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?
  - Why does it cost so much to “fix” it?
- Policy issues
  - Problems with the SGR
  - Expenditure target considerations
  - Alternatives that have been proposed
- Discussion

What is the SGR?

- Medicare's formulaic method for annually updating fee-schedule services furnished by physicians and other health professionals
- Designed to keep aggregate Medicare expenditures for fee-schedule services on an affordable ("sustainable") trajectory
- Established by the BBA '97, but expenditure targets in physician fee schedule since its inception in 1992

What updates has the SGR produced?

- In early years, volume growth was below per-capita GDP, so updates were at or above the Medicare Economic Index (MEI)
- In later years, volume growth increased and per-cap GDP slowed, so SGR has called for rate cuts every year since 2002
- Since 2003, Congress has passed a series of bills to override these cuts
  - Resulting updates have been fairly modest
  - Next cut: ≥ 25% (January 1, 2012)

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

- **SGR adjustments (“fixes”) have high scores**
  - 10-year freeze (0% update) = $276 billion
  - 10-year MEI update = $330 billion
  - New CBO scores (for 2012-2021) are expected to be higher
- **Key contributing factors:**
  - SGR fixes that restore future fees to today’s levels must account for a 25-30% increase in every future year
  - From 2003-2006, the difference between actual and target spending compounded when fee reductions were postponed
- **Other cost ramifications: MA, TRICARE, Medicaid, Part B premiums**

Problems with the SGR system

- **The SGR system**
  - Does not differentiate by provider
  - Strictly budgetary—no tools for improving quality or efficiency
- **Resulting updates**
  - Large negative updates loom large and threaten provider willingness to serve beneficiaries
  - Temporary, stop-gap “fixes” create uncertainty and problems for medical practices and CMS

Considerations for an expenditure target system

- Constrains price growth, but effect on spending (volume) less direct
- Regularly alerts policymakers of spending growth
- Requires significant Congressional effort to override
- Not a mechanism for improving care delivery
- Narrow target (fee-schedule only) offers no spending flexibility across provider sectors

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
  - Would retain some expenditure control
  - Can be implemented relatively quickly
- Disadvantages
  - Forgiving any excess spending will increase costs, relative to exact target policies
  - Maintains budgetary focus: other incentives for improving quality and efficiency still needed

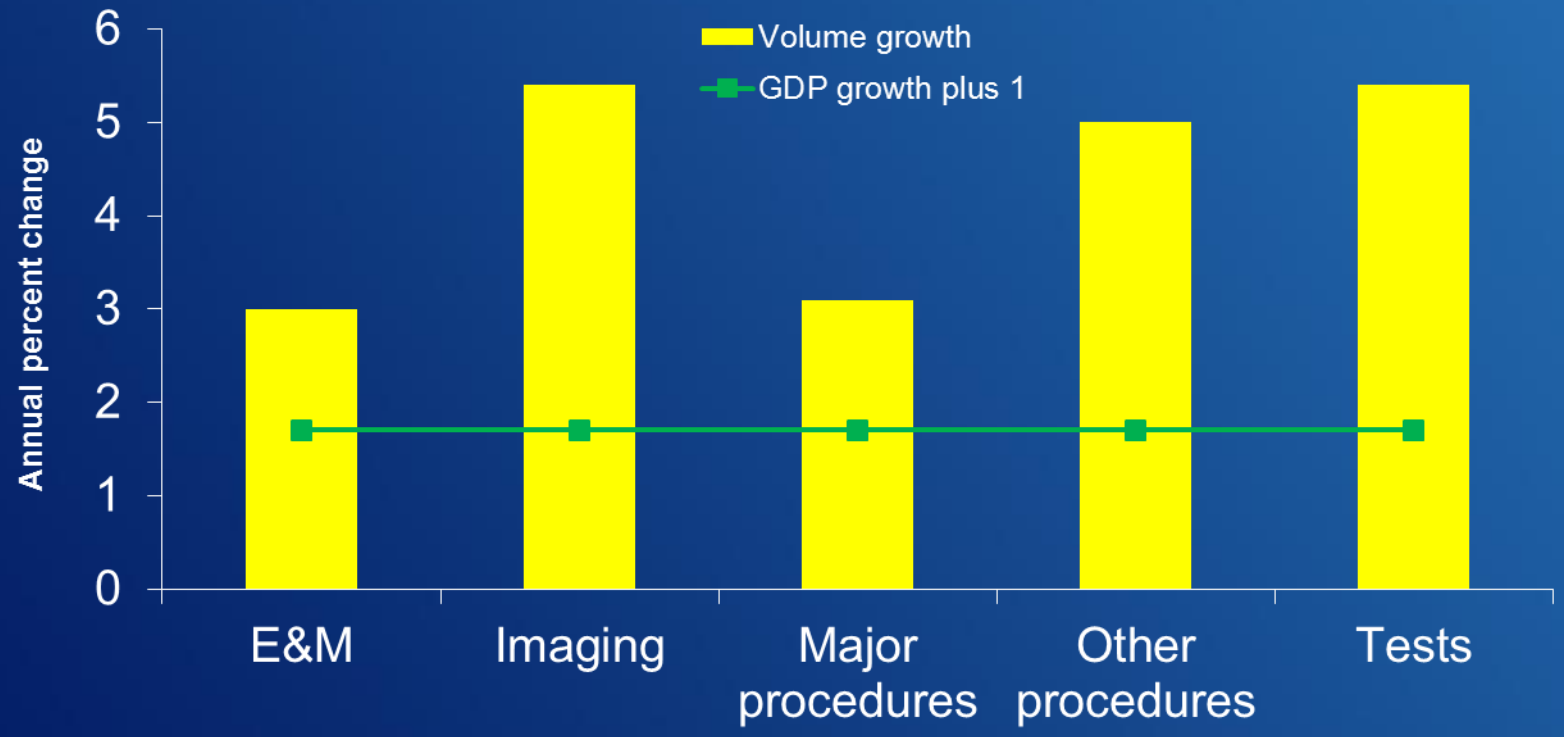
Type-of-service SGR

- Target growth rate and update are calculated and applied separately for each service category
- Rationale
  - Accounts for volume growth that varies by type of service
  - Might also restrain prices of services that are overpriced
- Service categories considered
  - E&M and preventive, all other
  - Primary care, other E&M, imaging and tests, major procedures, minor procedures, anesthesia

Implementing a type-of-service SGR

- By itself, a type-of-service SGR would not solve the SGR scoring problem
- Rebasing would reset the spending targets, but at considerable cost
- Further options in setting the targets

Recent volume growth has exceeded GDP-based volume allowances



Note: E&M (evaluation and management), GDP (gross domestic product). Volume growth is average annual growth from 2004 to 2009. GDP growth plus 1 is a 10-year moving average of growth in real GDP per capita plus 1 percentage point.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries and OACT 2010.

Advantages and disadvantages of a type-of-service SGR

Advantage

- Recognizes that volume growth varies by type of service
- May signal mispricing

Disadvantages

- No accountability for practitioners who order services furnished by others
- Perverse incentives to substitute services
- Changes in relative values assigned to services can affect achievement of targets

SGR exemption alternatives

Exempt certain providers from the current SGR target, but hold them accountable to other targets

- Potential exempt providers:
  - Those affiliated with organizational structures well-suited to manage the health and spending for a population
  - Examples: ACOs, medical homes
- Accountability targets would include quality (e.g., health outcomes, consumer experience) and spending
- Payment updates could be positive or negative, depending on performance

SGR exemption alternatives

- Advantages
  - Can accelerate delivery system reforms to improve quality and restrain cost growth
  - Promotes efficient team-based care and comprehensive patient care management
  - Spending targets and resulting rewards/penalties are more individualized
- Disadvantages
  - Complex administrative component; further operational issues (e.g., provider eligibility standards, measures)
  - Rates of provider participation with exemption options are difficult to predict

Outlier alternative

- Large variation in resource use among physicians at very disaggregated levels
  - While service use across MSAs varies by 30% between the 10th and 90th percentiles, variation within the MSA is significant
  - For example, orthopedic surgeons at the 90th percentile use 40%-90% more resources than the average physician in the same MSA and specialty
- This option would address physicians who use significantly more resources than their peers

Illustrative outlier policy

- Identify outlier physicians within MSA and specialty
- Policy could target persistent physician outliers
  - Of physicians in the top tenth percentile in 2007:
    - 27% were outliers for the second year in a row
    - 9% were outliers for the fourth year in a row
- Policy could inform physicians of their high resource use, then apply a penalty

Policy should use both episode and per-capita measures of resource use

- Concern that a physician may be efficient on an episode basis, but may be generating lots of episodes
- Between 60% and 70% of physicians identified as outliers using an episode-based analysis were also outliers using a per-capita based analysis

Advantages and disadvantages of an outlier alternative

- Advantages
  - Can target feedback and payment adjustments to physicians with persistently higher resource use than their peers
  - Episode and per-capita methods together can offer a comprehensive view of resource use
- Disadvantages
  - Complex methodological issues
  - Resources to build and maintain transparent grouper (essential for physician acceptance)
  - By definition, outlier physicians do not comprise a substantial share of the workforce

Ongoing work to address valuation of practitioner services

- Validating the fee schedule's time estimates
  - Identifying and evaluating data currently available
  - Assessing the feasibility of primary data collection
- Alternative approaches
  - Identifying innovative approaches used by private payers, health systems, and provider groups
  - Evaluating whether approaches could be transferrable to fee-for-service Medicare

Discussion: SGR's main issues

- Scoring
  - Unrealistic future updates
  - Eliminating prescribed negative updates requires significant offsets in federal spending
- Policy
  - Need to structure a payment system for physicians and health professionals that rewards quality and efficiency, while also improving payment equity among providers
  - Expenditure target considerations
  - Proposals have advantages and disadvantages