMA a permanent fix to the troublesome formula. As the details of the Patient Protection and Affordable Care Act became public, an increasing number of state, county and national medical societies openly stated their opposition. In early October 2009, Senator Reid, Senator Baucus and Senator Chris Dodd reportedly met with the AMA to discuss a strategy for passage of the legislation. It was reported that the “doctors group” was offered a deal; Congress would pass a "doctors’ fix" bill in return for support from the organization on the ACA. On October 13, 2009 Sen. Stabenow introduced The Medicare Physician Fairness Act of 2009. Despite the failure of her 2005 bill to meet the PAYGO rules this bill also had no offsets attached to it. On Oct 29, 2009, Congressman John Dingle introduced The Medicare Physician Payment Reform Act of 2009. This bill was more comprehensive than the Stabenow bill and somewhat in line with AMA requirements but still had no provisions to deal with the cost. Congressman Dingle’s bill was by passed in the House by substantial margins, and was sent to the Senate in November. That same month, the AMA, the American Academy of Family Physicians, and the American College of Physicians, lent their support to the evolving ACA legislation. Meanwhile, letters of concern and opposition from a variety of state, county and national medical societies continued to arrive in legislators offices and appear in newspapers. On December 19, with the 21% reduction in the conversion factor upon us, President Obama delayed the impending cut in our Medicare reimbursement for two months. Why was the delay limited to a brief two months? I suspect to keep the pressure on physician organizations and, in turn, Republican legislators to get the Presidents healthcare reform initiative passed. On January 20, 2010 Senator Tom Coburn, MD had all of the letters from 43 state, county and national physician organizations opposing the healthcare reform bill read into the Congressional Record. On the same day,
Senator Reid had Congressman Dingell’s SGR repeal bill placed on the Senate calendar for consideration. It became item number 252 on the list to be considered, where it lingered for nine months after passage of the ACA, until it expired with the end of the 111th Congress.

While each succeeding piece of SGR reform legislation has been introduced with no provisions to compensate for the cost, Congress has progressively restructured the Medicare payment system culminating in the ACA. This legislation is a particularly noteworthy example of delegation of rulemaking authority to federal agencies resulting in an unprecedented degree of healthcare micromanagement by the federal government. A decade of legislation and associated rule making has established programs and policies that have affected all areas of healthcare and are meeting the federal goals:

The Marketplace
- National Strategy for Quality Improvement in Health Care
- The Center for Medicare and Medicaid Innovation
- The Patient Centered Outcomes Research Institute
- The DMEPOS Competitive Bidding Program
- Increased Anti-fraud Activities
- Accountable Care Organizations
- The Patient Centered Medical Home

Hospitals
- Financial penalties for Hospital Acquired Conditions,
- Financial penalties under the Hospital Readmissions Reduction Program,
- Medicare-specific episode grouping
- Payment Bundling Pilot Program
- Hospital Value Based Purchasing
- Electronic Medical Records

Physicians:
- Physician Quality Reporting Initiative
- Physician Resource Use Measurement & Reporting (RUR) Program
- The Correct Coding Initiative and Medically Unlikely Edits
- National Provider Identifier (NPI)
- CMS Physicians Value Based Purchasing Steering Committee.
- Physician Feedback Program
- Rewards and penalties for meaningful use of EHR
- Differential physician compensation; Value Based Payment Modifier
- CMS authorized to identify and revalue the RVU’s of certain CPT codes
- Independent Payment Advisory Board
- Documentation Requirements for DME
- Expanded Coverage of Care Coordination Services.
- Physician Compare Website

The intriguing conundrum of the SGR.

It is clear from years of comments recorded in the Federal Register, the Congressional Daily and the lay press that policy makers have viewed physicians and their medical societies as the problem rather than the solution to improving health care quality and reducing the expense. Separating the public posturing from the reality, there are legislators, administrators and even some physician organizations who are in no rush to see the current compensation formula changed.
The enthusiasm for SGR repeal is not equal across all medical societies. The burden of the SGR/RBRVS system falls unequally on physician practices and primarily affects those with a significant portion of Medicare patients requiring management of chronic diseases. Many specialties have been able to maintain their level of compensation by increasing diagnostic and therapeutic procedures while primary care providers have steadily lost ground with rising overhead expenses. The most recent legislative proposals would rebalance Medicare compensation in favor of primary care and significantly reduce compensation to certain other specialties. It is difficult for many societies to support reform legislation that would reduce their members income.

As banks were deemed too large to fail, repeal of the SGR would result in a federal budget debt that has grown too large to put on the books. While there has been annual angst over dealing with the need to override the physician payment formula, the government has been able to use this tool to restrain Medicare physician reimbursement. The conversion factor in 1992 was $31.00; in 2014 it is $35.82. The Consumer Price Index (CPI) inflation over this period of time has been a cumulative 69%. The resulting net reduction in physician compensation has helped to meet the federal priority of shifting providers out of fee for service and into employment or contracting for services. Evolving payment policies combined with changes in the market place have led to a marked decrease in the number of physicians in independent practice and an increase physicians electing to seek employment. The annual deferrals of the SGR penalties are the easiest path for Congress in the current legislative climate. It gives the administration a tool to hold over the heads of providers trying to remain in the fee for service program. Although politicians and physician lobbies have loudly decried this process as unsustainable, it continues to make the most political sense—particularly for House members who have to run for reelection every two years. Given that 2014 is an election year for Congress, don’t expect a deviation from what has become business as usual.
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- Discounted Annual Meeting registration fees;
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- The knowledge that NAMDRC is an advocate for you and your profession.

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Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

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