# The SGR – Data Behind the Story
# Can P4P become P4 Value?

**Larry deGhetaldi, MD**

**Sutter Health**

**Palo Alto Medical Foundation**

# Topics

- Why is the SGR so polarizing?
- Can Transparency bend the cost curve?
- What is “Risk & Price Adjusted Total Cost of Care”?
- Engaging physicians on P4P to P4Value:
  - The nine box Medicare Grid
- If the U.S. Medicare spend = San Francisco’s
- The Future of the SGR

# Different Stakeholders' Perspective

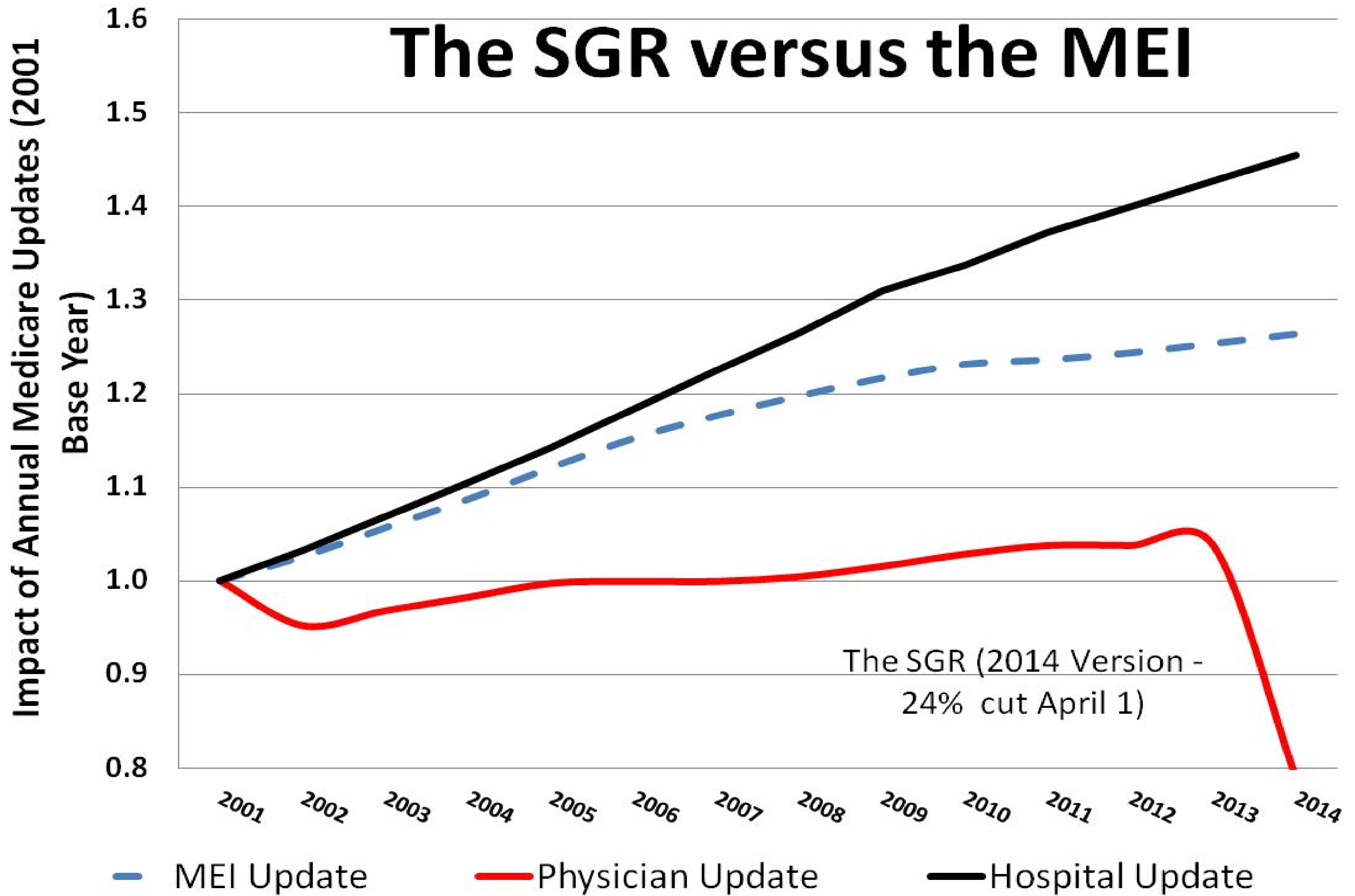
**Part B Providers**

- Offended by the SGR
- "The U.S. is not an ACO"
- Annual Doc Fix (15 since 2003) – policy wasted energy
- "Why us and not them?"
- "This is just a budgeting scam"
- "Those other guys, states or groups are wasteful"

**Part A, C, & D Providers & Pundits**

- "What's the SGR"?
- "Doctors control the bulk of expenditure decisions"
- "It won't affect us, will it?"
- " It has perversely increased spending in some areas"
- "Why should we pay for the SGR fix?"
- "It won't affect MA rates or our ACO rates, will it?"

Why is the SGR so polarizing?




Why is the SGR so polarizing?

# If the SGR was a big ACO, WHY DID IT FAIL?

- Group practice as an “anchor system”
- E & M expenditures versus post-acute
- The Perverse Incentive of fee for service in an SGR world
- Line of sight is < 20 miles
- We cannot control Miami
- We never see the total cost of care

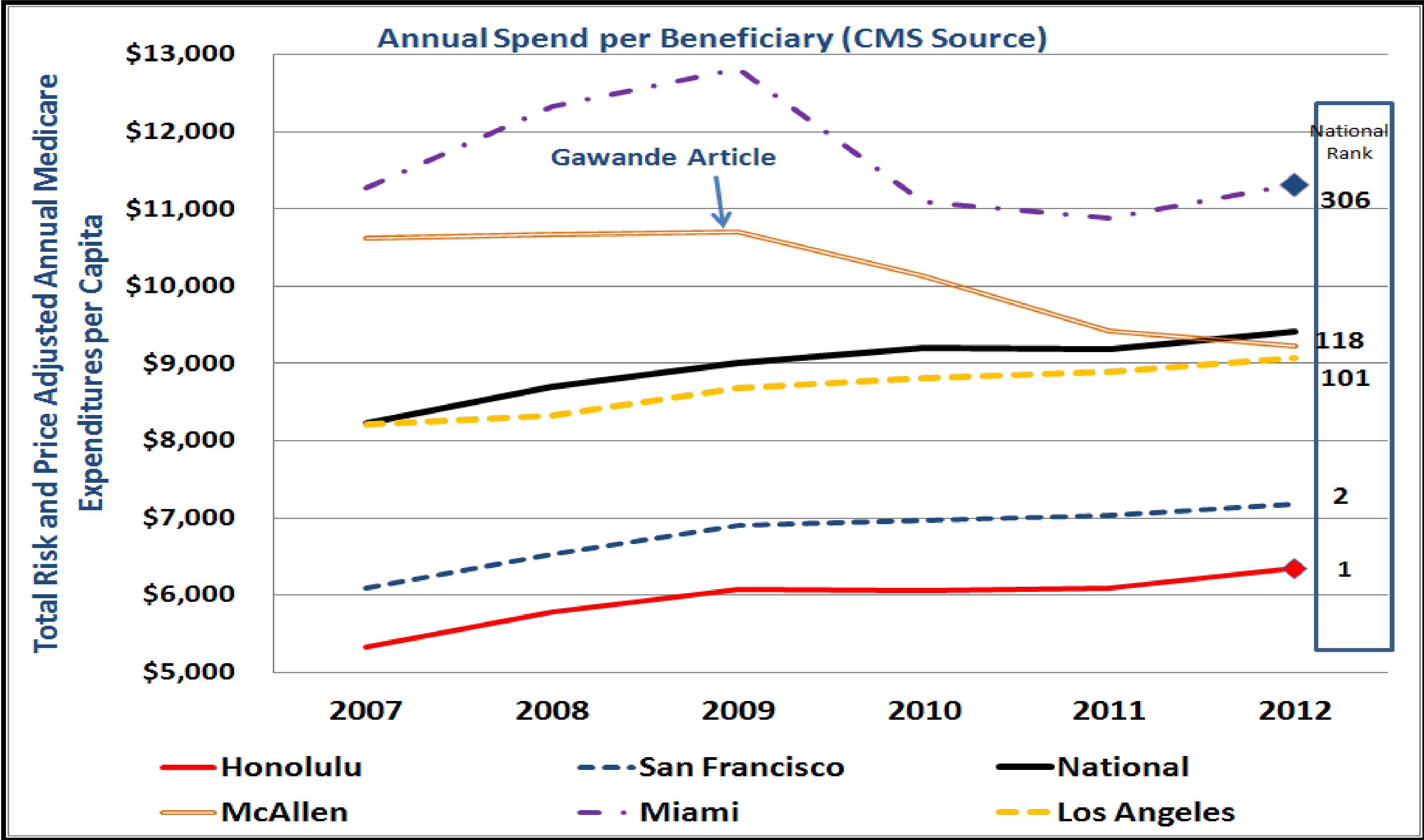
Why is the SGR so polarizing?

# The Stages of Transparency Denial

- Stage 1 – This Data is Flawed
- Stage 2 – My Patients are Sicker
- Stage 3 – Don't Tell Me How to Practice
- Stage 4 – We want the good old days
- Stage 5 – We agree that 18% is not sustainable
- Stage 6 – Give us the data and give it now
- Stage 7 – Carve in the carve outs and pay us for value

Can Transparency Bend the Cost Curve?

# Gawande 2009




Can Transparency Bend the Cost Curve?

# Joe Newhouse Letter to Don Berwick

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## Background Information

### New Data on Geographic Variation

In January 2011, the Institute of Medicine (IOM) Committee on Geographic Variation in Health Care Spending and Promotion of High-value Care (the Committee) sent a letter to Dr. Donald M. Berwick, the Administrator for the Centers for Medicare and Medicaid Services (CMS), requesting new datasets and analyses. The requested information would help the Committee evaluate geographic variation and growth in health care spending and the volume and intensity of health care services utilization.

What is Risk & Price Adjusted Total Cost of Care?

# Old versus New Total Cost of Care

## OLD CMS/Dartmouth Method

Part A Dollars Spent + Part B Dollars Spent

## NEW CMS Method

$$\left\{ \frac{\left( \frac{\text{Part A Dollars Spent}}{\text{Hospital Wage Index}} \right) + \left( \frac{\text{Part B Dollars Spent}}{\text{Physician GPCIs}} \right)}{\text{Population Risk}} \right\}$$

What is Risk & Price Adjusted Total Cost of Care?

# Talking Points for Physicians

- The conversation is easier in group practices
- Valid <u>panel</u> attribution is the starting point
- Population Risk Adjustment goes next
- Adjusting for Geographic Practice Cost goes next
- Adjusting for Cost without Quality/Service will lose them
- Transparency for total cost and quality goes last

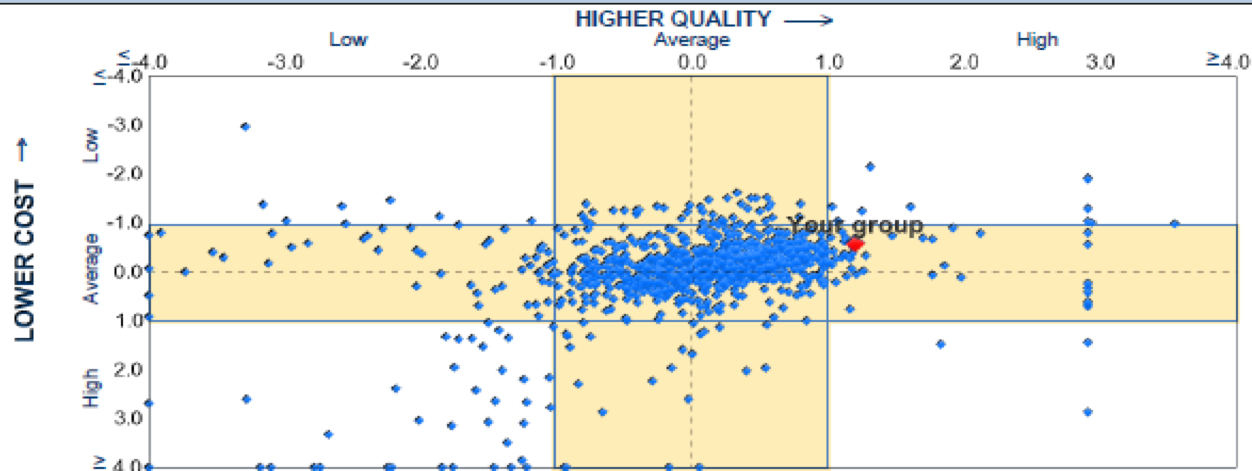
Engaging Physicians on P4P to P4Value

# The Nine Box Medicare Grid Works

## YOUR BENEFICIARIES' AVERAGE RISK SCORE: 61ST PERCENTILE

- To account for differences in patient risk and reduce the influence of very high cost beneficiaries, the overall per capita costs of your beneficiaries were risk adjusted upward by 11.6 percent.
- Because your Medicare beneficiaries' average risk score is not at or above the 75th percentile of all beneficiary risk scores, your group would not be eligible for an additional upward adjustment under the quality tiering approach for serving high-risk beneficiaries.

## YOUR QUALITY TIERING PERFORMANCE: HIGH QUALITY, AVERAGE COST




## YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +1.0x%.

*Payment adjustments for each level of performance are shown below:*

| | Low Quality | Average Quality | High Quality |
|---|---|---|---|
| Low Cost | +0.0% | +1.0x% | +2.0x% |
| Average Cost | -0.5% | +0.0% | +1.0x% |
| High Cost | -1.0% | -0.5% | +0.0% |

*Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.*

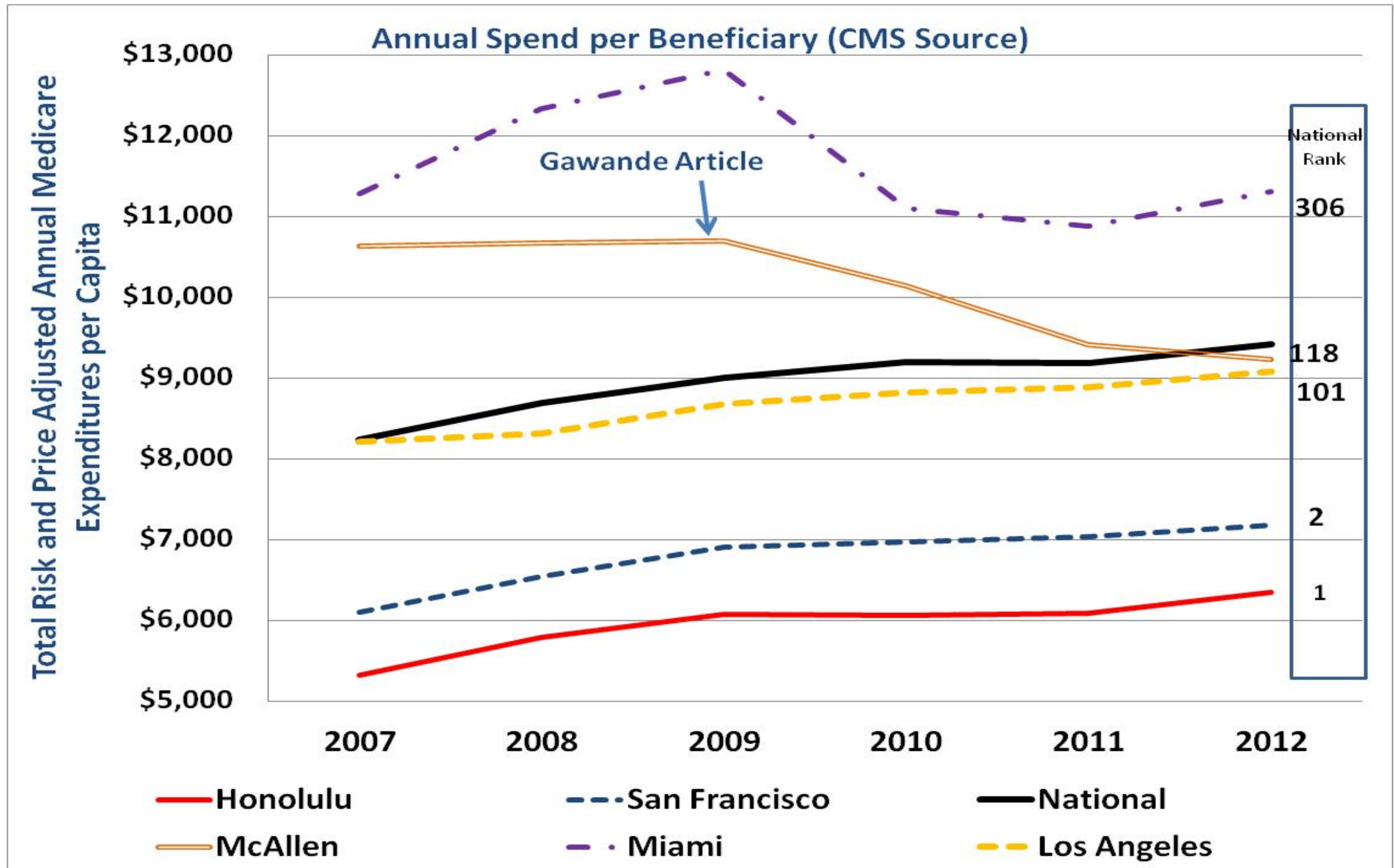
Engaging Physicians on P4P to P4Value

# Geographic Variation is Real & Sustained

- If quality/service will be moderated by total cost of care, what is the baseline of TCoC?
- Will this impact the future of the SGR modifier? Should it?
- Does this impact MA county rates?
- Does this impact ACO or MSSP rates?
- What if the U.S. Behaved Like S.F. or Honolulu?

If the U.S. Behaved Like S.F.

# Geographic Variation is Real & Sustained

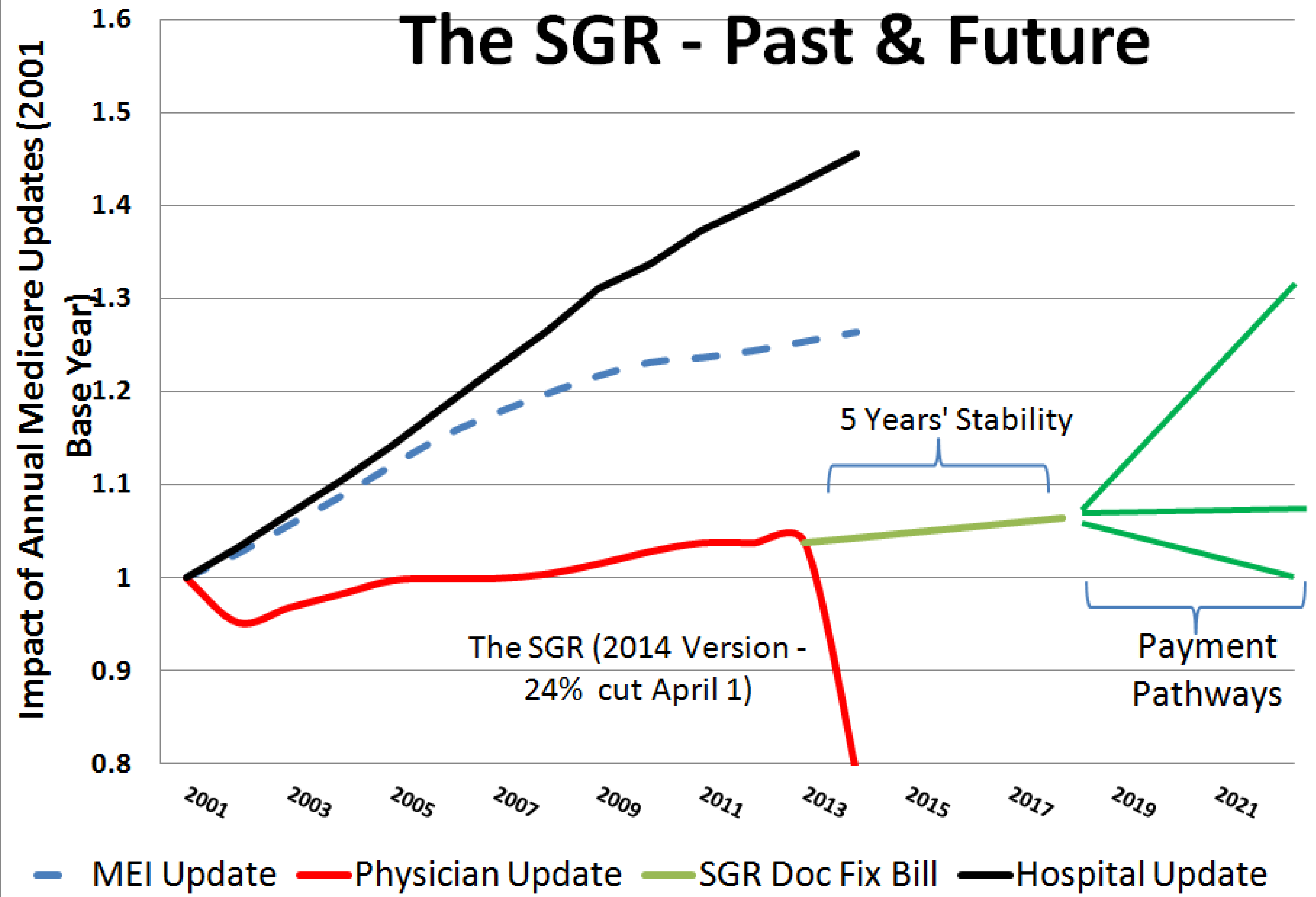



If the U.S. Behaved Like S.F.

# Geographic Variation is Real & Sustained

- Fee for Service Medicare Total Expenditures:
  - Affects MA County rate setting
  - Establishes four county quartiles under the ACA
  - Defines ACO/MSSP benchmarks

If the U.S. Behaved Like S.F.




The Future of the SGR