The Sustainable Growth Rate System: Policy considerations for adjustments and alternatives

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Overview

- Brief background on the sustainable growth rate (SGR) system
  - What is it? How does it work?
  - Why does it cost so much to “fix”?
- Policy issues
  - Problems and advantages of expenditure controls
  - Selected proposals for longer-term SGR modifications
- Discussion

What is the SGR?

- The formulaic method for annually updating fees for physician services
- Designed to keep aggregate Medicare expenditures for physician services on a “sustainable” trajectory
  - In-line with growth in the nation’s per-capita GDP
  - GDP selected as measure of national affordability
- Established by the BBA ’97
  - Expenditure targets have been a part of the Medicare physician fee schedule since its inception in 1992.

How does the SGR system work?

CMS performs the following annually:

- Step 1: Calculates the year's SGR target—the amount of cumulative spending allowed. It is based on:
  - Per-capita GDP growth
  - Beneficiary enrollment
  - Inflation in practice costs (MEI)
  - Changes in law and regulation that affect volume
- Step 2: Compare the cumulative amount actually spent to the SGR target
- Step 3: Set the update for the subsequent year
  - If actual is greater than target (Step 2), update for subsequent year is reduced (and vice versa).

Where does volume growth fit in?

- Spending↑ ~ Volume↑ (FFS)
  - Growth in spending on physician services varies directly with growth in the volume of services provided.
- The SGR formula is designed to allow volume to grow at the rate of per-capita GDP (and other allowances listed in Step 1).

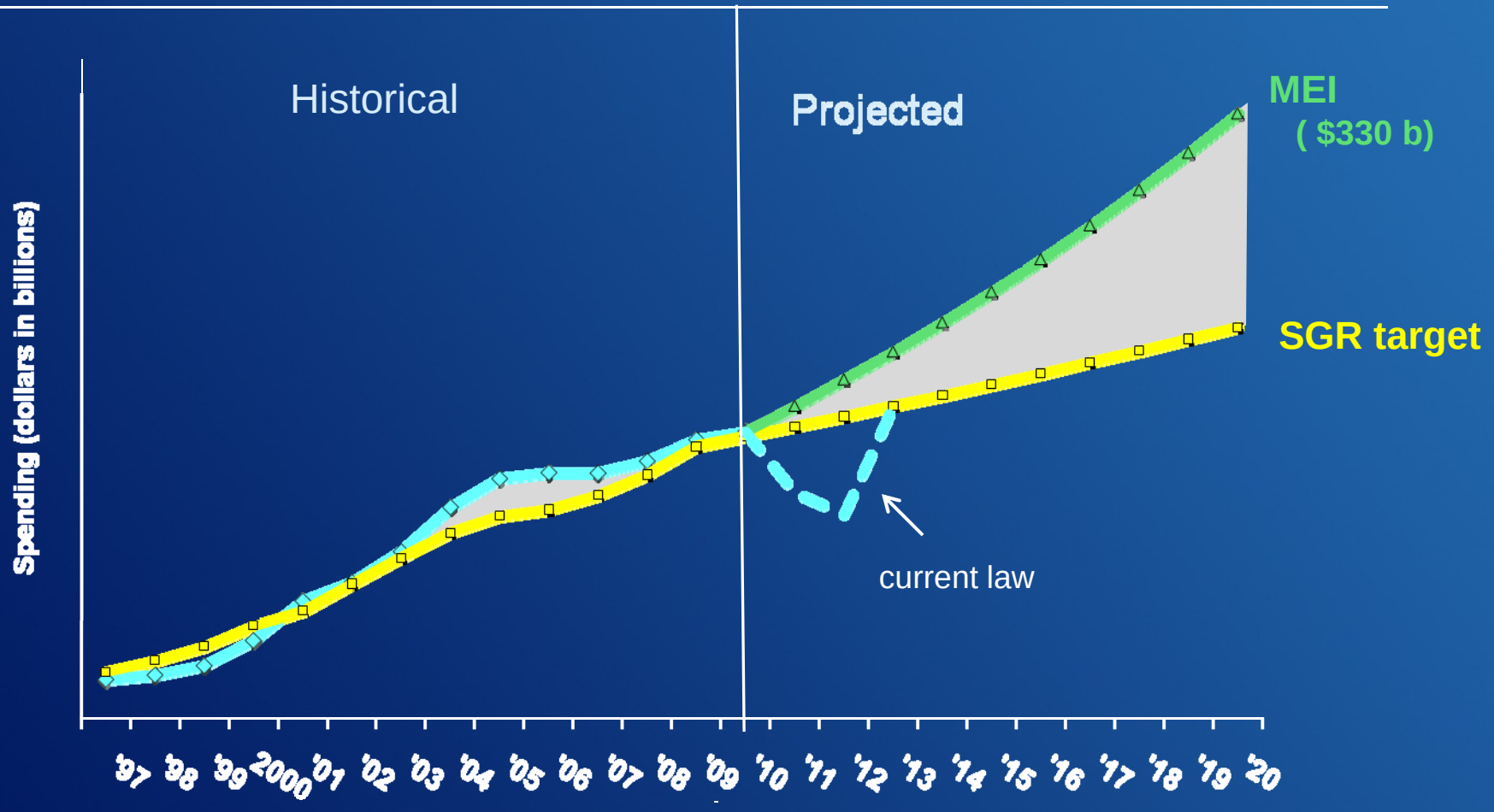
What updates has the SGR produced?

- In early years, volume growth was below per-capita GDP, so updates were at or above the MEI.
- In later years, volume growth increased and per-cap GDP slowed, so SGR has called for rate cuts every year since 2002.
- For 2003 through November 2010, Congress has passed a series of bills to override these cuts.
  - Resulting updates have been fairly modest.
  - Next cuts: –23% (Dec. 2010); –6.5% (2011); –2.9% (2012)

Why does it cost so much to “fix” the SGR?

- SGR adjustments (“fixes”) have high costs (CBO scores)
  - 10-year freeze (0% update) = $276 billion
  - 10-year MEI update = $330 billion
- Key contributing factors:
  - The difference between actual and target spending compounds each year that fee reductions are postponed
  - Current law bases future updates on fees that are ~30% lower than today. SGR changes that restore fees to today’s levels must account for this difference.
- Other cost ramifications: MA, TRICARE, Medicaid, Part B premiums

Scoring considerations: illustration of MEI update through 2020



Source: MedPAC analysis of data from Office of the Actuary 2010 and CBO 2010.
Note: For spending beyond 2009, projections are inexact and for illustrative purposes.

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Problems with the SGR system

- **The SGR system**
  - Does not differentiate by provider
  - Does little to counter FFS volume incentives
- **Resulting updates**
  - Multiple consecutive years of large negative updates for physician services would be detrimental to beneficiary access to care
  - Temporary, stop-gap “fixes” create uncertainty and problems for physician practices and CMS

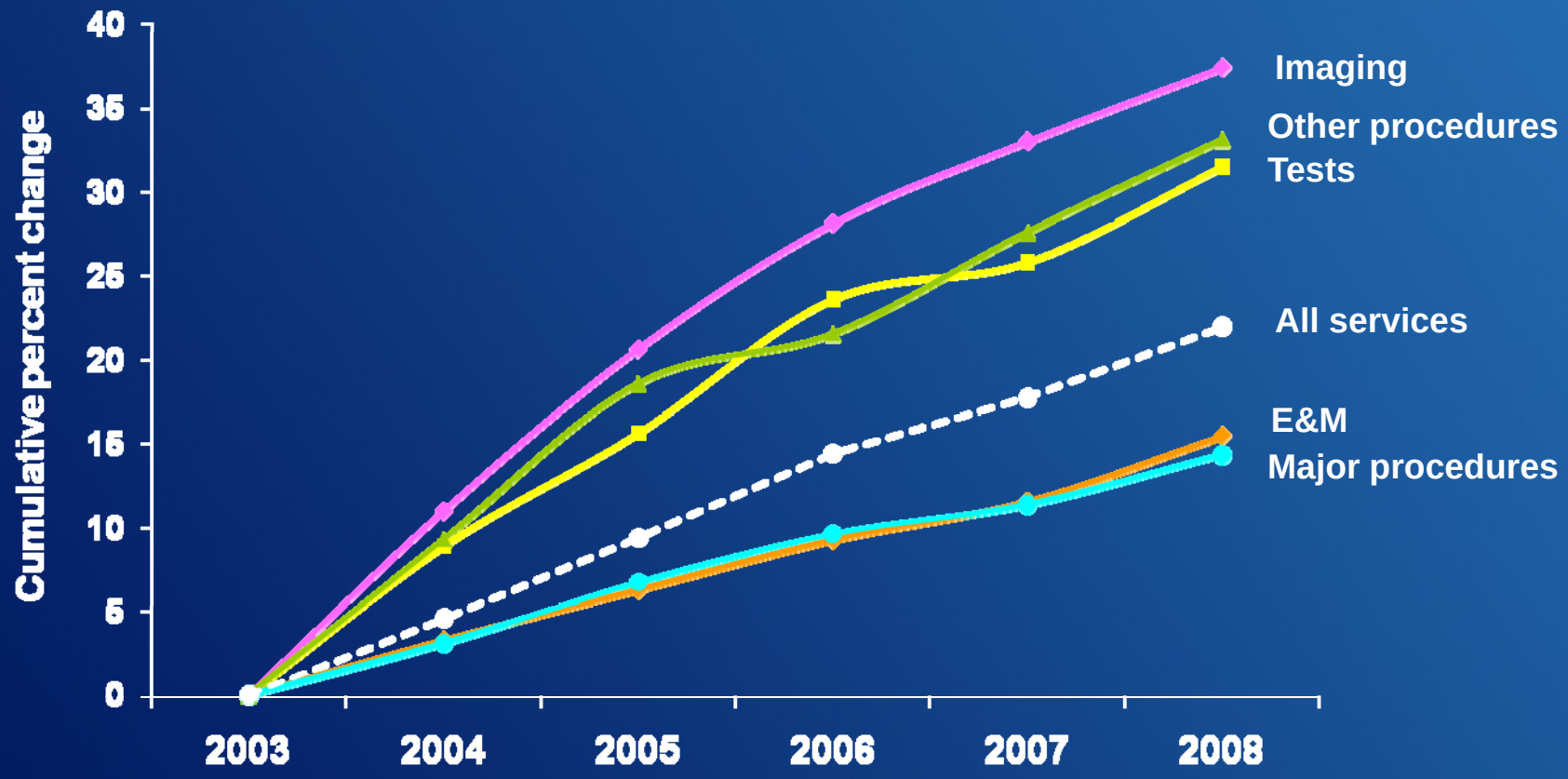
Advantages of expenditure target system

- Useful tool for restraining Medicare spending on physician services
  - Regularly alerts policymakers of spending growth
  - Requires significant Congressional effort to increase spending
- Draws attention to health system problems and can accelerate policies to achieve needed payment reforms

Adjustments by type-of-service

- Main premise: Growth rate and target for each service category is calculated and applied separately.
- The Medicare Physician Payment Reform Act (2009)
  - E&M and preventive
  - All other
- CHAMP Act (2007): Six service categories
  - Primary care
  - Other E&M
  - Imaging and tests
  - Major procedures
  - Minor procedures
  - Anesthesia

Volume of physician services per beneficiary has continued to grow



Note: E&M (evaluation and management).
Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

Advantages and disadvantages of type-of-service proposals

- Advantages
  - Recognizes variation in volume growth rates across categories
  - Produces updates that are more specific to specialties' volume growth (penalizes high-growth, protects low-growth)
  - Creates an opportunity to boost payments for categories that may be undervalued or underused
- Disadvantages
  - Difficult to adjust for evolving changes in optimal service mix across categories
  - Could distort the relative resource values underlying the physician fee schedule

Technical changes to reconfigure the SGR formula

- Adjust the cumulative aspect of the formula
  - Could use annual targets: Excess spending that is not recouped in one year is forgiven
  - Could keep cumulative aspect, but require that only a *portion* of excess spending be recouped
- Create an allowance corridor around the spending target line
  - Relax the precision of spending target (e.g., 2 ppts)
  - Excess spending would be forgiven

Advantages and disadvantages of these technical changes

- Advantages
  - Would suppress the extent of negative/positive updates
  - Could diminish year-to-year variation in updates
  - Retain some expenditure control
- Disadvantages
  - Forgiving any excess spending will increase costs, relative to current law

SGR exemption alternatives

- Multispecialty group practice alternative
  - Premise: Because research suggests that these practices are associated with better coordinated care and lower overall spending, they should get a separate target
  - Pros/cons: May reward this practice style, but problems with inequity and low numbers of eligible physicians
- Hospital medical staff alternative
  - Premise: Hold a smaller group of physicians responsible for the health and spending of a beneficiary population
  - Pros/cons: Increases accountability, but hospital and physician coordination not prevalent

SGR exemption alternatives

- Outlier alternative
  - Premise: After a year of confidential feedback on resource use, penalize providers with extreme overutilization of physician services
  - Pros/cons: Would promote more individual accountability, but assessment methods may be complex and savings will be small.

Broader expenditure target

- Encompass all of FFS Medicare in expenditure target approach
  - "Path 2" from our 2007 SGR report
  - Allows more flexibility in setting targets among different settings and types of services
  - More equitable among all provider-types
  - But, without subsetting by specified populations (e.g., ACO models), may not affect incentive of individual providers

Issues for discussion

- Revisit work on the SGR?
- Potential modifications to the SGR
- Scoring considerations