“Physician Payment Reform and the Sustainable Growth Rate”

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Iron Triangle

- Congressional support, via lobby
- Policy choices & execution
- Friendly legislation & oversight
- Electoral support
- Funding & political support

Low regulation, special favors
"I'm pleased that Congress has acted to ensure the security of our seniors' health care," Obama said.

"A 23 percent pay cut to physicians' payments would have forced some doctors to stop seeing Medicare patients—an outcome we can all agree is unacceptable."
Chairman Pete Stark (D-CA)
Ways and Means Health Subcommittee

• "Seniors and military families should not have to wonder on a month-to-month basis if they'll be able to see their doctor."
“Once we repeal the current health care law, the current health care system needs to be reformed, and, you know ... fix the doctor reimbursement system, the SGR system.”
The short-term Band-Aid passed tonight gives little reassurance to the 46 million Americans in Medicare who need reliable access to their doctors."

The time for Congress to find a long-term physician payment solution is far past due."
AMA

• AMA President Cecil Wilson called it a "very temporary" fix that doesn't solve a "Medicare mess" created by Congress.

• "Congress is playing a dangerous game of Russian roulette with seniors' health care."
Dr. Hendricks (Neurosurgeon) in Ayn Rand’s “Atlas Shrugged”

• “Do you know what it takes to perform a brain operation?”

• “I would not let them dictate the purpose for which my years of study had been spent, or the conditions of my work... or the amount of my reward.”

• “Let them discover the kind of doctors their system will now produce.”
How should we pay physicians?

- Barter
- Fee for service
- 3rd party payment
- Public/Private
- Capitated fee
- Salary
- Pay for performance
- Bundled payment
Policy Questions: Physician Payment

- How to we improve the value of Medicare while assuring the financial sustainability of the program?

- What about that 25% SGR cut?
  - “Doc Fix”
Ideal Policy for Physician Payment

- Reimburse physicians fairly
- Maintain adequate access for patients
- Incentivize desired health outcomes
- Promote safety and quality improvement
- Maintain autonomy for physicians and patients
- Permit sustainable growth
Outline

• Where are we?
• How did we get here?
• How does it work?
• What we’ve tried
• What’s next?
What Americans Value

• Individual freedom
• Personal choice
• Innovation and the promise of technology
• Unfettered access to care
• Professional autonomy
  – “Eat what you kill”

Medicare has no authority “to exercise any supervision of control over the practice of medicine or the manner in which services are provided.”
Current Physician Payment Policy

• Rewards volume over value
• Incentivizes doing and spending more
• Rewards “partialist” and proceduralist care
• Disincentivizes “comprehensivist” and cognitive care

Commonwealth Fund Commission on a High Performance Health System. Commonwealth Fund, 2009 Feb
Medicare Spending as a Share of Total Federal Outlays, FY2010

- Defense Discretionary: 19%
- Nondefense Discretionary: 19%
- Net Interest: 5%
- Other: 16%
- Medicaid and SCHIP: 8%
- Medicare: 13%
- Social Security: 20%

2010 Total Outlays = $3.5 trillion

$510B in FY 2010

Part A $186
Part B $140
Part C $116
Part D $68

$62B Physician Services

SOURCE: Congressional Budget Office, Medicare Baseline, March 2010
Medicare Part B Payments to Physicians
Annual in $ Billions, 1996-2009

Is Part B an entitlement for patients or for docs?
Vladeck. Health Affairs 1999
Part B Expenditures Increasing Faster than per Capita GDP
History of Physician Payment

• 1960’s-1980’s: “Golden Age”
  – “customary, prevailing, and reasonable” charges

• OBRA 1989: MVPS
  – Medicare Volume Performance Standard
  – Targets for Surgery, Primary Care, and Non-Surgery

• 1992: RBRVS
  – Resource-Based Relative Value Scale

• 1997: Balanced Budget Act
  – Sustainable Growth Rate (SGR)
  – Single target (with teeth)
### Medicare Physician Fees, Dec 2010

<table>
<thead>
<tr>
<th>Service</th>
<th>Relative Value (RVU)</th>
<th>Conversion Factor</th>
<th>Physician Fee *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit (intermediate)</td>
<td>1.90</td>
<td>$36.87</td>
<td>$70</td>
</tr>
<tr>
<td>Echocardiogram</td>
<td>5.66</td>
<td>Same for all services and all specialties during that year</td>
<td>$209</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>8.99</td>
<td></td>
<td>$331</td>
</tr>
</tbody>
</table>

* Before adjustments
Physician Services Payment System

RVU \times \text{Conversion Factor (\$)} = \text{Physician Fee (\$)}

\text{Actual vs. Targeted Spending}

SGR

\text{Enforcement Mechanism}
Sustainable Growth Rate (SGR)

• BBA 1997 formula intended to control growth in aggregate Medicare spending for physician services
  – Updates Medicare payments each year

• Sets sustainable growth path for spending
  – Physician payments grow with the economy

• Enforcement mechanism that “claws back” excess annual and cumulative spending

• Elegant & arbitrary
  – FFS → Capitation
SGR

- SGR adjusts prices to account for changes in service volume

\[
\text{Cost} = \text{Price} \times \text{Volume}
\]

SGR and Intensity

# and Intensity
SGR = Product of Four Components

• Inflation adjustment
  – % change in physicians practice costs

• Allowance for economic growth
  – % change in real GDP per capita (10-year average)

• Enrollment
  – % change in Medicare fee-for-service (FFS) enrollees

• Law/Rules
  – % change in spending due to legislation or regulation
## 2011 SGR Calculation (CMS)

<table>
<thead>
<tr>
<th>Estimated Change in Costs</th>
<th>0.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Change in FFS Enrollment</td>
<td>2.4%</td>
</tr>
<tr>
<td>Estimated Change in Real GDP Per Capita</td>
<td>0.7%</td>
</tr>
<tr>
<td>Estimated Change in Law or Regulation</td>
<td>-16.2%</td>
</tr>
</tbody>
</table>
Physician Services Payment System

**FIGURE 1**
Physician Fee Update

*If* Actual Physician Spending $\leq$ Spending Target
*then...* Update $>\text{Inflation}$

*If* Actual Physician Spending $\geq$ Spending Target
*then...* Update $<\text{Inflation}$

Conversion Factor

\[ CF_{2010} \times CF\text{ Update}_{2011} = CF_{2011} \]
Conversion Factor Update

\[ \text{CF Update} = (1 + \text{MEI}) \times (1 + \text{UAF}) \]

• MEI = weighted average price to produce physician services
• UAF = annual SGR adjustment to MEI
• Budget neutrality adjustments
Update Adjustment Factor (UAF)

\[
\text{UAF}_1 = \left( \frac{\text{Target}_{10} - \text{Actual}_{10}}{\text{Actual}_{10}} \right) \times 0.75 + \left( \frac{\text{Cumulative Target}_{96-10} - \text{Cum. Actual}_{96-10}}{\text{Actual Spending}_{10} \times (1 + SGR_{11})} \right) \times 0.33
\]

2011 SGR is -13.4% \(\Rightarrow\) \((1 + SGR) = 0.866\)

\[
\begin{align*}
\left[ \frac{$97.0 - $92.9}{$92.9} \right] \times 0.75 &+ \left[ \frac{$1,014.7 - $1,029.9}{$92.9 \times 0.866} \right] \times 0.33 = -0.029 \\
\text{2011 UAF is -} &\ 2.9\%
\end{align*}
\]
### Conversion Factor (CF) Update

<table>
<thead>
<tr>
<th>2010 CF (Actual)</th>
<th>$36.87</th>
</tr>
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</table>

- **2010 CF (Actual)**: $36.87
MEI and CF Updates
20 years since 1992

MEI Increase
CF Update

Annual Mean
MEI = 2.2%
CF Update = 0.4%

Cumulative
MEI = 55.7%
CF Update = 9.0%
Scheduled SGR vs. Actual Updates
Myopic Magical Thinking*

- Budget rules require CBO to assume current law
  - SGR will make cuts in perpetuity
- Any change in law to avert or decrease the cuts is scored as a spending increase
- 10-year budget windows with interest
  - $25B $300+B

Physicians’ Opinions on Reimbursement Reform

National survey of 1,222 physicians (48% response)

- 78% - Medicare reimbursement inequitable
- 78% - procedures are over/under compensated
- 69% - opposed bundling of payments
- 80% - support increased pay to generalists
  - 39% would decrease pay to specialists
Critique of the SGR

• Volume and intensity of physician services are growing > double the rate allowed by SGR

• Tragedy of the Commons
  – no direct link between individual behavior and the subsequent update
  → do well rather than good
Critique of the SGR

- Fatal flaw – can’t distinguish appropriate from inappropriate growth

- Inequitable – some specialties and regions contribute more to growth

- Cumulative spending cuts lead to cliffs & overhangs
Two Policy Paths
2005 GAO & 2007 MedPAC reports

• Reform the SGR
  – Revise & stabilize expenditure targets

• Repeal the SGR
  – Use payment incentives to promote efficiency
Two Policy Paths

- Reform the SGR
  - Adjust target
  - Add Part B providers
  - Slice/dice
    - Service type
    - Geographic area
    - Practice

- Repeal the SGR
  - P4P and Quality
  - Info/feedback
    - Reward efficiency
  - Improve FFS
    - Bundling, PCMH
  - ACOs
Political Problem*

• Schulze’s Law
  – “Do not be seen to do harm”

• Palpable threat from budget deficit
  – Congress unlikely to relinquish even a flawed mechanism

* Aaron H. SGR for Physician Payment: An Indispensible Abomination. NEJM 2010
Three Swings

• Children’s Health and Medicare Protection (CHAMP) Act of 2007

• Medicare Physician Fairness Act of 2009

• Medicare Physician Payment Reform Act of 2009, HR 3961 (House, 243-183)
  – Repeal SGR, set 2 target growth rates
  – CBO: $210 B
SGR Cut Postponed ~$1B/month

- Dec 19: FY10 Defense Appropriations
- Mar 2: Temporary Extension Act of 2010
- Apr 15: Continuing Extension Act of 2010
- June 30: The American Jobs and Closing Tax Loopholes Act of 2010
- Nov 30: Physician Payment and Therapy Relief Act of 2010
- Dec 31???
Interest Group Positions

• The “Docs”
  — AMA, AOA, ACP, ACS
    • State Med & Prof Societies, AARP
  — "Medicare meltdown"
  — SGR fatigue

• Double jeopardy of SGR & IPAB (2014) cuts
Health Reform Politics

• Republicans upset with docs
  – Usual strong alliance
  – White coats @White House
  – Doc Fix as carrot and stick

• More than technical issue
  – CMS & AMA
  → Admin leaders at the table
Memorial Day Deadline

• SGR in a PAYGO universe
  – $90B in budgetary headroom
  – 10 year repeal policy: ~$250B
  – Limited pay-fors

• Policy → Politics
Framing Expectations

AMA

Other
Doc Groups
Deficit Politics

- Tremors start in Senate
  - reverberations felt in the House
  - Blue Dogs nervous
- Politics have changed, election-year
Pelosi vs. Hoyer (vs. Reid)

• Controversy over Reid’s assessment of votes

• Speaker Pelosi fighting for longer SGR fix

• Majority Leader Hoyer unwilling to risk House’s neck again
  – Fears Senate amendment to cut back
  – Who is more fiscally responsible in election year?
The Ever-Shrinking Doc-Fix

• 5 year policy for $89B
  – Couldn’t get votes in Senate

• 3½ year policy for $65B
  – Sen Gregg amendment to reconciliation bill (3/24)
    • All but 1 Republican voted for $65B policy (4 yr freeze)

• 19 months @23B to seal the deal
  – 5/27 passed House (245 - 171)

→ SGR patch through Nov 30
“Experts: 'Doc fix' a budget band-aid”

“The New York Times

“The Doctor Payment Follies”
What Next?

• Divided Government
  – House Majority Rs need to govern
  – Senate Minority Rs will still obstruct
Physicians Worried about Payment Reform

- Failure to modify FFS will be worse for docs
- Downward pressure on payment rates

What Next?

• Divided Government
  – House Majority Rs need to govern
  – Senate Minority Rs will still obstruct

• SGR will live on
  – Kept docs at the table for health reform
  – Keep them at the table for implementation
    • Accept bundling, capitation, ACOs, PCMH, etc
Cost Control*

• Painless
  – HIT, Prevention, PC
• Painful
  – Bundling, PCMH, ACO, PFP
• Very Painful
  – Price cuts (SGR, IPAB), reduce variation, limit consumer choice (VBP), reduce specialist payment

*Grumbach K, Bodenheimer T. Painful vs Painless Cost Control. JAMA Nov 1994
Group Employed Model (GEM)*

• Physician groups – PC & Specialists
  – Salaried or contracted
• Keys to success
  – Patient-centered
  – Leadership promotes trust
  – Teamwork and coordination
  – Transparent and accountable governance
  – HIT → quality improvement

National Commission on Fiscal Responsibility and Reform

• “Commission Impossible?” – 11/18 (7Ds, 4Rs)

• Freeze current physician payment rates through 2013

• Cut rates by 1% in 2014

• Time to reform SGR formula to promote quality vs. quantity
  — Punt to IPAB in 2014
FDR

• “The country needs, and unless I mistake its temper, the country demands, bold, persistent, experimentation. It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something.”

F. D. Roosevelt, Address at Oglethorpe University, May 22, 1932
Ten Principles for Physician Payment Reform
ABIM Foundation: Lesser et al. Health Affairs May 2010

1. Support physicians in engaging patients as partners
2. Pay for team-based care
3. Focus on total cost and outcomes vs. encounters
4. Encourage use of evidence to guide clinical decision making
5. Recognize the equally important contributions of primary and specialist physicians
6. Ensure performance measures are valid and meaningful
7. Support the infrastructure needed for innovation
8. Use hybrid approaches to payment to counterbalance incentives and unintended consequences
9. Adopt multiple pathways to payment reform
10. Harmonize public- and private-sector innovation
Commonwealth Fund

Exhibit 1. Relationship Between Payment Methods and Organizational Models

Continuum of Payment Bundling

- Global Payment
- Global Case Rates
- Blended FFS/Care Management Fee
- Fee-for-Service

Continuum of Organization

- Small practices; unrelated hospitals
- Independent Practice Associations; Physician Hospital Organizations
- Fully integrated delivery system

Outcome measures; large % of total payment
Care coordination and intermediate outcome measures; moderate % of total payment
Simple process and structure measures; small % of total payment

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  — Professional Staff, Committee on Ways and Means

• Jim Hahn, PhD
  — Health Economist, Congressional Research Service
• **Part A:** Hospital Insurance Program

• **Part B:** Supplementary Medical Insurance

• **Part C:** Medicare Advantage

• **Part D:** Prescription Drug Coverage
Resource-Based Relative Value Scale

AMA’s RUC → CMS

• RVUs for each of >7000 services with three components of complexity
  – Physician Work
  – Practice Expense
  – Professional Liability Insurance

  – Adjusted by
    • Geography
    • Provider type
    • HPSA status
AMA/Specialty Society RVS Update Committee (RUC)

- The RUC is an independent group exercising its First Amendment Right to petition the federal government.
- The RUC is comprised of 29 members, 26 voting members (14 of these 26 voting members are from specialties whose Medicare allowed charges are primarily derived from the provision of E/M services).
- Meets three times a year to review new and revised codes developed from the CPT process.
- (CMS) publishes final recommendations in the Final Rule each November for implementation January 1 each year
- Since 1991 and CMS has historically implemented 95% of the RUC recommendations.
SGR PASSES THE HOUSE - The House passed the one-month patch through a voice vote on Monday, just as expected.

WHITE HOUSE RESPONSE:

“President Obama is pleased Congress has passed legislation that will prevent payment cuts to doctors from taking effect next month. The President urges Congress to now pass a one-year extension to ensure seniors maintain access to the doctor they know and trust over the coming year. Passing this one-year extension is important, but it is no substitute for a long-term fix. The President has long called for a sustainable solution, and we look forward to working with Congress to further address this matter.”
Difference Between Cumulative Allowed and Actual Expenditures for Physician Services Under the SGR System
1996-2008

Medicare Spending as a Share of Total Federal Outlays, FY2010

- Social Security: 20%
- Nondefense Discretionary: 19%
- Defense Discretionary: 19%
- Other: 16%
- Net Interest: 5%
- Medicaid and SCHIP: 8%
- Medicare: 13%

2010 Total Outlays = $3.5 Trillion

Children’s Health and Medicare Protection (CHAMP) Act 2007, HR 3162

• 6 separate target growth rates
  – PC/prevention, Other E&M, Imaging and Dx tests, Major procedures, Minor procedures, Anesthesia

• Passed House, 225-204
  – Senate did not consider
Medicare Physician Fairness Act of 2009, S. 1776

• Sunset the SGR policy

• Permanent freeze (0% update)

• Oct: cloture motion failed, 47-53
Medicare Physician Payment Reform Act of 2009, H.R. 3961

• Repeal SGR and set 2 target growth rates
  – E&M and preventive services (GDP+2%)
  – All other services (GDP+1%)

• CBO: $210 B (2010-2019)
  – Fully exempted from PAYGO

• Nov: Passed House, 243-183
  – Senate replaced with USA Patriot Improvement and Reauthorization Act
Relative Value Units (RVU)

Total RVUs from physician fee schedule

Adjusted for:
- Complexity of service and expenses
  - Work RVU
  - PE RVU
  - PLI RVU
- Geographic factors
  - Work GPCI
  - PE GPCI
  - PLI GPCI

Adjusted (multiplied) by

Policy adjustments (multiplicative)

Provider type
- Nonphysician
- Nonparticipating
  (decreases)

Geographic
- HPSA bonus
  (increases)

= RVU
SGR Drives Annual Spending Target

\[ 2010 \text{ Spending Target} = \$97B \]
\[ 2011 \text{ SGR} - 13.4\% \]
\[ = \]
\[ 2011 \text{ Spending Target} = \$84B \]