Moving forward from the Sustainable Growth Rate system

Cristina Boccuti, Kevin Hayes, Kate Bloniarz

October 6, 2011

MEDPAC

Principles for repealing the SGR system

1) Sever the formulaic link between annual updates and cumulative expenditures for fee-schedule services

2) Protect beneficiary access to care

3) Offer fiscally responsible policy to replace the SGR system

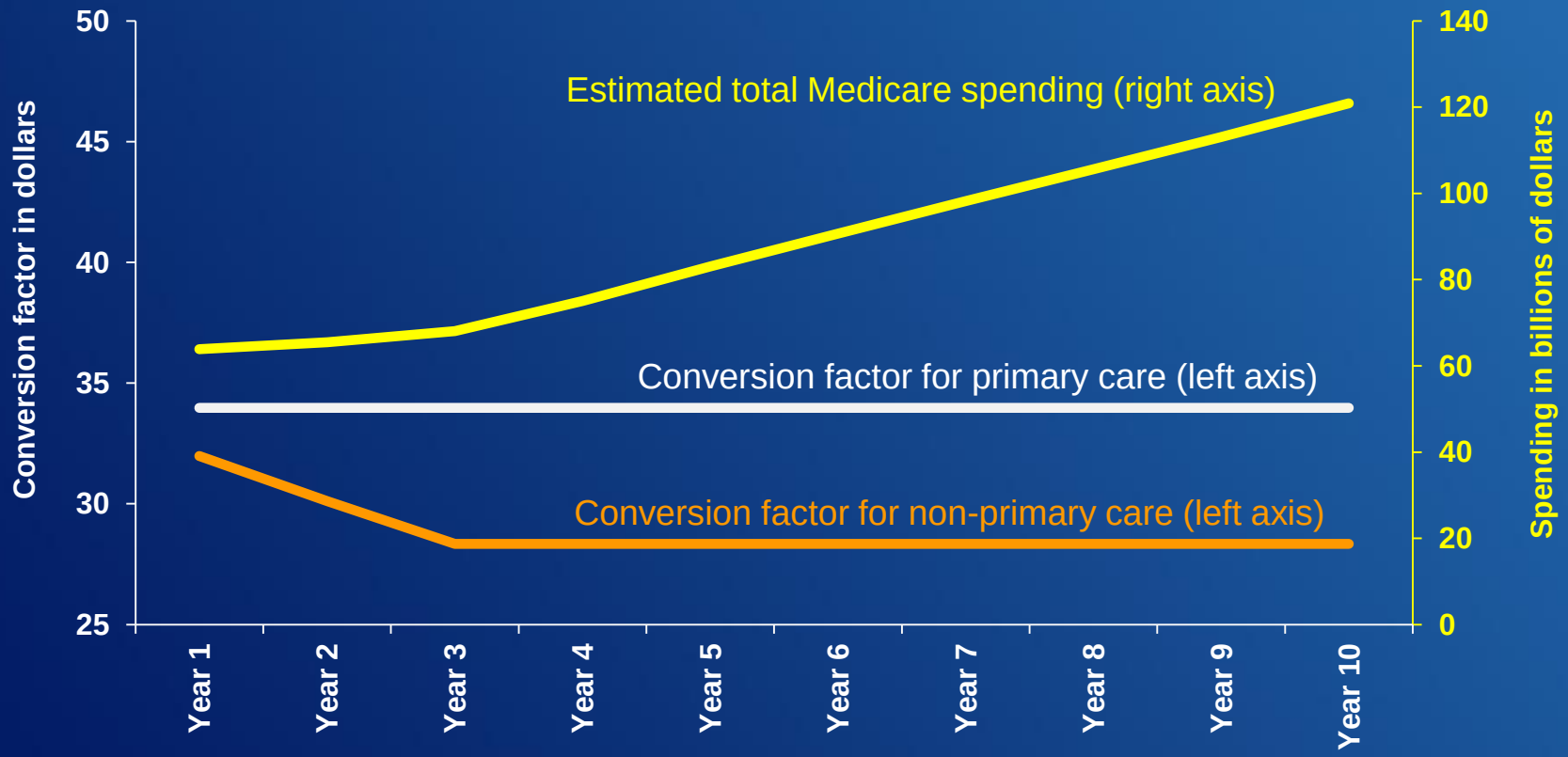
Principle 1 – Sever formulaic link between annual updates and cumulative expenditures

- **Basing annual updates on expenditure target system has created greater problems**
  - SGR has failed to restrain volume growth and may have exacerbated it
  - Although SGR's presence has maintained fiscal pressure on updates, it has disproportionately burdened providers in specialties that cannot easily increase volume
  - Numerous temporary, stop-gap "fixes" to override SGR are undermining Medicare's credibility—engendering uncertainty for providers and anxiety for beneficiaries

Principle 2 – Protect access to care

- Greatest threat to access over the next decade is concentrated in primary care
  - Medicare and privately insured patients are more likely to encounter problems finding a new PCP than a specialist
  - PCPs are less likely than specialists to accept new Medicare and privately insured patients
- Realign fee-schedule to support primary care
  - Reduce payments for non-primary care services, but allow fees for primary care to remain at current levels
  - Two-part definition of primary care: specialty, practice pattern
- Allow growth in annual Medicare spending due to increases in beneficiary enrollment and per-beneficiary service use
- Annually review access to fee-schedule services

Update path for fee-schedule services



Source: MedPAC analysis of 2009 claims data for 100 percent of Medicare beneficiaries.
Data are preliminary and subject to change.

MEDPAC

Principle 3 – Offer fiscally responsible policy to replace the SGR system

- Repealing the SGR has high budgetary costs
  - 10-year freeze across all services: ~$300 billion
  - Repeal will require significant offsets
- If the Congress chooses to offset the costs within Medicare, the costs should be shared across physicians, other health professionals, providers in other sectors, and beneficiaries
- Offsetting the cost within Medicare compels difficult choices—both in offsets and in fee reductions—that MedPAC may not support outside of the context of repealing the SGR system

Collecting data to improve payment accuracy over the longer term

- Secretary lacks current, objective data needed for work and practice expense RVUs
  - Surveys: costly and low response likely
  - Time and motion studies: costly and subject to bias
  - Mandatory cost reports for all: concerns about burden
- Secretary could instead use data from a cohort of practitioner offices and other settings to:
  - Base RVUs on efficient practices
  - Validate and adjust RVUs (PPACA requirement)
  - Data from EHR, patient scheduling, and billing systems
- Resulting RVU changes: budget neutral

Identifying overpriced services

- Evidence that some services are overpriced
  - Research for MedPAC, CMS, and ASPE
  - Anecdotal evidence and experience of Commissioners
  - Recommendations from the RUC on misvalued services
- Current reviews are time consuming and have inherent conflicts
- To accelerate process, Secretary has annual numeric goal (e.g., 1.0 percent) for reducing RVUs
- Budget neutral RVU changes would redistribute payments to underpriced services

Accelerate delivery system reform

- Current FFS payment system is inherently flawed—It rewards volume growth, penalizes providers who constrain unnecessary spending, and provides no accountability for care quality
- Delivery system reforms should shift Medicare payment policies away from FFS
- New models (e.g., ACOs, bundled payments, capitated models, shared savings programs) can potentially improve accountability for efficient use of resources and care quality
- Medicare payments should strongly encourage providers to move towards these models and make FFS less attractive
- Beneficiary incentives must also be aligned with objectives for greater accountability in our health delivery system

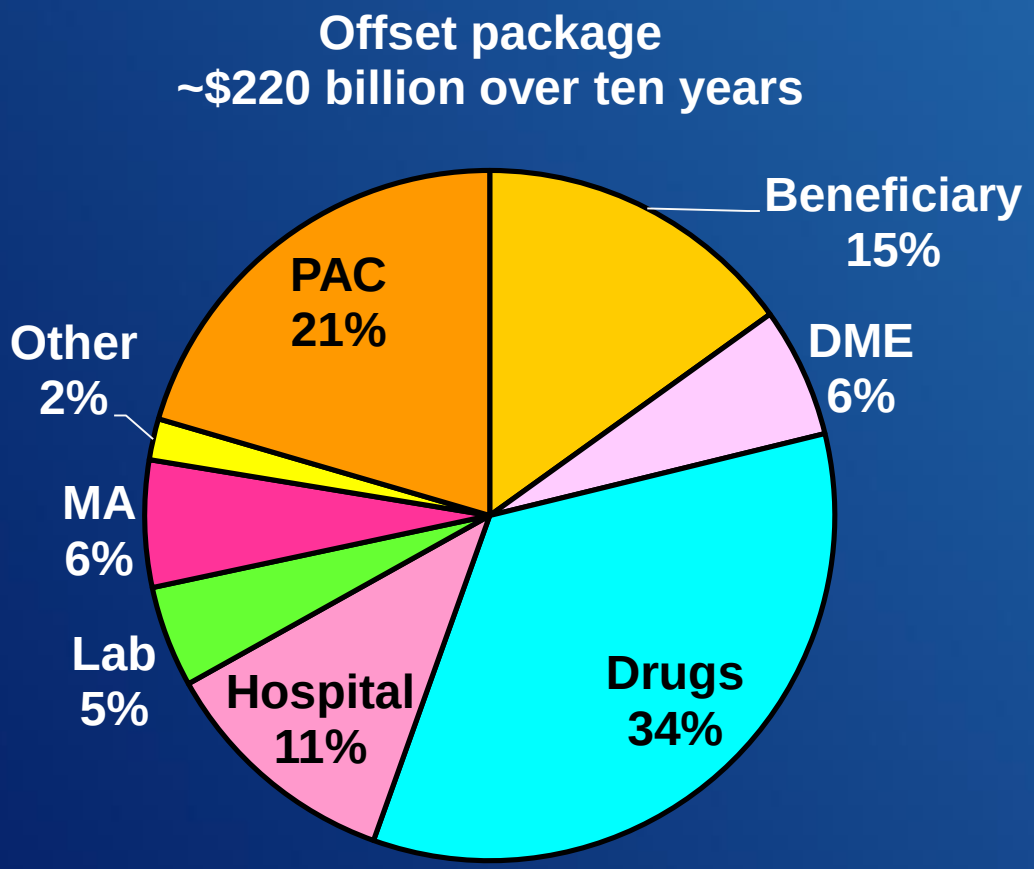
Encourage physicians and other health professionals to join or lead ACOs

- Align payment policies for fee-schedule services with incentives for improved quality and prudent resource use
- Allow greater opportunity for shared savings to those physicians and health professionals who join or lead ACOs in two-sided risk models
  - Two-sided risk ACO models: ACOs subject to penalties OR bonuses based on performance (in contrast to bonus-only models)
  - Spending benchmark could be based on higher overall fee-schedule growth rates (i.e., freeze)

Principles for offsetting the cost of repealing the SGR system

- Recommendation carries a high budgetary cost. The Commission is offering options that the Congress may use to offset the cost.
- Congress may choose to offset the cost of SGR repeal outside the Medicare program.
- Reflects compromise between ensuring beneficiary access to care and sharing the cost of repeal among physicians and other health professionals, other providers and beneficiaries.
- Offsetting the cost within Medicare compels difficult choices, including conversion factor reductions and offsets in other sectors that the Commission may not support outside of the context of repealing the SGR.

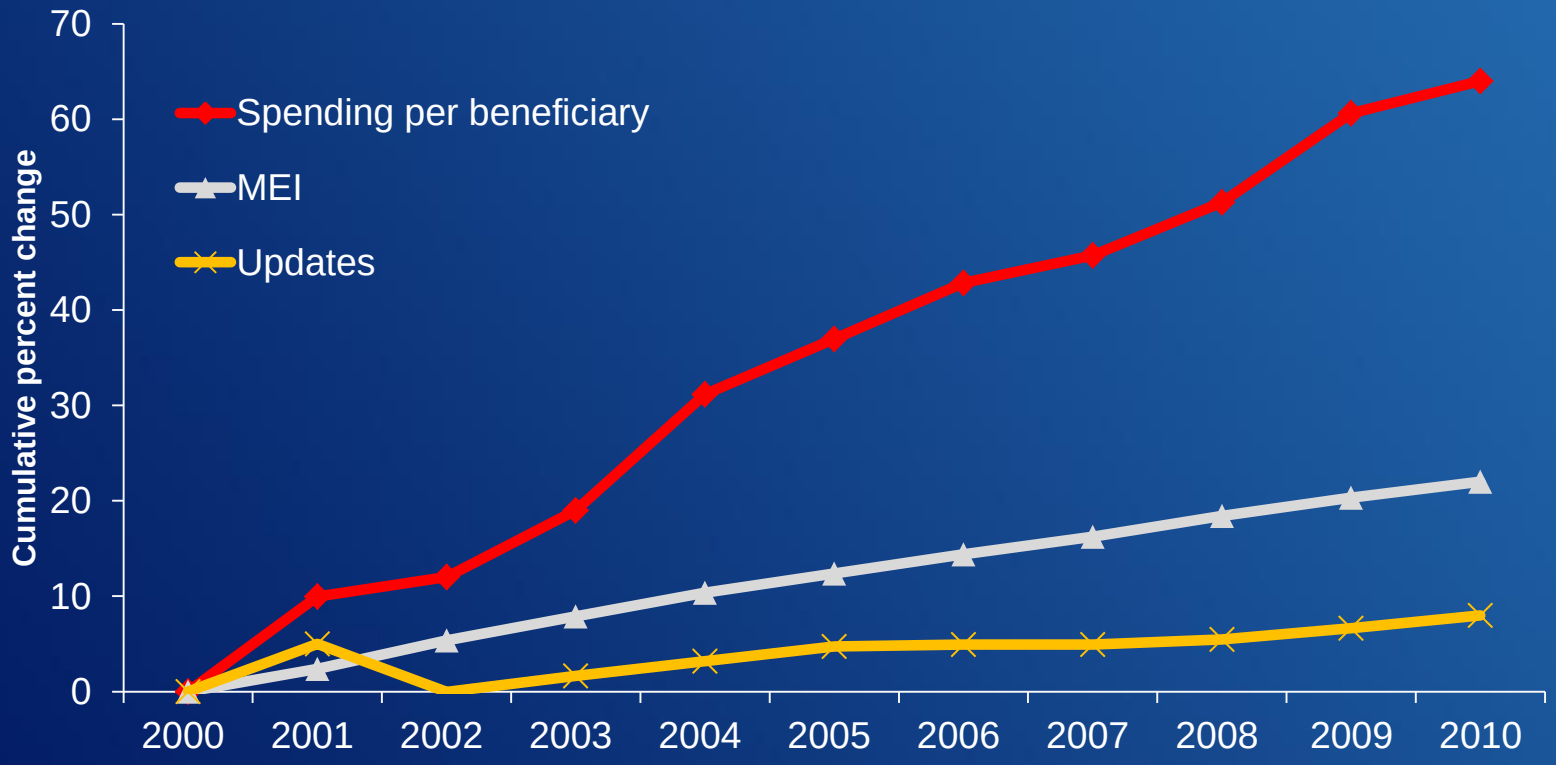
Potential offset options for repealing the SGR



MEDPAC

Data are preliminary and subject to change.

Spending has grown faster than input prices or the updates



Note: MEI (Medicare Economic Index).
Source: 2011 trustees' reports, Global Insight 2010q4 MEI forecast, and OACT 2011.

MEDPAC

Spending for fee-schedule services

- Total spending for fee-schedule services
  - 2000: $37 billion
  - 2010: $64 billion
  - Total growth: 72%
- Growth in spending per beneficiary
  - 2000: $1,200
  - 2010: $2,000
  - Average annual growth: 5% per beneficiary, per year

Source: 2011 trustees' report.