The Sustainable Growth Rate (SGR) System

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What problem did spending targets address?
The Case for SGR

• In 1989, the Secretary of HHS cited the need for spending targets to constrain spending growth for physician services. He noted that:

  • past efforts to control such spending had not been successful;

  • a fee schedule alone would not control volume and may exacerbate the current spending trajectory; and

  • the administration opposed implementation of the RBRVS-based fee schedule unless it was linked to an expenditure target.
Growth in Volume and Intensity of Medicare Physician Services Per FFS Beneficiary, 1980-2012

Percentage

Fee schedule and spending targets first affected updates

Charge-based system

Fee schedule and MVPS
(Medicare volume performance standard)

Fee schedule and SGR

Source: Data from CMS and the Boards of Trustees of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds. Data for 2003 through 2011 are based on the 2013 Annual Report of the Boards of Trustees of the Federal HI and Federal SMI Trust Funds.
Increased Volume Growth Has Impacted Physician Spending More than Input Prices and Payment Updates, 2000-2012

Cumulative percent change

- Spending per beneficiary
- MEI
- Updates

Source: MedPAC, June 2013 Databook
Basic Mechanics of SGR
SGR’s Four Factors

• SGR accounts for factors that one would expect to affect spending growth:
  • increases in input prices
  • changes in FFS enrollment, and
  • changes in spending due to laws and regulation.

• In addition, SGR allows spending to grow with the economy—real GDP per capita.

• This additional factor was intended to allow for some growth in technology and in the volume and intensity of services.
The Fee Update is Determined in Part by Spending Targets and the Medicare Economic Index (MEI)

<table>
<thead>
<tr>
<th>Cumulative Spending Compared to Cumulative Target</th>
<th>Update Compared to the MEI</th>
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<tbody>
<tr>
<td>Above</td>
<td>Below</td>
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<tr>
<td>Equal</td>
<td>Equal</td>
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<tr>
<td>Below</td>
<td>Above</td>
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</table>
SGR Compares Cumulative Actual Spending Since 1996 to a Cumulative Allowed Spending Target

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Actual Spending&lt;sup&gt;a&lt;/sup&gt; ($ billions)</th>
<th>Allowed Spending Target&lt;sup&gt;a&lt;/sup&gt; ($ billions)</th>
<th>Actual Compared to Allowed Spending&lt;sup&gt;a&lt;/sup&gt; ($ billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996-2011&lt;sup&gt;b&lt;/sup&gt;</td>
<td>$1,136.7</td>
<td>$1,122.2</td>
<td>-$14.5</td>
</tr>
<tr>
<td>2012</td>
<td>$100.8</td>
<td>$107.4</td>
<td>$6.6</td>
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<sup>a</sup>CMS Office of the Actuary estimate as of April 2013

<sup>b</sup>April 1, 1996 through December 31, 2011

Source: CMS
Experience Under SGR
Overriding the Updates

• The SGR was permitted to work per statute from 1998-2002.

• Congress has overridden reductions in fees every year beginning in 2003.

• To try to maintain budget neutrality over a 10-year window for these overrides Congress has used either a “clawback” (override is “paid for” over the budget window) or “cliff” (override is “paid for” in the following year) approach.

• “Patches” have typically been for one or two years at a time to keep the CBO score low.
Actual Updates Compared to Required Updates, 1998-2013

Source: Data from the Boards of Trustees of the Federal HI and SMI Trust Funds and CMS Office of the Actuary

Notes: Beginning with 2008, required updates are a result of both the SGR formula and legislative changes. The physician updates for 2010 and 2011 reflect the impact of the two different updates that were effective during parts of 2010. For January through May 2010, the physician update was 0 percent. For June through December 2010, the physician update was 2.2 percent.
Positives:
• Experience of 1990s was hopeful
• Without SGR, Medicare spending would have been higher
• SGR has kept Medicare (and larger health care) spending problem in full view

Negatives:
• Limited effect on volume and intensity (no incentives for individual physicians to control spending growth)
• Blunt instrument (SGR doesn’t differentiate between “good” and “bad” actors)
• System has been difficult for Congress to “live with” and has created annual uncertainty for physicians
Change is on the Horizon?
Previous Obstacles to Reform

• How to pay for any repeal or replace

• How to overcome inherent FFS incentives

• How to develop a policy that various stakeholders can “live with”
## CBO Estimates of the Cost of Simple SGR Fixes

<table>
<thead>
<tr>
<th>Date of Score</th>
<th>Fee Freeze 10-Year Score (billions of dollars)</th>
<th>MEI Update 10-Year Score (billions of dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2005</td>
<td>$48.6</td>
<td>$154.5</td>
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<tr>
<td>March 2007</td>
<td>$177.7</td>
<td>$262.1</td>
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<tr>
<td>May 2009</td>
<td>$285</td>
<td>$344</td>
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<tr>
<td>June 2011</td>
<td>$297.6</td>
<td>$358.1</td>
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<tr>
<td>July 2012</td>
<td>$271.0</td>
<td>$362.0</td>
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<tr>
<td>November 2012</td>
<td>$243.7</td>
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<tr>
<td>February 2013</td>
<td>$138.0</td>
<td>(no estimate)</td>
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<tr>
<td>May 2013</td>
<td>$139.1</td>
<td>$224.8</td>
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</table>

Source: Congressional Budget Office (CBO)
## Common Elements in Previous SGR Reform Proposals

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<tbody>
<tr>
<td>Repeals SGR</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Retains SGR with modifications</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Statutory updates/transition period</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Specialty-based payment differentials</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Incentives to move away from FFS</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Encourages new models of payment and delivery</td>
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<tr>
<td>Reforms FFS</td>
<td>✓</td>
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<tr>
<td>Incorporates performance on cost and quality</td>
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- ✓: Present
- ☑: Absent
What’s Different Now?

• Lower CBO score

• Committees of jurisdiction working together on broad agreement

• Legislative draft unanimously passed full E&C Committee
Energy and Commerce Bill

H.R. 2810: The Medicare Patient Access and Quality Improvement Act of 2013

- Repeals SGR and replaces with transitional annual updates of 0.5 percent for 5 years (2014-2018)

- Implements Update Incentive Program (UIP) for fee schedule providers beginning in 2019
  - based on successful quality reporting and thresholds, updates could range from -4.5 percent to 1.5 percent

- Encourages Alternative Payment Model (APM) participation either through existing or future provider-developed models that aren’t reliant on FFS (e.g., ACOs, bundled payment demos, etc…)

- Other provisions include: expanded data availability for care improvement activities, additional care coordination codes, and data collection of practice costs for improving payment accuracy

- **CBO score $175.5 billion (September 13, 2013)**
Uncertainty Remains

• Current version of E&C legislation does not include:
  • Pay-fors
  • Direct volume/spending controls

• Other committees of jurisdiction (Ways and Means and Senate Finance) likely to develop their own SGR reform bills.
  • Such bills may include similar elements such as a “phased” approach and an emphasis on value over volume, but unclear what else could be included.

• Physician specialty societies and other stakeholder support.
Additional SGR Resource

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CMS website:
https://www.cms.gov/SustainableGRatesConFact/