Will Reform of the SGR Catalyze P4P in Medicare?

Pay for Performance Summit
February 15, 2007

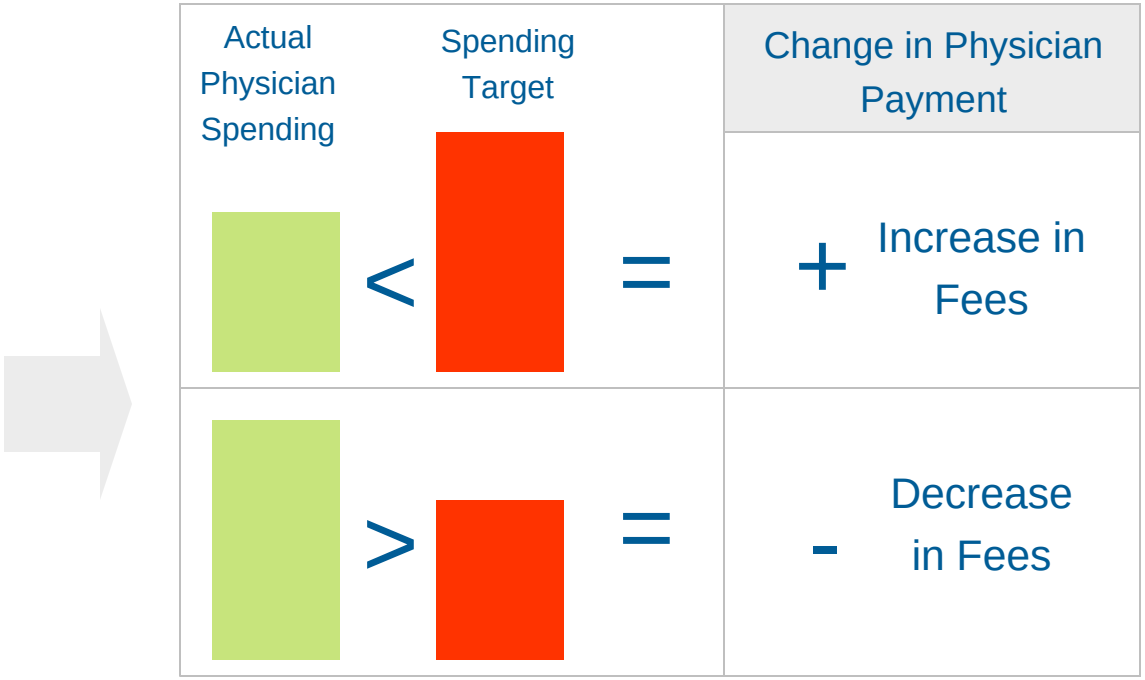
Agenda

- Understanding the Sustainable Growth Rate (SGR) and Its Impact on Physician Payment
- Examining Physician Pay-for-Performance (P4P) in the Context of Other Providers
- Framing Recent Legislation on Physician Payment and the Role for P4P
- Looking to ’08 and Beyond: Identifying the Critical Issues and Their Impact on Potential P4P Adoption / Expansion

The Sustainable Growth Rate Was Meant to Control Physician Spending

"By linking fee updates to spending, the Sustainable Growth Rate (SGR) is intended to provide physicians a collective incentive to control the volume and intensity of physician services."[1]

Physician Updates are based on the difference between actual and target spending



[1]National Health Policy Forum, "*Updating Medicare's Physician Fees: The Sustainable Growth Rate Methodology.*" November 10, 2006

SGR Mechanism Determines Spending Target for Physicians

- The spending target is updated annually, and based on several key components

Year 1 Target Spending

$81.7 billion in 2006

X

Year 2 SGR Factor (1.007 in '07)

- Inflation adjustment (1.026 in 2007)
- Changes in # of FFS Beneficiaries (0.971)
- GDP (1.022)
- Changes in coverage mandated by laws and regulations (0.990)

=

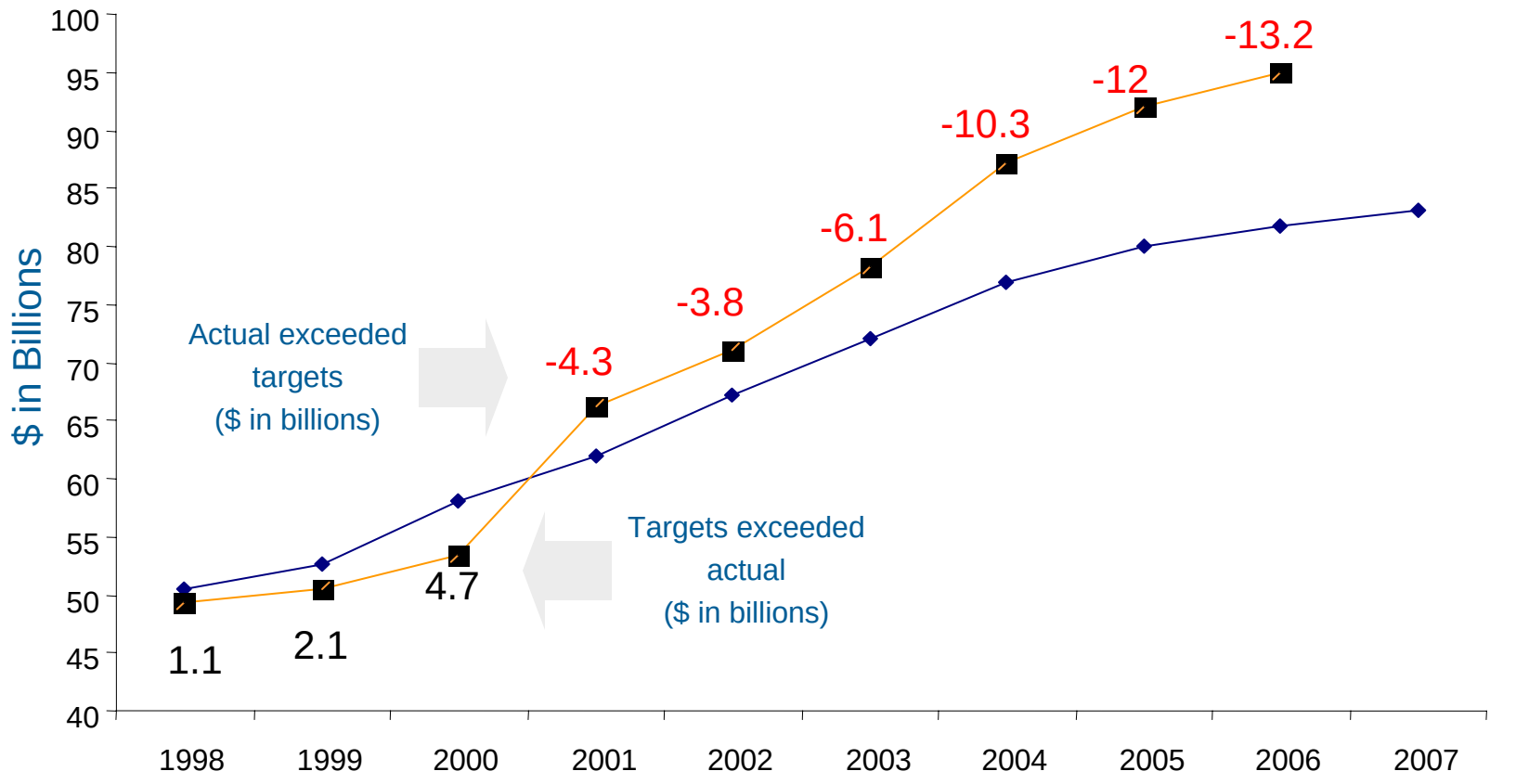
Year 2 Target Spending

$82.3 billion in 2007

Initial SGR target based on spending over the 4/1/96-3/31/97 period. SGR targets are both annual and cumulative, and annual payment changes are designed to reduce cumulative overage/underage to zero, over time, with limits to min/max updates (>-7% and <+3%).

Adapted from National Health Policy Forum, "*Updating Medicare's Physician Fees: The Sustainable Growth Rate Methodology."* November 10, 2006

Despite Annual Updates and Revisions, Physician Expenditures Have Exceeded the Annual Targets Since 2002



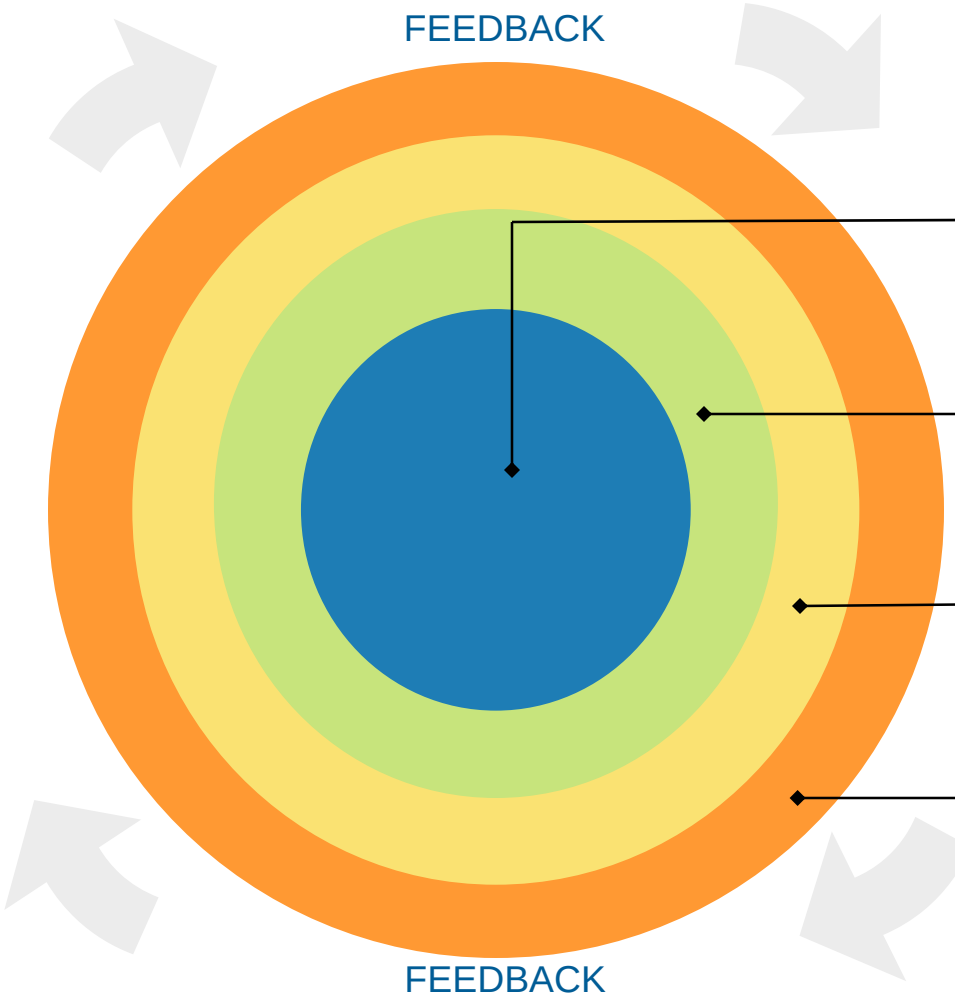
Source: CMS Final Rule: Medicare Program; Revisions to Payment Policies, Five-Year Review of Work Relative Value Units, Changes to the Practice Expense Methodology Under the Physician Fee Schedule, and Other Changes to Payment Under Part B; Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; and Ambulance Inflation Factor Update for CY 2007.

Congress Tends to Override Cuts "Required" Under SGR

	1998-2001	2002	2003-2007
Physician Payment	Actual Physician Spending < Spending Target	Actual Physician Spending > Spending Target	Actual Physician Spending > Spending Target
▲ In Fees*	+	-	-
Congressional Action	Complied: Fee Increased	Complied: Fee Decreased	Overridden: Negative update prevented

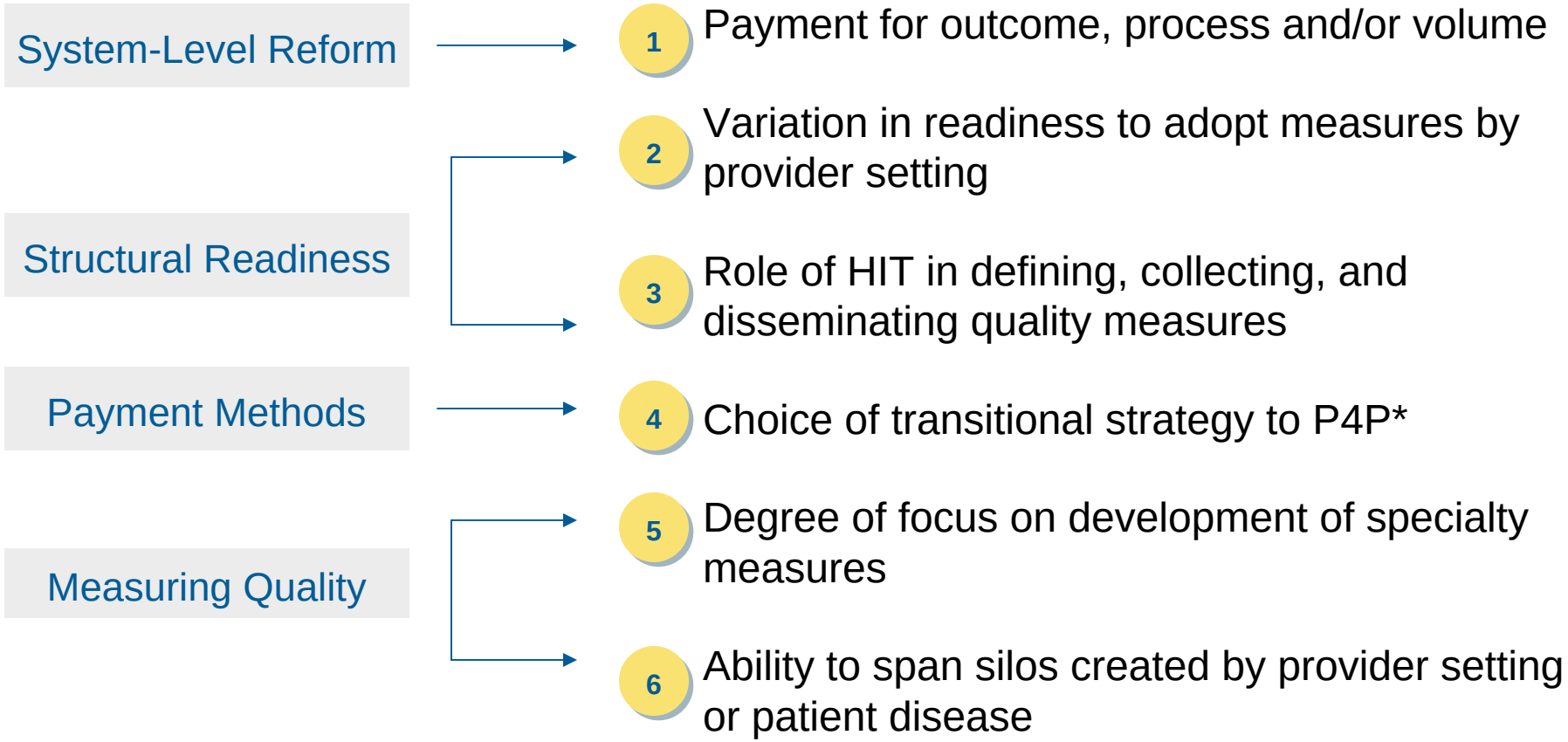
*As mandated by SGR

Linking Payment and Performance Requires Activity and Agreement At Multiple Levels, Across Multiple Stakeholders



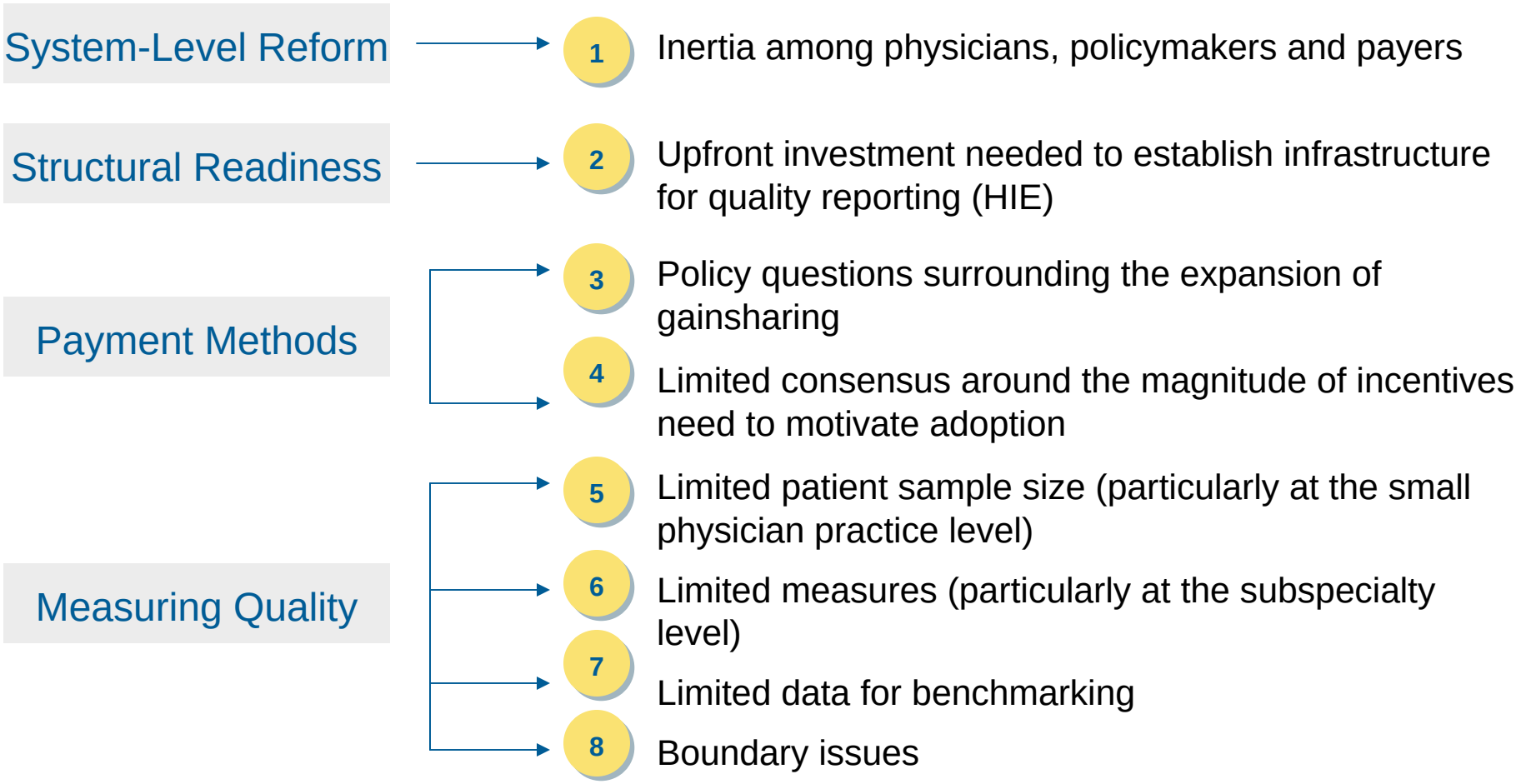
1. **Measuring Quality**
   Defining quality along the healthcare continuum
2. **Payment Methods**
   Development of new approaches to link quality to payment
3. **Structural Readiness**
   Adjustments at the provider/payer level needed to incorporate P4P
4. **System-Level Reforms**
   Building an environment to encourage 1, 2, and 3

Six Critical Trends Influencing the Adoption of P4P



*Efforts to introduce P4P begin with incentives for providers to report data on quality measures; also known as pay-for-reporting

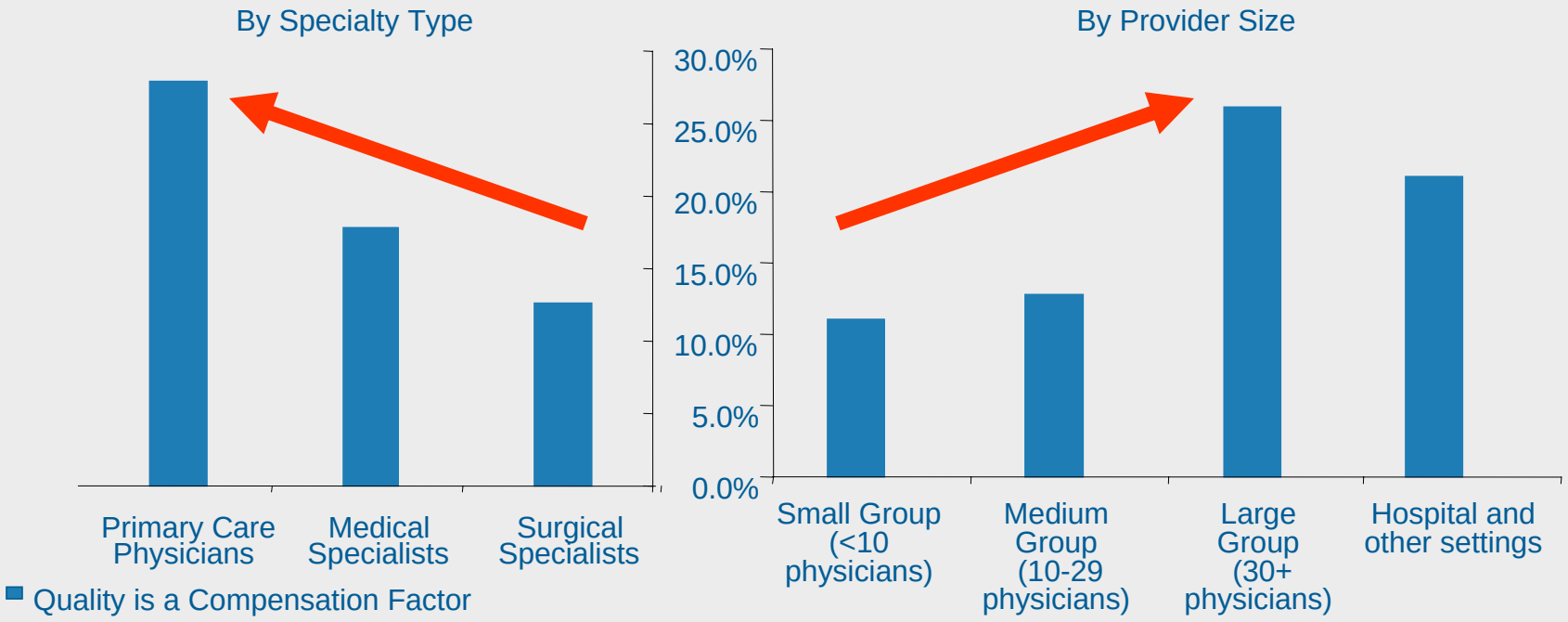
Challenges Affecting the Adoption of P4P Among Physicians



Today, Physician Reimbursement Based On Quality Varies By Specialty and Practice Size

- Proportion of physician compensation based on quality increased from 17.6% in 2000-01 to 20.2% in 2004-05
  - » Reverses a significant decline in proportion found between 1998-99 and 2000-01

Physicians Reporting Performance on Quality Measures is a Factor Used in Compensation, 2004-05



Source: Center for Studying Health System Change, *"Physician Financial Incentives: Use of Quality Inches Up But Productivity Still Dominates."* January 2007

Examples of Existing Medicare P4P / P4R Programs

HOSPITAL

- *Hospital Compare** Reporting Public Reporting
- Premier Hospital Quality Incentive Demonstration
- Medicare Health Care Quality Demonstration**
- Reporting Hospital Quality for Annual Payment Update*
- Gainsharing Demonstration

PHYSICIAN

- Medicare Physician Group Practice Demonstration*
- Medicare Care Management Performance Demonstration**
- Physician Voluntary Reporting Program*

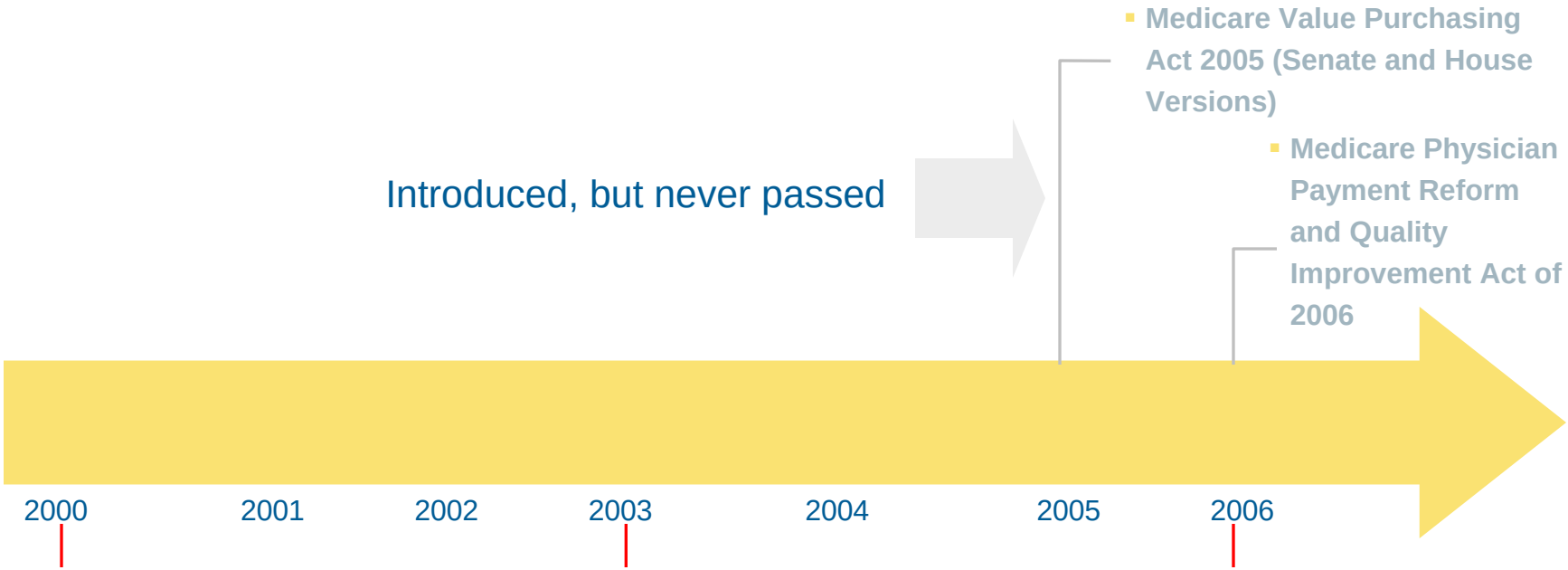
NURSING HOME

- *Nursing Home Compare* Public Reporting*
- Nursing Home P4P Demonstration**

*Pay-for-reporting Initiatives
**Implemented with phased-in approach: pay-for-reporting evolves to pay-for-performance

NOTE: Programs sorted from oldest to most recent (based on establishment through law or regulations)

Medicare P4P / P4R Initiatives Tend To Have Long Gestation Periods



BIPA 2000

- **Physician Group Practice**

MMA

- **Medicare Health Support (Sec. 722)**
- **Medicare Care Management Program (Sec 649)**
- **Medicare Health Care Quality Demo (646)**

- **In January, CMS initiates PVRP** as part of its quality improvement initiative**

TRHCA***

- **Physician Payment and Quality Improvement (Division B, Title I, Section 101)**

*Medicare Modernization Act
**PVRP is Physician Voluntary Reporting Program
***Tax Relief and Health Care Act

New Law Links Physician Reimbursement in Medicare to Quality Reporting

The Tax Relief and Health Care Act of 2006 details the specifics of the quality reporting program

Incentive	1.5% Bonus Payment for all Medicare covered Part B services
Measures	2007 Physician Voluntary Reporting Program Measures (PVRP)
Eligible Providers	▪ Physicians ▪ Physician Assistants ▪ Nurse Practitioners ▪ Qualified Speech-Language Pathologists ▪ Other Medicare Covered Part B Providers

The 2007 Physician Voluntary Reporting Program

Objective	Facilitate gathering and analyzing data on the quality of physician care provided to beneficiaries to improve the quality of care
Implemented	▪ New measure set of 66 released October 2006 ▪ Reporting on new set began on January 1, 2007
Conditions Covered by Measures	▪ Cardiac care ▪ Diabetes ▪ End-stage renal disease ▪ Glaucoma, macular degeneration, and cataracts ▪ Osteoporosis ▪ Melanoma ▪ Depression ▪ Elder care

Specialties Without Measures*

- Physical medicine
- Nuclear medicine
- Interventional radiology
- Radiation oncology

Source: http://www.cms.hhs.gov/PVRP/01_Overview.asp; Inside Health Policy, "Therapy Providers Scramble To Create Quality Measures To Receive Bonuses Next Year." December 20th, 2006

*Four of six specialties without measures listed

The Legislation Establishes Timeline for Participation and Expansion

Jan 1:
2007 PVRP measures in effect

Jan 31:
Revisions to measures completed

April 1:
Revised measure published

July 1:
2007 Reporting program begins

August 15:
2008 measures must be released for public comment

November 15:
2008 measures must be published in the Federal Register

Dec 31:
2007 Reporting program concludes

Jan 1, 2008:
Absent Congressional/CMS intervention, physician payments face a ~ 10% cut

The New Law May Encourage Physician Participation in Pay-for-Reporting

Accelerants

Power of the law	▪ Consistent with the approach for hospitals and nursing homes, the legislation now establishes physician pay-for-reporting
Provides a phased-in approach	▪ Allows providers time to adapt by providing incentives for reporting ▪ No timeline to move from pay-for-reporting to pay-for-performance; reduces anxiety
Expands already existing CMS program (PVRP)	▪ May mitigate physician inertia since it leverages already established program
Provides bonuses not penalties	▪ May improve physician buy-in by providing a carrot not a stick

But, There Remain Several Unresolved Issues That May Limit Widespread Participation

− Retardants

Establishes 6 months reporting period for 2007	▪ May limit ability of program to gain momentum ▪ May be insufficient time to adequately assess program results ▪ Requires additional legislative action to continue reporting program in 2008
Establishes initial bonus payment at 1.5%	▪ Remains unclear whether 1.5% bonus payment will be sufficient
Limits pool of measures to approved PVRP measures	▪ May exclude specialty providers for whom no consensus measures exist
Deadline to revise measures is Jan 31	▪ May further restrict meaningful revisions to existing measurement set

MedPAC Believes Payment Incentives For Quality Are Key To Transforming Physician Payment in Medicare

For the Commissioners, though the nature of the transformation is unclear…

"Pathway One"

- Repeal SGR and expenditure target
- Develop and adopt new approaches for improving value
  - » Options to improve value to be outlined in MedPAC's March 2007 report

OR?

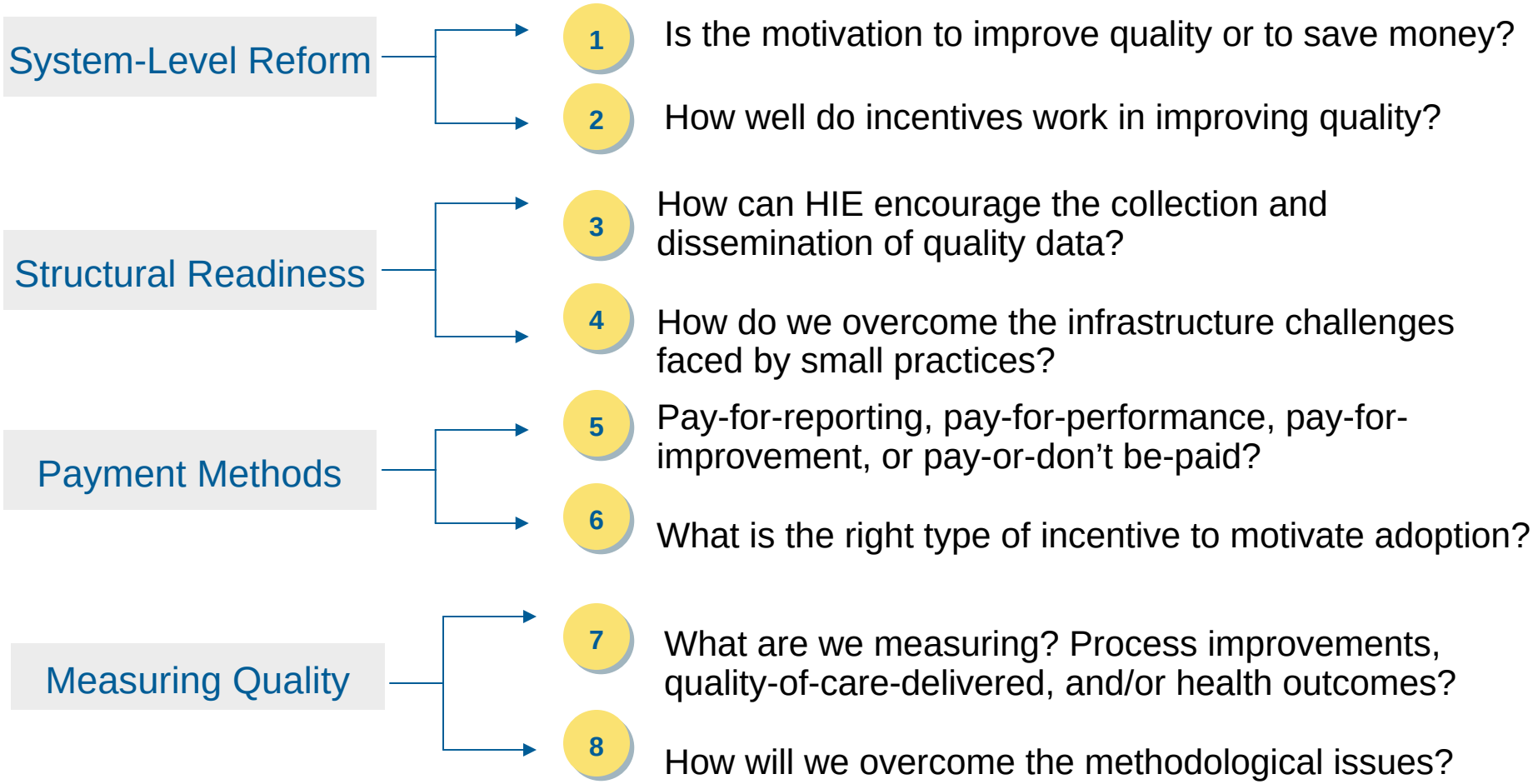
"Pathway Two"

- Expand expenditure targets to encompass ALL providers
- Expenditure targets based on geography
- Provisions to spur greater care coordination
- Incorporation of quality and efficiency ratings

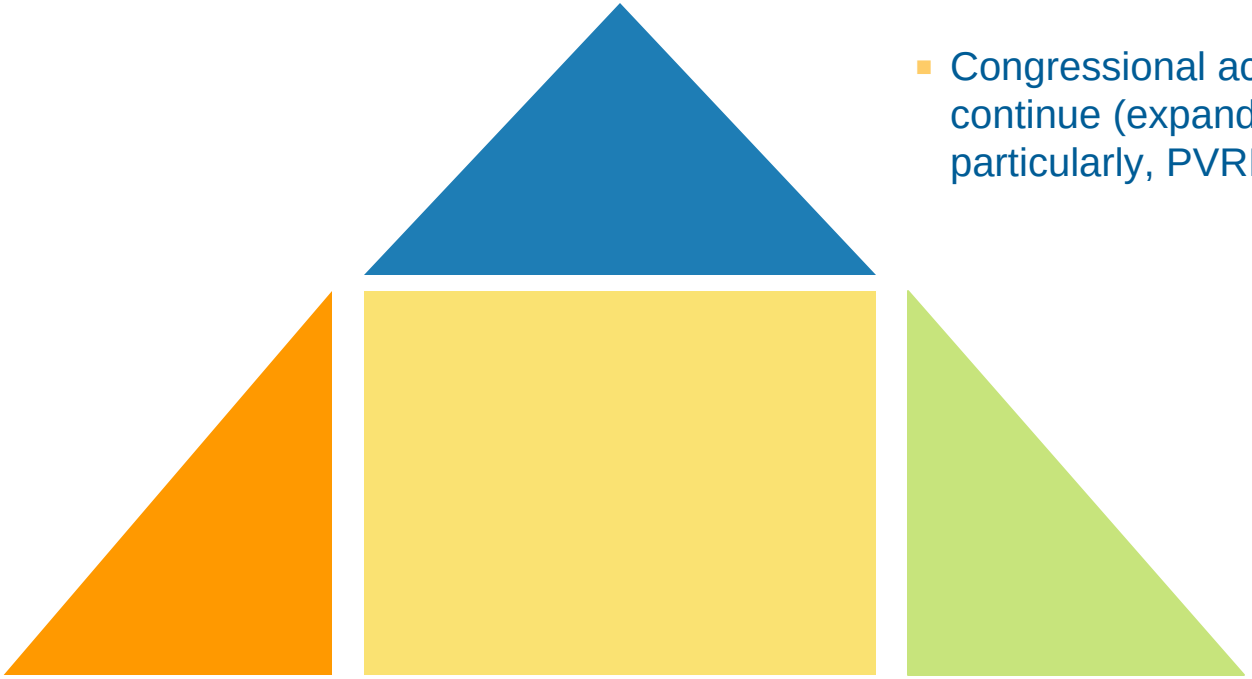
…pay-for-performance provisions are likely to be part of any SGR reform

Sources: Avalere Summary of MedPAC Public Meetings, Jan 8, 9, 2007
CQ HealthBeat, *MedPAC Fix For Flawed Doctor Payment System May Mean Transforming Health System*, Jan 10, 2007

Adoption of P4P in Medicare Is Likely To Rest on Our Capacity to Answer and Agree These Key Questions



Assessing the Probability of Adoption of P4P in Medicare: Keep a Lookout for…



- Congressional action to continue (expand) programs, particularly, PVRP

- Consensus among Congressional Support Agencies* on the future of SGR
- Greater specificity on the role of quality in payment reform

- Momentum from provider stakeholders (AMA, other specialty groups) to expand efforts

- Results from other P4P efforts
- The initial assessment of the success of PVRP

Congressional Support Agencies include: MedPAC, GAO and CBO