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ATTORNEYS AT LAW

MEMORANDUM

To: **Kim Giffords, Executive Director, ASTS**

From: **Peggy Tighe, Counsel**

Date: **March 21, 2013**

Re: **Sequestration and SGR/Medicare Payment Reform**

The first few months of 2013, Congress has been focused on the sequester and budget talks. But, what does the sequester really mean for the physician community?

Resulting from the failure of the "Super Committee" to reach a deal on spending cuts, Congress enacted the Budget Control Act (BCA) of 2011, which included the sequester. These automatic, across-the-board payment cuts to both domestic and defense spending occurred on March 1, 2013 as part of an effort eliminate a total of $1.2 trillion from the federal budget over the next decade. Originally scheduled to take place on January 1, 2013, the cuts were delayed for two months by the American Taxpayer Relief Act (Fiscal Cliff legislation) enacted on January 3, 2013. According to a report released by the Office and Management and Budget (OMB) on February 28, 2013, the $85 billion sequester cuts are "approximately 9 percent for nondefense programs and 13 percent for defense programs."

For physicians, hospitals, and other health care providers, sequestration's greatest impact will be through the 2 percent cut in Medicare physician payments; cuts to the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the National Institute of Health (NIH), the Food and Drug Administration (FDA) and other agencies with direct health care oversight; Graduate Medical Education(GME) funding; and potential delay of efforts to move a permanent fix to Medicare physician payments.

Medicare payments to providers and health insurance plans will continue to be cut by 2 percent. These cuts are not cumulative. So, for the entire nine-year period 2013-2021, providers and plans will be paid 98 cents on the dollar; however, because Medicare costs are projected to rise from 2013 through 2021, the dollar amount saved by this 2 percent cut will increase, from $11.0 billion in 2013 to $11.4 billion in 2014 and ultimately to $17.8 billion in 2021. For 2014 through 2021, the Medicare cut will remain at 2 percent while the percentage cuts in other programs will gradually shrink.

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The Obama Administration, federal agency leaders, and House and Senate Democrats engaged in a month-long, full-scale communications campaign to warn the American people about the impact of the sequester upon a myriad of federal programs facing automatic cuts. The Senate appropriations committee posted letters from each agency as to the impact of the cuts and the White House issued a state-by-state breakdown of health care cuts just a week before the sequester deadline. By comparison, see a much shorter list of what will not be cut, published on February 27, 2013 by the National Journal. With all of that said, even several weeks into the sequester, it remains somewhat unclear exactly how each agency is implementing the required cuts, with discussions and decisions ongoing.

Despite Congress, White House, and agency focus on sequestration during the first two months of 2013, there have been positive indications regarding potential passage of a permanent SGR fix in 2013. Since 1997 when the Medicare physician payment formula was enacted, Congress has interceded a total of 15 times to temporarily correct negative updates to the formula's sustainable growth rate (SGR). For the first time in nearly as many years, Congressional leaders and Medicare Payment Advisory Commission (MedPAC) officials are saying that 2013 may indeed be the right time for a permanent fix.

In a hearing held on Thursday, February 14, 2013 by the House Committee on Energy and Commerce (E&C) committee, the "SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System," Glen Hackbarth, J.D.. Chairman of MedPAC said that the SGR repeal is "on sale," and now is an optimal time to fix the SGR as the costs of the projected repeal are at their lowest levels and may increase quickly. E&C committee chairman, Fred Upton (R-MI), announced, that same day, that Congress can fix the SGR by "this summer." The Congressional Budget Office scored a permanent fix at $138.3 billion last month, a drastic reduction from last year's score of $316 billion.

The debate has shifted toward serious efforts to reform Medicare physician payments. While the concept of pay-for-performance or quality measurement has been circulating on Capitol Hill for over a decade, Congressional leaders on both sides of the aisles and Capitol are agreeing that the time for a law to tie Medicare payments to quality is now. Republicans on the House Ways and Means Committee recently partnered with the House Energy and Commerce committee Republicans to outline their construct for a new system and elicit comments from the physician community on this four-pronged approach, outlined below.

- After the period of stability, physician fee schedule payment updates will be based on performance of meaningful, physician-endorsed measures of care quality and participation in clinical improvement activities.

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- Medical specialty societies will develop meaningful quality measures and clinical improvement activities using a standard process.

- Performance will be based on both risk-adjusted relative rankings amongst physician specialty peer groups and improvement on quality over time.

- This proposal will reduce the reporting burden on physician practices, override the current eMS quality measurement programs, and align Medicare payment initiatives with private payer initiatives.

Senate Finance committee Republicans are working with their House counterparts and House and Senate Democrats are hoping to also work closely to come to bipartisan, bicameral agreement on a permanent fix construct. Most Hill staffers say, "the devil is in the details" and predict that areas of disagreement will revolve around CMS involvement, timeframe for implementation, and penalties associated with non-compliance. Further, it is unclear whether Congress will find the money to fund the fix and exactly what will replace the SGR formula. A partisan divide exists over paying for the SGR fix by using unspent Overseas Contingency Operations (OCO) funds from the drawdown of foreign wars or alternatively readjusting the budget baseline to cover all or part of the SGR cost. Also, there is a strong possibility and fear on the part of hospitals that Part A of the hospital trust fund will be raided by Congress to pay for the fix. Of course, in any such proposals there will be "winners and losers" and the physician community will remain actively engaged in each step in the process.

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