Border Health Caucus

Federal Legislative Agenda

Here's something Congress can do to make an immediate, positive impact on health care: Eliminate costs and hassles that don't add value to patient care. New regulations and mandates are bombarding physician practices seemingly every day. Last January, a new electronic format for claims and other electronic transactions (called "HIPAA 5010") added costs to physician practices. The switch to the International Classification of Diseases and Related Health Problems version 10 (ICD-10) next year will require physicians to adopt an entirely new language to record all possible diagnoses and inpatient procedures, adding significant training costs.

It's time for Congress and government agencies to consider the disruption that new regulations and penalties introduce into medical practices and refrain from introducing new hurdles.

Medicare's required Physician Quality Reporting System pays a bonus at first but imposes penalties beginning in 2015. New state and federal privacy laws introduce more paperwork, and severe penalties for noncompliance. Stepped-up state and federal "fraud" detection has resulted in monumental compliance programs that further increase the cost of running a practice. These changes have limited documented evidence they will improve care or reduce fraud or protect privacy but absolute and complete assurance they will increase the cost of doing business in medicine.

All of those bureaucratic hassles come against the backdrop of the never-ending payment uncertainty due to the annual, cliff-hanger battle over Medicare payment cuts imposed by the Sustainable Growth Rate (SGR) formula. Frustrated physicians are dropping out of the program; last year only 58 percent of Texas physicians accepted all new Medicare patients, down from 78 percent in 2000.

Put ICD-10 on permanent hold

(HR 1701 by Poe; Coburn amendment to S 954)

ICD-10 adoption, which will mandate extensive revision of physicians' paper and electronic systems, is a costly regulation that will create significant burdens on the practice of medicine with no direct benefit to individual patient care. The mandatory Oct. 1, 2014, transition to the new system will cost solo physicians as much as $83,000 each, and group practices of up to 10 doctors as much as $250,000. And the punishment for noncompliance is severe: no payment for any medical services provided.

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BHC Recommendations

- Repeal the broken Sustainable Growth Rate formula. Enact a rational Medicare physician payment system that works and is backed by a fair, stable funding formula.
- Put ICD-10 on permanent hold until ICD-11 or another appropriate replacement for ICD-9 is ready for widespread implementation. *(HR 1701 by Poe; Coburn amendment to S 954)*
- Protect physicians who care for chronically ill or noncompliant patients from quality-of-care measures that do not account for such variances in patient populations. Stop implementation of Medicare's "value-based purchasing" program, unless physicians who treat these populations are treated fairly.
- Repeal legislation that limits physician ownership of hospitals. *(HR 2027 by Sam Johnson)*
- Repeal the IPAB. Keep Congress accountable for the Medicare system. If decisions are made to limit funding for health care services, priorities will have to be set. That should not be left, however, to an unelected and unaccountable Independent Payment Advisory Board. *(S 351 by Cornyn; HR 351 by Roe)*
- Pass the Medicare Patient Empowerment Act. Give physicians the ability to contract directly for any and all Medicare services. *(HR 1310 by Price; S 236 by Murkowski)*

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Access to Care

Support physician ownership of hospitals

(HR 2027 by Sam Johnson)

One of the Patient Protection and Accountable Care Act's (PPACA's) sections inhibits physicians' legal rights to own or invest in hospitals and other facilities that provide their patients high-quality care. Section 6001 prohibits new doctor investment in hospitals that take care of Medicare patients; no physician-owned hospitals may start nor may current ones expand.

Congress should focus not on who owns the medical facility but on the quality of the facility and appropriateness of patient care. Physician-owned hospitals receive the highest quality ratings and have better outcomes, shorter hospital stays, and much higher patient satisfaction scores than nonphysician-owned hospitals.

Stop the Medicare Meltdown — repeal the SGR

Without a robust network of physicians to care for the millions of patients dependent on Medicare, the program will not work. As bad as today's numbers are, half of all Texas physicians are considering opting out of Medicare altogether. This is because federal law requires Medicare payments to physicians to be modified annually using the SGR. Because of flaws in how it was designed, the formula has mandated physician fee cuts every year for more than decade.

However, momentum is building in Congress to overturn Medicare's flawed payment formula and replace it with a new one. The new payment system discussed by Congress would pay physicians based on quality measures. Physicians agree, their patients deserve quality care — and providing high-quality care is the goal of most physicians. However, as Congress debates this concept, we believe Medicare must develop an objective standard of quality measurements — one based on evidence-based science — and not one based on bureaucratic, arbitrary data points. Physicians must clearly understand the quality measurements enforced, have access to timely comparative data, and have the ability to control patient variables. Physicians shouldn't be penalized because they care for a sicker, poorer Medicare population or because they work in rural Texas. The new payment model must pay all physicians fairly, regardless of specialty and practice type.

It's critical that the SGR's replacement not continue to threaten the viability of physicians' practices or add new bureaucratic hassles to caring for Medicare patients.

Repeal the IPAB

(S 351 by Cornyn; HR 351 by Roe)

PPACA created the 15-member Independent Payment Advisory Board (IPAB) to recommend measures to reduce Medicare spending. The panel cannot recommend changes to eligibility, coverage, or other factors that drive utilization of health care services. This means the board will have only one option — cut payments. And through 2019, hospitals, Medicare Advantage plans, Medicare prescription drug plans, and health care professionals other than physicians are exempt. This means the board really will have only one option — cut Medicare payments to physicians.

Allow Medicare beneficiaries to contract directly with physicians for care

(HR 1310 by Price; S 236 by Murkowski)

As baby boomers come of Medicare age, we must change some of Medicare's inflexible rules to ensure patients have access to a physician. One way to accomplish this is to allow Medicare patients to see any physician of their choice. The Medicare Patient Empowerment Act would allow seniors to use their current Medicare coverage to see a doctor who is not accepting Medicare. It would strengthen patient choice and access to physicians.

Protect state medical liability reforms

(HR 1473 by Phil Gingery and Henry Cuellar)

This bill would clarify that the federal health reform laws passed in 2010 were not meant to establish medical standards of care for physicians and other providers. This bill would protect the ability of states to determine their own liability laws as appropriate for their citizens.

Texas has gained more than 10,000 new physicians above the expected baseline to take care of Texas patients as a result of its tort reform. Many of these new physicians practice high-risk specialties such as emergency medicine, neurosurgery, pediatric intensive care, and pediatric infectious disease. Twenty-seven rural Texas counties have added at least one obstetrician since the passage of Texas' medical liability reform, including nine counties that previously had none. Sick and injured Texans now have more physicians and more timely access to medical care when needed.