

SGR Reform—Improved Outlook for Congressional Action This Year?

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- A bicameral impetus to reform the SGR, and a coalescence around legislative principles, has been a rare bipartisan development in an otherwise divided Congress this year.
- The primary potential sticking point for achieving SGR reform is how to “offset” or pay for the overhaul, which has up to a \$175 billion price tag, amidst the political context of budget negotiations and implementation of the Affordable Care Act.
- A major overhaul of the SGR will have significant operational and reimbursement implications for health care providers.
- With just over two months remaining in the legislative calendar, there is precedent for large legislative items to move following a government shutdown.

What is the SGR?

The Sustainable Growth Rate (SGR) formula was enacted in 1992 as a statutory means of controlling Medicare spending by calculating annual updates to the Medicare physician fee schedule. The fee schedule established a fixed minimum payment for over 7,000 defined services that is updated by the Centers for Medicare & Medicaid Services (CMS) each year to reflect current total per capita spending for physician services versus gross domestic product (GDP).¹

When per capita GDP grew more than Part B expenditures, as it did for 1997 through 2000, payments were relatively stable. However, as the economy began to slow down after 2000 and health care costs began to outpace GDP growth, application of the SGR formula **produced decreases, not increases, in physician fees** from year to year.

To avoid a cut in physician reimbursement that has grown from a moderate percentage reduction to an almost staggering 25% cut in payment, Congress has acted to “patch” the SGR, either by increasing physician payment rates, notwithstanding the SGR requirements, or freezing the rates to prevent decreases.² So while physicians were made whole or were even given moderate increases in payment, the overall cut as mandated by the SGR was pushed off by Congress to deal with in the future through one of two possible outcomes: 1) eliminate the SGR formula, or 2) allow the cut to be implemented, reducing physician payment. Unless Congress acts by the end of this year, **physicians treating Medicare beneficiaries will be faced with an estimated 24.4% reduction in reimbursement.**³

The SGR, and the annual (or more frequent) SGR “patches” that Congress has needed to make every year, has created a huge source of uncertainty for physicians who do not know whether or when they will receive a large cut to their Medicare reimbursement. In turn, the uncertainty creates the potential to drive down the number of Medicare patients physicians are willing to see and to impact negatively on physicians’ willingness to invest in expenditures like clinical equipment and facilities. This uncertainty translated into a significant financial burden on providers as recently as 2010, when Congress went 18 days without “patching” the SGR, resulting in withheld Medicare claims for that entire period.

Legislative Prospects for SGR Reform

Recognition that the SGR formula must be overhauled has grown recently, spurred, in part, by projections by the CBO drastically lowering the cost of a permanent elimination of the SGR. Whereas in January 2012, the CBO estimated that the cost of repeal would be \$316 billion, in February 2013, the CBO calculated that repeal would cost only \$138 billion over ten years, due to lower estimated spending on physician services.⁴ This major decrease in the estimated cost was a key factor in pushing bipartisan cooperation, and a reason why stakeholders sense an opportunity to get SGR reform done this year.

The first major step toward reform was taken by the full House Energy and Commerce Committee on July 31st in unanimously approving the Medicare Patient Access and Quality Improvement Act of 2013 (H.R. 2810). H.R. 2810 would repeal the SGR effective 2014, replacing it with annual updates of 0.5 percent, and uses a two phase plan to address the fee-for-serve (FFS) program. Specifically, the legislation would:

- Create a new physician reporting system to improve relative value accuracy, incorporating existing data, patient scheduling systems, and cost accounting systems;
- Adjust for misvalued physicians’ services by reducing relative value adjustments by up to 1% for years 2016-2018;

- Create a new Quality Update Incentive Program (QUIP), which would trigger incentives and penalties beginning in 2019;
- Establish a new program for the evaluation, approval, and implementation of Alternative Payment Models (APMs); and
- Increase the availability of Medicare data, allowing qualified entities to sell claims data and allowing qualified clinical data registries to access claims data.⁵

While the House committee has taken a first step, no Senate committee has yet to put forth a proposal to reform the SGR. However, the Senate Finance Committee has held two hearings on the subject, a May 14th hearing entitled “Advancing Reform: Medicare Physicians Payments” and a July 13th hearing entitled “Repealing the SGR and the Path Forward: A View from CMS.”

At the July Senate Finance Committee hearing to consider the perspective of CMS, Chairman Max Baucus (D-MT) indicated that the Committee is utilizing the comments and suggestions made by the American College of Physicians (ACP).

On the same day the House Energy and Commerce Committee advanced its SGR legislation, Chairman Baucus invited members of the Senate to participate in a discussion regarding SGR reform. He and Ranking Member Orrin Hatch (R-UT) are currently working on draft legislation, and the Senate Finance Committee is reportedly working with the House Ways and Means Committee to release SGR reform proposals by the end of this month. According to reports, the two committees will release draft bills similar to that put forward by the House Energy and Commerce Committee.

Outlook for the Remainder of 2013

Health care stakeholders have not been quiet about legislative efforts to repeal the SGR, spurring Congress to action. For example, the American Medical Association (AMA) has long been a vocal critic of the SGR, estimating that the SGR will cut physician payment rates by 40% by 2016 even as practice costs rise 20%, causing physicians to limit the number of new Medicare patients they treat and creating a crisis of health care access. As such, the AMA has weighed in on the Energy and Commerce proposal, noting, among other things, that any change in payment systems must be sufficient to create a sustainable practice environment, including maintaining budget neutrality related to adjustments to correct misvalued codes as part of that ongoing process. Earlier this month, the President of the AMA expressed optimism that Congress will take steps to reform the SGR, saying the momentum in Congress is “palpably different” than in previous years. To support the effort to reform the SGR, the AMA launched a grassroots campaign to urge Congress to reform the payment system.

Further, the respective Chairmen of several of the committees of jurisdiction will be leaving their roles at the end of this term. Chairman Baucus and Senator Tom Harkin (D-IA), Chairman of the Senate Health, Education, Labor, and Pensions Committee, are retiring and Representative Camp (R-MI) is term limited from continuing as Chairman of the House Ways and Means Committee by Republican caucus. This has made proposing and passing a permanent SGR replacement a personal commitment, with these key members presumably less beholden to potential political limitations.

Obstacles to Consensus

While Congress may be closer than it has in many years to moving forward with a major overhaul of the SGR, as with any complex program, there remain stumbling blocks, both technical and political, and **how Congress will pay for the reform remains the focal sticking point**. The CBO has recently scored the House Energy and Commerce legislation, estimating the cost of the bill at around \$175 billion over 10 years.⁶ This score represents nearly \$40 billion more in Medicare spending than simply freezing current rates over the next decade.

Acknowledging that resolving the question of offsets remains crucial to reforming the SGR, the House Ways and Means Committee is said to be working diligently to reach a proposal that scores closer to \$140 billion and working to address complaints raised by industry sectors that have expressed concerns about the House Energy and Commerce proposal. For example, the College of American Pathologists has been out front to ensure that reforms include language that accounts for the kinds of quality metrics actionable by diagnostic practices, such as pathology; and the American College of Radiologists has repeatedly noted that reforms should not include broad cuts to diagnostic imaging, but rather incorporate imaging utilization management policy employing computerized decision support (CDS) tools.

Still, how these additional costs will be paid for via **finding offsets is already becoming a partisan food fight, with midterm elections already on the horizon**, made more difficult due to vehement opposition from industry sectors that are proposed to be targets to pay for the SGR permanent replacement. (This is reminiscent of an observation made during federal health care reform that, in the health care system, one person’s savings is another person’s loss of revenue.) In this context, industry lobbyists report that the House Ways and Means and Senate Finance Committees are planning to introduce their own SGR replacement bills, without offsets. This runs counter to the earlier expectation of the Energy and Commerce Committee that the Ways and Means Committee would complement the Energy and Commerce proposal with an offset bill.

On the heels of a shutdown largely over President Obama’s signature legislative achievement in the Affordable Care Act, Washington analysts are also watching how Tea Party Republicans, primarily freshmen and sophomore members in the House, approach the SGR issue. Reports indicate that the

larger price tag from the Energy and Commerce bill is drawing criticism from conservative corners and there is also concern that the newer members of Congress are not as invested in the multi-decade battle to find a permanent replacement for the SGR formula. Adding to the political complexity is whether Tea Party Republicans will attempt to tie an SGR replacement with a delay or defunding of the Affordable Care Act (ACA) (a line in the sand drawn by Democrats during budget negotiations leading up to the October government shutdown).

Paying for a Permanent Replacement

The Congressional committees are continuing to struggle to find pay-fors via significant Medicare cuts from stakeholders already cut as a result of the ACA, sequestration, the specter of an additional 2% across the board sequester cut coming in 2014, etc. Especially going into debt ceiling negotiations and the 2014 election cycle, offsets for the SGR replacement bill would likely come largely from the same stakeholders, who feel they cannot withstand any further cuts. As a result, these potential pay-fors carry a host of controversial political and policy implications. Their potential to impose devastating impacts on the industries they target will make answering the question of how to pay for an SGR overhaul continuously contentious.

Based on the various savings proposals and historical pay-fors in other health care legislation, the sectors that are most likely at risk to help pay for a permanent SGR replacement bill include diagnostic imaging providers; home health care; hospitals; inpatient rehab hospitals; labs; long-term acute-care; Medigap insurance carriers; and skilled nursing facilities. For example, earlier this year, when discussions of a broader initiative to reform the nation's entitlement system were in play, the House Ways and Means Committee proposed a number of changes to Medicare's cost sharing, including changes that could be used to pay for the repeal of the SGR. Among these proposed changes were:

- Requiring wealthier seniors to pay more than low-income beneficiaries for Medicare Parts B and D;
- Increasing the Part B deductible across the board;
- Creating a home health copay;
- Decreasing market-basket updates for home health agencies, skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care facilities; and
- Establishing bundled payments for post-acute care.⁷

Finding savings from the health care sector will be a challenge, perhaps ultimately insurmountable. However, lawmakers have already done more to advance a permanent replacement bill than at any time since the SGR was created. Congressional committee staff have already begun to debate how the legislation will proceed, setting up the ground rules for how industry stakeholders and lawmakers may manage this issue heading into the end of the year.

Government Shutdown Complexity

Up until the 17-day government shutdown in October, the House was expected to proceed in one of two ways: (1) Rules Committee consideration of the House Energy and Commerce proposal, during which an offset offered by House Ways and Means or House Leadership would be included as an amendment; or (2) inclusion of the SGR repeal as part of a larger piece of legislation that would submerge the cost of the bill within a broader proposal.

The deal to end the government shutdown included a timeline that, while it does not diminish the prospects for reform, complicates the process. The deal funds the government at \$986 billion through a Continuing Resolution (CR) through January 15th, and extends the debt ceiling through February 7th. The agreement also requires a budget conference, with a report due on December 13th that would provide a framework for spending, taxes, and entitlements, while possibly addressing the mandatory spending cuts of sequestration.

A bill to reform the SGR could move as a standalone measure in December or as part of a broader deal to fund the government based on the budget conference to conclude on December 13th; however, with Congress' focus on budget talks, tax reform, and entitlement reform, selling a measure that would raise the deficit may become more difficult—though if Congress is able to find \$140 billion in offsets the likelihood of achieving SGR reform increases greatly. As the government reopened, the CBO took up the Senate Finance Committee SGR bill, which like the House proposals, does not include offsets as staff is awaiting a CBO score before moving to pay-fors.

However, should SGR reform, or a temporary “patch,” be included in broader budget talks, with the government funded through January 15th, and the physician pay cut scheduled to hit on January 1st, and assuming Congress takes up to the deadline to act, CMS could be forced to hold claims for up to 15 days. While the delay may help ensure that providers do not get hit with hefty cuts, it will complicate things and force providers to wait for weeks for an SGR fix or overhaul to be passed.

The prognosis for an SGR overhaul to be included in a December/January deal to fund the government is strengthened by the experience, in the period following a government shutdown, of “big ticket” legislative items moving successfully through Congress. For example, following the 1996 government shutdown, Congress passed the Balanced Budget Act of 1997, the Health Insurance Portability and Accountability Act (HIPAA), the FDA Export Reform and Enhancement Act of 1996, the Telecommunications Act of 1996, and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. With big picture issues, though, partisan politics will certainly come into play and complicate legislative efforts.

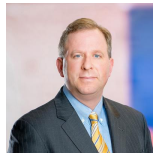
Conclusion

As with any major piece of legislation, the SGR fix will have stumbling blocks toward becoming law before physician payment rates are cut at the end of the year. It remains to be seen whether the offset issue will stall the advance of the legislation. In addition, with the focus on Congress narrowing to a debate on funding the government, the national debt limit and “unfunding” the Affordable Care Act, it may be that momentum is fading for SGR reform. However, with the CBO projecting that the cost of a fix is comparatively lower relative to previous estimates, bipartisan support for repeal, stakeholder advocacy, and coordinated, bicameral movement on versions of the legislation, it appears that SGR reform has a better opportunity than in previous years to actually get done.

Endnotes

- ¹ “Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System.” Congressional Research Service. August 2, 2012.
<http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/documents/R40>
- ² “Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System.” Congressional Research Service. August 2, 2012.
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- ³ “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule.” Department of Health and Human Services. 42 CFR Parts 405, 410, 411, et al. July 19, 2013.
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- ⁴ “The Budget and Economic Outlook: Fiscal Years 2013 to 2023.” Congressional Budget Office. February 2013. <http://cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf>
- ⁵ “Medicare Patient Access and Quality Improvement Act of 2013.” H.R. 2810. 113th Congress.
<http://docs.house.gov/meetings/IF/IF00/20130730/101240/BILLS-113HR2810ih-HR2810.pdf>
- ⁶ “H.R. 2810 Medicare Patient Access and Quality Improvement Act of 2013.” Congressional Budget Office Cost Estimate. September 13, 2013.
- ⁷ “Discussion Draft: Medicare Post-Acute Reform Proposals.” House Ways and Means Committee. June 14, 2013.

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Alex Hecht is a trusted attorney and policy strategist with over 20 years of experience advising clients across a broad range of industries on how to navigate complex policy environments. His strategic insight and hands-on experience in both legislative and regulatory arenas empower clients to advance their priorities with clarity and confidence in an evolving policy landscape.

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