Moving forward from the Sustainable Growth Rate System

Cristina Boccuti, Kevin Hayes, Kate Bloniarz

September 15, 2011

Problems with the SGR system

- **Formulaic link between annual fee-schedule updates and cumulative spending is flawed**
  - Is strictly based on aggregate expenditures—no tools for targeting improvements in quality, efficiency, or price accuracy
  - Does not differentiate by provider
  - Currently calls for a 30% cut ("cliff") to 2012 fee-schedule services
  - Numerous temporary, stop-gap "fixes" to override cuts create uncertainty and problems for medical practices and CMS
- **Repealing the SGR has high budgetary costs**
  - 10-year freeze across all services: ~$300 billion
  - Repeal will require significant offsets

Principles for repealing the SGR

- Sever the formulaic link between annual updates and cumulative expenditures for fee-schedule services
- Replace the SGR formula with stable, predictable 10-year path of legislated fee-schedule updates
- Eliminate 30% cut in 2012
- Strike a balance between the total cost of repeal and the need to ensure beneficiary access to care
  - Share cost of repealing SGR across physicians, other health professionals, providers in other sectors, and beneficiaries
  - Estimate update path to allow positive growth in average annual, per-beneficiary Medicare revenues

MEDPAC

Access to primary care is at risk over the next decade

- **Patients are more likely to encounter problems finding a new PCP than a specialist**
  - Experience among patients seeking a new **PCP**:
    - “No problem”: **79%** Medicare / **69%** private insurance
    - “Big problem”: **12%** Medicare / **19%** private insurance
  - Experience among those seeking a new **specialist**:
    - “No problem”: **87%** Medicare / **82%** privately insured
    - “Big problem”: **5%** Medicare / **6%** privately insured

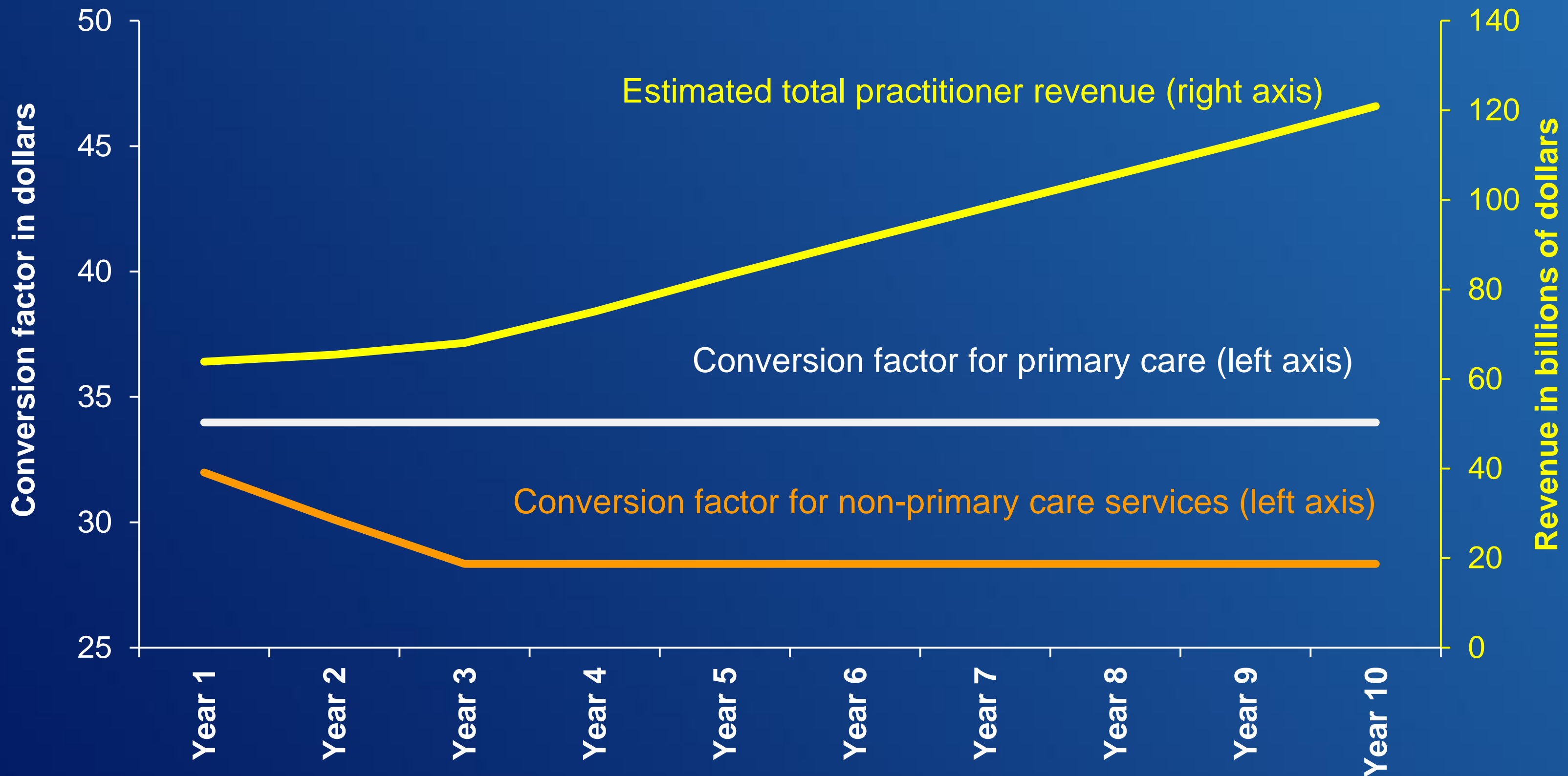
- **PCPs are less likely than specialists to accept new patients**
  - 83% of PCPs and 95% of specialists accept new Medicare patients
  - 76% of PCPs and 81% of specialists accept new private (non-capitated) patients

MEDPAC

Realigning fee-schedule payments to support primary care

- Implementing the realignment: Reduce the fee schedule’s conversion factor for services other than primary care
- Freeze payment rates for primary care
  - Two-part definition of primary care: specialty, practice focused on primary care
  - Implement with conversion factor freeze or payment modifier
- Results
  - Allow increase in fee-schedule revenue
  - Ensure access
  - Control cost of SGR repeal

Potential 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

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 potentially misvalued services
- Current reviews are time consuming and have inherent conflicts
- To accelerate process, Secretary directed to achieve 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
  - Spending benchmark could be based on higher overall fee-schedule growth rates (i.e., freeze)
  - Incentive would only apply to ACOs in two-sided risk models (i.e., ACOs subject to penalties or bonuses based on performance)

Principles for offsetting the cost of repealing the SGR system

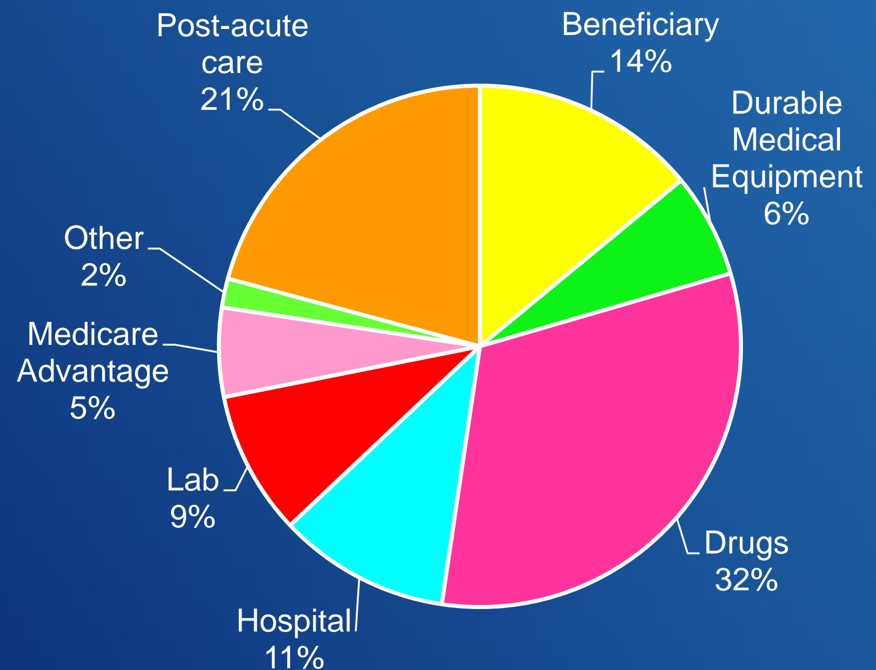
- High budgetary cost for repealing the SGR system
  - Full offsets necessary in context of current deficit picture
- Cost of repealing SGR shared by physicians, other health professionals, providers in other sectors, and beneficiaries
- These offsets are offered in the context of repealing the SGR system
- Sources of offsets
  - MedPAC recommendations (~$50 billion)
  - Proposals from other sources (e.g. CBO, HHS OIG, GAO) and MedPAC analysis (~$180 billion)

Offsetting the cost of repealing the SGR system

Fee schedule updates

- Primary care freeze
- Non-primary care reduction then freeze
- Estimated 2% annual increase in revenue per beneficiary for fee-schedule services
- Estimated cost: ~$200 billion

Offset package: ~$235 billion over ten years



MEDPAC

Data are preliminary and subject to change.

Medicare's provisions on balance billing

- Most Medicare-covered services (99.5%) are paid "on assignment" (i.e., fee-schedule rate accepted as payment in full)
- For the remaining 0.5%, physicians may charge a higher rate and "balance bill" patients for the difference
  - Limited to 109.25% of the standard charge
  - Beneficiary cost-sharing can be up to 30% of total charge
  - Physicians may not balance bill beneficiaries with Medicaid
  - Health professionals who are not physicians cannot balance bill
- Implications of raising the "limiting charge"
  - Allowing physicians to charge higher Medicare cost sharing could improve beneficiary access in some market areas and specialties
  - Could worsen access for beneficiaries with lower incomes
  - Patient ability to "shop around" not always possible in emergency or hospital-based situations