SUSTAINABLE GROWTH RATE

An Idea Whose Time has Gone

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SGR – UNLIKE GRAVITY…

…not such a good idea
SUSTAINABLE GROWTH RATE (SGR)

\[(x + a)^n = \sum_{k=0}^{n} \binom{n}{k} x^k a^{n-k}\]

• A formula sets an annual expenditure target for physicians’ services, and other Part B services “incident to” physician services

• Target includes
  o Trends in cost of the market basket of goods and services purchased to produce the covered services
  o Anticipated productivity adjustment
  o Change in Medicare FFS enrollment
  o Long-term annual trend in real GDP (inflation adjusted)
  o Impact of changes in law and regulation on benefit costs (i.e. a new benefit would result in an increase in the target)
  o Adjustments for prior year estimation errors, or Congressional overrides

* Actually, this is the equation for the binomial theorem. SGR isn’t this simple…*
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  - Adjustments for prior year estimation errors, or Congressional overrides
- **Spending in excess of the target produces an off-setting reduction in physician fees. Spending below the target has generated fee increases.**

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SUSTAINABLE GROWTH RATE

• Negative every year since 2002
• In 2002, the SGR generated a cut to physician fees of 4.8%
• In 2003, the SGR would have cut an additional 4.4%. Instead, Congress increased fees by 1.7% (an annualized swing of 6%, although only effective for 10 months).
• In 2004, the SGR would have cut physician fees by 4.5%. Congress increased fees by 1.5%.
• And so on every year to this very day
• Cumulative cost of annual fixes: $150 billion
• Each year, the overrides are added to the SGR, increasing the problem.
• 2014 projected cut is 24.1% -- postponed until 4/1.
SOLUTION EXISTS

• Long-term solution
  o Bi-partisan, bi-cameral bill to repeal the SGR and enact value-based pricing for physician services
  o Approved by House Energy & Commerce and Ways & Means, and Senate Finance Committees

• But, how to pay for it??
  o 10 year cost is $138 billion
  o Congress’ “Pay-Go” rule requires offsetting 10 year savings.
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Long-term solution

- Bi-partisan, bi-cameral bill to repeal the SGR, enact value-based pricing for physician services, and...
- …House of Representatives passed the bill, but tied SGR fix to a 5-year postponement in the Obamacare individual mandate
- Obamacare’s broad coverage goal requires guaranteed issue (no pre-existing limitations), and guaranteed issue without an individual mandate allows people, in effect, to wait until the house catches fire before buying fire insurance.
- President will veto this, even if it were to pass the Senate (it won’t).

See Stuart Butler, “The Heritage Plan”, Heritage Foundation, 1989, for justification of individual mandate
SOLUTION EXISTS

- Short-term solution
  - The bill that rolled back a reduction in certain military pensions paid for change by extending the 2% Medicare sequestration by one year, to 2024.
  - The “savings” anticipated ten years hence are more than enough to fund the pension increase.
  - The difference, $2.3 billion, is available for a short-term postponement of the 2014 SGR cut.
  - **Still needed:** about $7 billion for a 9-month postponement, until 1/1/2015.
SOLUTION EXISTS

- Path of least resistance is…

…deal with the SGR again after the election
So who will pay?

- Medicare providers and health plans: One year extension of 2% sequestration, 10 years from now. Done deal.
- Hospitals? Possible one year extension of DSH reduction (but no one expects to see that money come back, anyway).
- Congress will probably find the rest in other provider payments.
- Expect a bill this week??
BUT WHAT IF??

Details of the bi-partisan, bi-cameral proposal
1. Repeal the SGR
2. 5-year period (2014 – 2018) of 0.5% annual increases in physician fee schedule (update to conversion factor)
3. Updates from 2019 – 2023 = 0%
4. Updates from 2024 onward = 0.5% or 1.0%, depending…
5. Consolidates three existing quality programs into one Merit-based Incentive Payment System (MIPS):
   a. EHR meaningful use
   b. Physician Quality Reporting System (PQRS)
   c. Value based payment modifier (VBPM)
SGR REPLACEMENT

• MIPS*: Positive and negative adjustments for…
  o Quality
  o Resource use
  o EHR meaningful use
  o Clinical practice improvement activities
• Absolute and relative improvement (relative to peers)
• Range
  o 2018 = -4% to +12%
  o 2021 = -9% to +27%, plus

*In Geek Speak, MIPS means “millions of instructions per second”
SGR REPLACEMENT

• Alternative Payment Models (APM)
  o Physicians with significant revenue through APMs may opt out of MIPS
  o APM involves financial risk, quality, EHR
  o 5% bonus
  o After 2024, 1% annual update rather than 0.5%
  o Payment Model Technical Advisory Committee
DETAILS

• MIPS
  o Implements a process to improve payment accuracy for individual provider services.
  o Incentivizes care coordination efforts for patients with chronic care needs.
  o Introduces physician-developed clinical care guidelines to reduce inappropriate care that can harm patients and results in wasteful spending.
  o Requires development of quality measures and ensures close collaboration with physicians and other stakeholders regarding the measures used in the performance program.
DETAILS

• MIPS
  o Implements a process to improve payment accuracy for individual provider services.
    • Studies and reports
    • Factors associated with desired outcomes – quality and resource use
    • Race, health literacy, limited English, patient activation, health status, other factors
    • HHS to recommend payment adjustments for risk related to the identified factors
  o Code creep? Improved accuracy and completeness of data?
DETAILS

- Episodes of Care and Condition Groups
  - With stakeholder input regarding composition and expected resource use
    - To ultimately cover 2/3 of Medicare spending
    - Attribution rules: patient to episode, and episode to physician
    - Resource use measurement
    - Could be basis for payment (not in the bill)
DETAILS

• Quality metrics to be developed
  o Clinical care
  o Safety
  o Care coordination
  o Patient and caregiver experience
  o Population health and prevention
  o Input and output measures
DETAILS

• Chronic care
  o New HCPCS code or codes for management
  o Payment for management starting 1/1/2015
  o For practitioner functioning within a patient-centered medical home – certified
  o Budget neutral payment

• Relative Value Scale
  o Improve resource use quantification
  o Fix mis-valued services
  o Still a relative cost scale, not relative value
  o Goal is saving money
 DETAILS

• Evidence-based Care
  o Imaging guidelines: ordering criteria, location, appropriate use
  o Tied to payment
  o Prior authorization for outlying ordering professionals (up to 5%)

• “Consumer Reports”
  o Physician-specific data on charges and payments, number/frequency of services

• Consideration of broader gain-sharing with hospitals
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