Legislative Update

March 4, 2014

CRA Advocates for SGR Repeal

After years of temporary "doc fixes," a permanent solution to the flawed Sustainable Growth Rate (SGR) may be on the horizon. On February 6, 2014, leaders of the Senate Finance and House Ways and Means and Energy and Commerce Committees announced they had reached a bi-partisan deal, the so-called, SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (H.R. 4015/S. 2000). The legislation would repeal SGR and provide for a 5-year period of payment stability with annual payment updates for providers of 0.5% for years 2014-2018. A new merit-based incentive payment system (MIPS) would be created, replacing and consolidating the current physician quality reporting system, the value-based payment modifier and meaningful use program for electronic health care records, and would be used in later years, beginning in 2018, to make adjustments to provider payments. Professional organizations and other stakeholders would play a role in developing quality measures for MIPS. In addition, it would provide bonus payments to physicians who collect a certain percentage of their revenue from alternate payment models. The bill also provides for increased public access to provider payment data and encourages care coordination initiatives for patients with chronic diseases.

An important issue that this legislation fails to address, however, is how to pay for the SGR repeal. The CBO announced in late February that the cost of repealing SGR under H.R. 4015/S. 2000 would be $138 billion for 2014-2024. The debate over how to come up with this money, the "payfors," will likely be more difficult than the debate surrounding the SGR repeal legislation. The Medicare payment cuts of roughly 24% that were to take effect January 1 under SGR were postponed until March 31 as a result of a budget compromise reached in late 2013. With time running out for an agreement on payfors and the upcoming 2014 elections, many expect that another temporary fix or patch will be the net result of all these efforts come April 1.

CRA issued a Call-to-Action to its members encouraging them to participate in a nationwide Congressional call-in effort on March 5. CRA also joined with the American College of Rheumatology in sending a letter of support.

CMS Chief Promises ICD-10 Will be Implemented Oct. 1

Two announcements from Centers for Medicare & Medicaid Services Administrator Marilyn Tavenner at a health information technology conference on February 27 will have wide-ranging implications for healthcare providers, insurers, and vendors. The deadline for implementing the ICD-10 diagnostic coding set, which had already been delayed one year to October 1, 2014, will not be delayed again, Tavenner said. While the Stage 2 Meaningful Use deadline will also not be delayed, Tavenner said that providers and vendors struggling to meet the incentive program's requirements will see some flexibility. Meanwhile, legislation (H.R. 1701/S. 972) seeking to repeal ICD-10 remains in committee.

If ICD-10 is implemented on October 1, CRA, Coalition of State Rheumatology Organizations (CSRO), American Medical Association (AMA), and ACR request true end-to-end ICD-10 testing and a two-year implementation period.

Key Legislators Propose Medi-Cal Cut Reversal, Governor Balks

Emboldened by reports that state revenue will outpace earlier projections, key members of the California Legislature are revisiting a 10% cut in Medi-Cal reimbursements they approved in 2011. As reported in California Healthline, Assembly Budget Chair Nancy Skinner asserted that even without additional revenues, "we may have the funds to reverse part if not all of the Medi-Cal cuts." Both she and Assembly Health Chair Richard Pan, MD, therefore introduced A.B. 1805 to restore "full funding" to Medi-Cal at the estimated cost of about $400 million next year.

Senator Noreen Evans introduced a more controversial measure that taxes the oil extraction industry and divides revenue amongst education, state parks, and the Health and the state Health and Human Services Agency. Evans said using the money to reduce or reverse the 10% cut to Medi-Cal reimbursements is "exactly the sort of thing we envision."

Prospects for favorable consideration of either bill remain uncertain. Should rosy revenue forecasts be realized, A.B. 1805 may gain some traction. However, Governor Brown is likely to put on the breaks. Having claimed responsibility for engineering the state's economic comeback, the likely candidate for a fourth term urges restraint. His 2014-2015 budget prevents health care providers from having to pay the cut retroactively, but does not stop it from going forward.

CRA Supports Medication Synchronization Proposal

Poor medication adherence is responsible for increased hospitalization and risk of death and approximately $290 billion in increased medical costs annually. In response, California Assemblywoman Susan A. Bonilla recently introduced medication synchronization legislation (A.B. 2418). This legislation will allow patients to opt out of mandatory mail order programs if they prefer to obtain their prescriptions from a pharmacy or clinic and streamlines refill synchronizations to allow patients to pick up all of their prescriptions during one visit to the pharmacy. CRA is voicing its support along with the California Pharmacists Association, California Healthcare Institute, and specialty medical associations, while insurers are expected to assert opposition.

Bill Seeks To Ban All Product Clauses

Several Californian physicians have been surprised to learn they are contracted to accept patients covered by insurance exchange plans although they have previously rejected offers to participate. Insurers across the country have begun to invoke all product clauses on a larger scale as they are experiencing difficulty encouraging enough physicians to voluntarily participate in exchange plans.

A.B. 2400, sponsored by Assemblyman Sebastian Ridley-Thomas, would prohibit health plans and insurers from executing agreements with physicians that contain provisions requiring them to participate in all products or networks that are currently offered or that may be offered by the health plan. Physicians would be allowed to opt-in to each product or network.

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