Ensuring Access to Specialty Care: Physician Payment Reform

Key Takeaways: Leading up to the latest SGR patch, Congress made significant progress towards a bicameral, bipartisan SGR repeal and payment reform bill. The Alliance urges Congress to build on this momentum and enact a permanent solution before the end of the 113th Congress.

Repeal the Sustainable Growth Rate (SGR) and enact permanent physician payment reform this year. Since 2002, the SGR formula has called for ever-increasing cuts to Medicare physician reimbursement, which threatens the viability of many physicians’ practices and imperils patient access to specialty care. Congressional, short-term overrides of these cuts have exacerbated the underlying issue by adding to the overall cost of a permanent solution. The latest patch, which overrides the latest cut until April 1, 2015, was preceded by significant progress towards bipartisan, bicameral permanent reform, and the Alliance strongly urges Congress to continue building on this momentum so that a permanent solution can be enacted, even in a lame duck session, before the end of the 113th Congress. The Alliance is on record supporting the “SGR Repeal and Medicare Provider Payment Modernization Act of 2014,” which provides a permanent repeal of SGR while addressing many of the specialty community’s core principles such as providing physicians with a five-year period of stable updates, preserving fee-for-service as a continued option, implementing a streamlined quality improvement program based on benchmarks achievable by all physicians, and allowing for physician and specialty society inclusion in the development of new performance measures and payment systems.

Repeal the Independent Payment Advisory Board (IPAB): Cosponsor H.R. 351/S. 351. The IPAB will require a board of non-elected government officials to recommend Medicare cuts when spending exceeds a targeted growth rate. These recommendations automatically go into effect unless blocked by a Congressional three-fifths supermajority. Although hospitals and Long Term Care Facilities comprise over one-third of Medicare spending, they are exempted from IPAB cuts until 2020. This means that a disproportionate share of the burden will fall onto physicians, who make up less than 10% of total Medicare expenditures.

The Alliance supports repeal of IPAB and urges you to cosponsor the “Protecting Seniors’ Access to Medicare Act,” introduced in the House of Representatives by Representatives Phil Roe, MD (R-TN) and Allyson Schwartz (D-PA) and in the Senate by Senator John Cornyn (R-TX). To cosponsor, please contact: John Martin (Rep. Roe) at 5-6356 or John.Martin@mail.house.gov, Madeleine Pannell (Rep. Schwartz) at 5-6111, Madeleine.Pannell@mail.house.gov, or Beth Nelson (Sen. Cornyn) at 4-2934 or Beth_Nelson@cornyn.senate.gov.

Support the Medicare Patient Empowerment Act: Cosponsor H.R. 1310/S. 236. The current structure of Medicare limits a beneficiary from accessing physicians who “opt out” of Medicare. If a doctor has “opted out” of Medicare in order to contract privately with even one patient, the physician is ineligible for Medicare reimbursement for two years. Under current law, beneficiaries who wish to privately contract with their physician must pay out of pocket for the entire service, despite paying into Medicare for many years.

The Alliance urges you to cosponsor the “Medicare Patient Empowerment Act,” introduced by Representative Tom Price, MD (R-GA) and Senator Lisa Murkowski (R-AK). The legislation removes the two-year Medicare ban for physicians who privately contract and allows patients who privately contract to recoup the amount Medicare would otherwise pay for the service.

To co-sponsor, contact Amanda Street (Rep. Price) at 225-4501 or Amanda.Street@mail.house.gov, or Amanda Makki (Sen. Murkowski) at 224-6665 or Amanda_Makki@murkowski.senate.gov.
Quality. In linking physician payment to quality care, Congress should use positive financial incentives rather than penalties and withholds. In the last year alone, CMS has doubled the maximum penalties associated with the Value-based Payment Modifier (VBM) program, specifically, and increased the pool of affected physicians by approximately 50 percent, leaving physicians with very little time to prepare to avoid penalties. The VBM penalties, when combined with penalties associated with other programs, such as the Physician Quality Reporting System (PQRS), and the Electronic Health Record (EHR) Incentive Program, could reduce physician reimbursement by almost ten percent. Congress should consolidate existing quality reporting programs—which are administratively burdensome, duplicative, and rely on metrics of questionable value—and repeal penalties associated with each. Physicians must be given the flexibility to demonstrate quality improvement in a way that is most relevant to their practice, most meaningful to their patient populations, and deemed appropriate by medical societies.

Transparent evaluations and adjustments to physician payment code values. CMS has reviewed the relative value units (RVUs)—a ranking of resource requirements—for approximately 1,000 Medicare physician procedures and services, but the agency does not release its proposed RVU changes to these codes until the final rule (November). Reimbursement adjustments then become effective in January—a mere two months after the announcement. This provides very little time for physician practices to prepare for reimbursement changes and provides no opportunity for stakeholders to comment until after RVU modifications have been implemented. The recent SGR legislation included an expanded misvalued codes initiative, which renders a fair and transparent process even more critical. The Alliance urges Congress to direct CMS to announce reimbursement cuts, and the rationale behind such cuts, earlier in the process to allow stakeholders time to analyze and comment on pending changes before implementation of final cuts that could affect patients’ access to care.

ICD-10. Specialty physicians are anxious about the transition to ICD-10 that will now commence on October 1, 2015. The Secretary recently issued an interim final rule that codifies the new deadline and requires that covered entities must continue using ICD-9-CM through September 30, 2015. Specialty physicians are concerned with the transition to this vast new coding system, particularly as the volume of available codes is increased significantly. The Alliance urges the Congress to direct the Secretary to conduct robust, end-to-end testing with medical practices of all sizes and specialties, and to develop targeted educational resources geared toward specialty physicians. The Alliance also urges the Congress to closely monitor ICD-10 implementation, and direct the Secretary to create administrative processes and hardship exception processes that will ensure specialty physicians are held harmless from steep financial penalties in the form of denied claims, at least initially, should they face challenges with adoption of the new coding system.

EHR Interoperability. The healthcare industry lacks agreement on standards related to EHR interoperability, as well as a standard definition of interoperability itself. Interoperability is integral to the success of EHRs to enhance quality of care, promote patient centric treatment and outcomes, and reduce medical errors and the cost of health care delivery. Although there are many independent interoperability efforts in progress, appropriate government agencies, in consultation with Congress and other stakeholders, should oversee this process to achieve common EHR platforms and promote nationwide data exchange through robust, consistent interoperability standards.

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Support Medical Liability Reform: Cosponsor H.R. 36/S. 961; H.R. 1733/S. 2196; H.R. 4750; and H.R. 4106

**H.R. 36/S. 961, the “Health Care Safety Net Enhancement Act of 2013”** was introduced in the House of Representatives by Reps. Charlie Dent (R-PA), Pete Sessions (R-TX), Jim Matheson (D-UT), and Jim Langevin (D-RI) and in the Senate by Senator Roy Blunt (R-MO). This legislation would extend Federal Tort Claims Act liability protections to on-call physicians. The inherently risky lifesaving care provided by on-call specialists exposes these providers to an increased likelihood of litigation because emergency and trauma patients are often sicker, have more serious complications, and usually have no pre-existing relationship with the treating physician. Unfortunately, the high-risk of being sued and the increased professional liability costs have reduced the pool of these providers to critically low levels. Please cosponsor this bipartisan bill by contacting Dan Martini (Rep. Dent) at 5-6411 or Dan.Martini@mail.house.gov, or Kristina Weger (Sen. Blunt) at 4-5721 or Kristina_Weger@blunt.senate.gov.

**H.R. 1733/S. 2196, the “Good Samaritan Health Professionals Act of 2013”** was introduced in the House of Representatives by Representatives Marsha Blackburn (R-TN) and Jim Matheson (D-UT) and in the Senate by Senator Lisa Murkowski (R-AK). The legislation limits the liability of health care professionals who volunteer to provide services in response to a declared natural disaster. Such protections would not be extended in cases of willful or criminal misconduct, gross negligence, or reckless misconduct. To cosponsor this bipartisan bill, please contact Karen Summar (Rep. Blackburn) at 5-2811 or Karen.Summar@mail.house.gov, or Joel Bailey (Rep. Matheson) at 5-3011 or Joel.Bailey@mail.house.gov, or Amanda Makki (Sen. Murkowski) at 4-6665 or Amanda_Makki@murkowski.senate.gov.

**H.R. 4750, the “Standard of Care Protection Act”** was introduced in the House of Representatives by Representative Phil Gingrey (R-GA). The legislation would help ensure that provisions of law regarding federal health care programs are not used, outside their intended purpose, to create new standards of care for medical liability lawsuits. With so many changes occurring in the health care system, many people have concerns that misinterpretations of federal rules and regulations could result in new and unwarranted liability exposures. This bill clarifies that lawsuits could not be based simply on whether medical providers followed the national guidelines or payment policies created in federal health care laws. To cosponsor H.R. 4750, please contact Michael Calvo (Rep. Gingrey) at 5-2931 or Michael.Calvo@mail.house.gov.

**H.R. 4106, the “Saving Lives, Saving Costs Act”** was introduced in the House of Representatives by Representatives Andy Barr (R-KY) and Ami Bera (D-CA). This legislation would create liability protection for physicians who practice using evidence-based guidelines developed by doctors. To cosponsor H.R. 4106, please contact Francis Brooke (Rep. Barr) at 5-4706 or Francis.Brooke@mail.house.gov, or Erin O’Quinn (Rep. Bera) at 5-5716 or Erin.Oquinn@mail.house.gov.

**Principles for Reform.** Meaningful medical liability reform should fully compensate patients for medical/economic damages, while placing a $250,000 limit on noneconomic damages and making a defendant liable only for damages equal to his/her share of responsibility; maximize patient awards and discourage frivolous lawsuits through sliding scale contingency fees; eliminate double recovery by accounting for evidence of collateral source benefits paid; and award punitive damages when there is clear and convincing evidence of malicious intent to injure or deliberate failure to avoid unnecessary injury.

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The Alliance of Specialty Medicine urges Congress to address the workforce shortages in many specialties that will jeopardize access to care by cosponsoring the bipartisan "Resident Physician Shortage Reduction Act" (H.R. 1180/S. 577) by Representatives Joseph Crowley (D-NY) and Michael Grimm (R-NY), and Senators Bill Nelson (D-FL), Harry Reid (D-NV), and Charles Schumer (D-NY). In addition, we urge support of the bipartisan "Training Tomorrow’s Doctors Today Act" (H.R. 1201) by Representatives Aaron Schock (R-IL) and Allyson Schwartz (D-PA).

Snapshot of the Issue. The United States will face a shortage of more than 130,000 physicians by 2025. Half of this shortage will come from specialty physicians, including neurosurgeons, urologists, cardiologists, gastroenterologists, plastic and reconstructive surgeons, and orthopaedic surgeons. A 2008 report by the Health Resources and Services Administration found that by 2020, ophthalmology and orthopedic surgery are each expected to need more than 6,000 physicians over current levels, while other specialties like urology will see shortfalls of more than 4,000 physicians. Growth in future demand for physicians will be highest among specialties that predominantly serve the elderly.

Specialty physicians require up to seven years of post-graduate residency training. By the time a true crisis manifests itself, we will be unable to quickly correct it. With 10,000 seniors aging into the Medicare program every day, along with the influx of patients seeking access to care as a result of the Affordable Care Act, the need for specialist services will increase significantly. We must take steps now to ensure a fully trained specialty physician workforce for the future.

Institute of Medicine (IOM) Report. The IOM will release a report on the governance and financing of graduate medical education at the end of July. Among other issues, the report will consider the geographic distribution of generalist and specialist clinicians and will include recommendations for workforce development. The Alliance will provide its perspective to Congress upon release of the report.

Legislation. The “Resident Physician Shortage Reduction Act,” and the “Training Tomorrow’s Doctors Today Act” will improve the nation’s GME system and help to preserve access to specialty care by:

- Increasing the number of GME residency slots by 15,000 over the next 5 years;
- Directing half of the newly available positions to training in shortage specialties;
- Specifying priorities for distributing the new slots (e.g., states with new medical schools); and
- Studying the needs of the U.S. healthcare system and to allocate residencies accordingly.

To cosponsor H.R. 1180/S. 577, “Resident Physician Shortage Reduction Act,” please contact Nicole Cohen (Rep. Crowley) at 5-3965 or nicole.cohen@mail.house.gov; Jessica Talbert (Rep. Grimm) at 5-3371 or Jessica.Talbert@mail.house.gov; Sasha Albohm (Sen. Nelson) at 4-5274, Sasha_Albohm@nelson.senate.gov; or Veronica Duron (Sen. Schumer) at 4-6542 or Veronica_Duron@schumer.senate.gov.

To cosponsor H.R. 1201, “Training Tomorrow’s Doctors Today Act,” please contact Margie Almanza (Rep. Schock) at 5-6201 or Margie.Almanza@mail.house.gov or Madeleine Pannell (Rep. Schwartz) at 5-6111 or Madeleine.Pannell@mail.house.gov.

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