Why (and how) we must repeal the sustainable growth rate

Elimination of the SGR has bicameral, bipartisan support in Congress. So what's holding up repeal?

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Imagine this: Your 20-year-old daughter tells you she wants to attend an expensive school for 5 years of intensive postgraduate training, amassing tens of thousands of dollars of debt, to provide expert services to the US population. There is no good substitute for the services she hopes to provide, and they are vitally needed. The services also carry risk. Despite this, she tells you that her salary will not increase every year in tandem with the cost of living; in fact, she expects her salary to be cut by nearly one-third each year. Compensation in her chosen field hasn't increased in real dollars for many years.

Sound like a good plan?

By now you have recognized this as your own story, at least if you're among the 92% of ObGyns who participate in Medicare.

ObGyn participation in the Medicare program reflects ObGyn training and commitment to serve as lifelong principal care physicians for women of all ages, including women with disabilities. Fifty-six percent of all Medicare beneficiaries are women. With continuing shortages of primary care physicians and the transitioning of the Baby Boomer generation to Medicare, it is likely that ObGyns will become more involved in delivering health care to this population.

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Medicare physician payments matter to ObGyns in other ways, too, because TRICARE and private payers often follow Medicare payment and coverage policies. Clearly, the Medicare program is a pretty big gorilla in every exam room. We all have much at stake in ensuring a stable Medicare system for years to come, starting with an improved physician payment system.

In 2011, Medicare paid $68 billion for physician care provided to nearly 50 million elderly and disabled individuals—about 12% of total Medicare spending—covering just over 1 billion distinct physician services. Physicians received a 10-month reprieve from a 27% cut in Medicare payments that had been scheduled for March 1, 2011, extending current payment rates through the end of this year. The agreement is part of a deal to extend a payroll tax cut and unemployment benefits. It is the 14th short-term patch to the sustainable growth rate (SGR) in the past 10 years. On January 1, 2013, we now face a 26.5% cut that Congress will have to find $245 billion to eliminate altogether.

How did we get here?

In 1997, Congress passed the Balanced Budget Act (BBA), at a time when many

members of Congress were frustrated by continued increases in Medicare costs, fueled on the physician side, in part, by increases in the number of visits, tests, and procedures. To control these costs, Congress included in the BBA a complicated formula to peg Medicare physician payments to an economic growth target—the SGR. For the first few years, Medicare expenditures stayed within the target, and doctors received modest pay increases. But in 2002, expenditures rose faster than the SGR, and doctors were slated for a 4.8% pay cut.

Every year since, the SGR has signaled physician pay cuts, and every year, Congress has stopped the cuts from taking effect. But each deferral just made the next cut bigger and increased the price tag of stopping each pay cut. Today, the price of eliminating the SGR is $245 billion over the next 10 years. In these days of sequestration and deficit reduction, $245 billion is hard to find.

What now?

The good news is that support for eliminating the SGR is bicameral and bipartisan, rare in these hyperpartisan political days. Both Republicans and Democrats in the US House and Senate agree: The SGR has got to go. It's a topic of conversation that wore out its welcome long ago.

The bad news? The $245 billion price tag. Remember, the SGR is in statute, so it requires an Act of Congress, signed by the President, to repeal it—and every Act is scored by the Congressional Budget Office.

The likeliest scenario is one we've seen many times before: Congress returns from a difficult election for a short, lame-duck session, during which it will have to address the cut before January 1. A real solution won't be within reach, so Congress will likely kick that well-dented can a few more yards down the road, delaying the cut for yet another legislative cliffhanger.

FAST TRACK

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ILLUSTRATION: JASON ABBOT FOR OBGMANAGEMENT

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Can we move from the SGR to a high-performing Medicare program?

ACOG, AMA, and 110 state and national medical societies think so, and prescribe driving principles and core elements for the transition

In their letter to Congressional leaders, ACOG, AMA, and other societies acknowledged the "profound change" sweeping through the US health-care system, noting that it offers a "unique opportunity to improve and restructure how we deliver and pay for care." When it comes to the SGR, however, these organizations conclude that it is "an enormous impediment to successful health-care delivery and payment reforms that can improve the quality of patient care while lowering growth in costs. Physicians facing the constant specter of severe cuts under the SGR cannot invest their time, energy, and resources in care redesign. The first step in moving to a higher-performing Medicare program must be the elimination of the SGR formula," they write, based on the following principles, values, and key reforms.

Driving principles

- Successful delivery reform is an essential foundation for transitioning to a high-performing Medicare program that provides patient choice and meets the health-care needs of a diverse patient population.
- The Medicare program must invest in and support physician infrastructure that provides the platform for delivery and payment reform.
- Medicare payment updates should reflect the cost of providing services as well as efforts and progress on quality improvements and managing costs.

FAST TRACK

ACOG, AMA, and others: The first step in moving to a higher-performing Medicare program must be elimination of the SGR

Core elements of reform

- Reflect the diversity of physician practices and provide opportunities for physicians to choose payment models that work for their patients, practice, specialty, and region.
- Encourage incremental changes with positive incentives and rewards during a defined timetable instead of using penalties to order abrupt changes in the delivery of care.
- Provide a way to measure progress and show policymakers that physicians are taking accountability for quality and costs.

Recommended structural improvements

- Reward physicians for savings achieved across the health-care spectrum.
- Enhance prospects for physicians adopting new models to achieve positive updates.
- Tie incentives to physicians' own actions, rather than the actions of others or variables beyond their influence.
- Enhance prospects to harmonize measures and alter incentives in current law.
- Encourage systems of care, regional collaborative efforts, and primary care and specialist cooperation while preserving patient choice.
- Allow specialty and state society initiatives to be credited as delivering improvements (deeming authority) and recognize the central role of the profession in determining and measuring quality.
- Provide exemptions and alternative pathways for physicians in practice situations in which making or recovering the investments that may be needed to improve care delivery would constitute a hardship.

Is there a solution?

In October 2012, the American Congress of Obstetricians and Gynecologists (ACOG) joined the American Medical Association (AMA) and 110 state and national medical societies in providing the US Congress with a clear and definitive document—Driving Principles and Core Elements—that describes a way to transition to a Medicare payment system that will endure and ensure high-quality care for the individuals who rely on that program, and for many millions more whose care is linked to Medicare payment policies.

This document is unique in many ways, perhaps especially in the unity it demonstrates among all physician organizations. It echoes ACOG's earlier guidance to the US Congress on essential elements for a Medicare payment system that benefits women's health. Among ACOG's recommendations:

Make the new system simple, coordinated, and transparent. A new Medicare physician payment system should coordinate closely with other health-care programs; ensure that information technology is interoperable; and guarantee that quality-measurement programs are the same across all payers and rely on high-quality, risk-adjusted data.

Maintain the global obstetric care package. Medicare currently uses this package to reimburse for pregnancy. It works well and may be a model for global payment options for care provided by other physician types. The global obstetric care payment covers 10 months of care, from the first antepartum visit through the final postdelivery office visit.

Global payments allow a physician to manage costs and care for a patient's course of treatment, rather than for a patient's individual medical encounters.

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Maintain fee for service for women's health physicians who have small Medicare populations. Depending on the practice mix, type, and area, ObGyns and ObGyn subspecialists could see relatively few Medicare patients; unique Medicare requirements can pose significant administrative challenges and create inefficiencies with participation. Physicians who have small numbers of Medicare patients must be accommodated—and not penalized—in a new payment system.

Ensure that payment fairly and accurately reflects the cost of care. Medicare payments to obstetricians are already well below the cost of maternity care; no further cuts should be allowed for this care.

Support innovative care models, including a women's medical home. These models should recognize the dual role that ObGyns may play as primary care and specialty care physicians.

Repeal the Independent Medicare Payment Advisory Board. Leaving Medicare payment decisions in the hands of an unelected, unaccountable body with minimal Congressional oversight is just a bad idea.

Pass medical liability reform. Congress must enact meaningful medical liability reform, which the Congressional Budget Office says could save $40 billion—enough for a small downpayment on SGR repeal.

A continuing promise

Rest assured that ACOG's work to ensure appropriate Medicare payments to physicians, and to ensure that your patients have access to needed care, won't stop until the job is done.