Repeal the SGR

Repeal Harmful and Onerous Federal Regulations

Administrative costs in the U.S. private and public health care system are more than $361 billion annually — 14 percent of all health care expenditures. Private insurers and Medicare require physicians and their patients to follow too many complex and redundant rules. Physicians employ more billing and posting clerks than any other industry. The huge numbers of regulations, coupled with the ongoing uncertainty in physician Medicare payments, are forcing more doctors out of the program. With the baby boomers coming of Medicare age, we need more physicians available to provide care, not fewer.

Congress must take action to stabilize Medicare now.

Stop the Medicare Meltdown

Congress came closer than ever to passing legislation that would repeal the faulty Sustainable Growth Rate (SGR) formula permanently last year. The bill had strong bipartisan support and the endorsement of more than 600 medical organizations. It provided meaningful, structural payment reform. But in the end, Congress could not agree on the funding sources. Instead, for the 17th time, Congress passed another short-term patch. Physicians now face the threat of another 24-percent payment cut on April 1, 2015. Physicians are the foundation of the Medicare program. This 13-year cycle of "Band-Aiding" the problem must stop.

Replace harmful restrictions with realistic quality-based incentives

Physicians are finding the transition to value-based payment models cost-prohibitive because of (1) the expansion of private and public "quality" programs, (2) the vast number of quality measures, (3) the difficulty of deciphering which measures are important, and (4) the difficulty of interpreting quality-data reports in a meaningful way for their practice. The overwhelming number of uncoordinated quality measurement and reporting initiatives across multiple insurance companies must be addressed.

Conduct robust testing of the ICD-10 coding system before implementation

Congress must hold the Centers for Medicare & Medicaid Services (CMS) accountable for a seamless transition to ICD-10. CMS must test the system across all physician practice settings — from large groups to small practices to solo practitioners. Because physician payments are tied directly to ICD-10, it must work perfectly. Any disruption in payment has the potential to bankrupt small groups and solo physicians, especially now as they make large investments in complex electronic health record systems. Therefore, CMS must make advance payments in the event payments are delayed.

Coalition of State Medical Societies Recommendations

1. Repeal the broken SGR formula. Enact a rational Medicare physician payment system that works and is backed by a fair, stable funding formula. Pass HR 4015/S 2000, the SGR Repeal and Medicare Provider Payment Modernization Act.
2. Accompany increases in compliance or reporting burdens with payment increases, not penalties.
3. Direct CMS to test ICD-10 robustly across all payer types and physician practice settings to ensure a seamless transition. Urge CMS to provide advance payments in the event there are delays in processing payments.

   Reform the meaningful use requirements under the Medicare and Medicaid Electronic Health Records Incentive Programs. Align meaningful use with the Physician Quality Reporting System and provide more flexibility depending on a physician's specialty and other practice factors.
4. Direct Recovery Audit Program contractors to focus only on practices with demonstrated inappropriate billing patterns and provide due process and fair procedures for physicians who are subject to a RAC audit.
5. Ensure Medicare's value-based payment program does not penalize physicians for providing services to chronically ill or disadvantaged patients, and does not punish them when patients cannot comply or choose not to comply with orders or recommendations for testing and treatment. Both cost and quality measures need to be risk-adjusted to account for the effects of illness, poverty, poor educational attainment, and cultural differences.
6. Ensure criteria used to measure physicians' performance are evidence-based, fair and accurate, and truly evaluate quality and efficiency of care, not just cost.
7. Simplify Medicare quality reporting by using transparent methodology and consistent, standardized measures and reporting processes across all physician reporting programs.
8. Pass the Medicare Patient Empowerment Act, giving physicians the ability to contract directly for any and all Medicare services.

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Stop Recovery Audit Program bounty hunters

CMS hires several types of contractors to review and audit medical care delivered by doctors — Recovery Audit Program contractors (RACs), zone program integrity contractors, Comprehensive Error Rate Testing contractors, and Medicare administrative contractors. It's confusing, burdensome, and expensive for physicians to defend their medical decisions with so many audit programs administered by multiple contractors — especially when many of the RAC claims are erroneous. Here are just a few of the problems with the Recovery Audit Program:

- RACs are essentially bounty hunters; they receive a commission on every claim they deny.
- RACs don't have a medical license. Personnel with little to no expertise in medical care conduct the reviews, which explains why their "overpayment determinations" are being overturned at an alarming rate. At the very least, RACs should have licensed physicians in the same specialty making medical necessity decisions. Only physicians should decide whether a physician service was medically necessary.
- RACs are not held accountable. According to CMS, RACs lose 43 percent of the cases when a physician or provider appeals an overpayment claim. Physicians should not bear the cost of legal and administrative fees to pursue appeals, especially when they win the appeal. RACs should be penalized for erroneous overpayment determinations and should be required to reimburse physicians for the costs incurred in defending against a recovery audit when the RAC loses the appeal.
- Extrapolations should not be allowed. RACs should not base their findings on a statistical sample of claims, which is not always an accurate assessment of a physician's coding and documentation. Instead, RACs should review claims on an individual basis.

Allow Medicare beneficiaries to contract directly with physicians for care

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. It would ensure that seniors can see any doctor they choose and still use the Medicare benefits for which they have paid, without having to change their Medicare plan. The act would allow Medicare patients and their physicians to enter into private contracts without penalty.

Coalition of State Medical Societies Mission

Protecting Patient Access to Physicians

The Coalition of State Medical Societies consists of the Arizona, California, Florida, Louisiana, New Jersey New York, North Carolina, Oklahoma, South Carolina, and Texas state medical societies.

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