

# Health Care Reform and the Sustainable Growth Rate: What's Happening Now?

Patrick R. Feehan, MD

## Practice Points

- The flawed Medicare payment system based on the sustainable growth rate (SGR) has increased physicians' rates by only 4% since 2001, even though the cost of operating a practice has risen by more than 20%.
- New positive calculations by the Congressional Budget Office have offered renewed enthusiasm among legislatures for the active pursuit of permanent SGR reform this year.
- Both policymakers and health care professionals believe that any outright repeal of the SGR must be replaced with a physician payment and delivery system rooted in quality and value and not solely based on volume of services.

Despite the many health care reform policies enacted by the Patient Protection and Affordable Care Act of 2010, one legislative fix that has beset physicians and policymakers for years remains to be made: Medicare's much maligned sustainable growth rate (SGR) formula for physician payment. Also known as (not so affectionately) the "doc fix," the SGR was enacted as part of the Balanced Budget Act of 1997<sup>1</sup> to lower physician payment rates but only modestly below the levels they would have reached under prior Medicare law. In 2001, the SGR formula began to create quite a fury among physicians when a 4.8% cut in physician reimbursement was projected.<sup>2</sup> Government policymakers and Congress agree that the SGR formula is "fundamentally flawed,"<sup>3</sup> but there is much less agreement on how to change it without creating an intolerable health care budget deficit.

Beginning in 2012, while trying to ameliorate this dilemma for physicians, Congress essentially kicked the can down the road by temporarily blocking the payment cuts each year; however, these deferrals simply added to the overall price tag on reform.<sup>4</sup> Because of the continued delay, the cost of physician payment reform escalated from \$48 billion in 2005 to nearly \$300 billion in 2011. Beginning in January 2014, physicians are in line again for a 25% cut.<sup>4</sup>

The uncertainty of these projected cuts and the last-minute temporary bailouts issued by Congress have weighed heavily on physicians for whom the ability to efficiently run their practices and render quality care to their Medicare patients is a continued source of concern and frustration. There already have been defections from the Medicare program, and if physician reimbursement continues to operate under the SGR umbrella, many more physicians threaten to do so.<sup>5</sup>

## A Glimmer of Light on the Horizon

In the last 2 years, Congress has begun to address permanent SGR reform. In the House of Representatives, serious proposals have been considered on both sides of the aisle to eliminate the flawed SGR formula and continue the reduction of Medicare costs. New positive calculations by the Congressional Budget Office have offered renewed enthusiasm for the pursuit of a long-term doc fix. Due to slower growth in estimated Medicare costs in recent years, the Congressional Budget Office issued a revised estimate of \$138 billion to repeal the SGR versus the \$315 billion that originally was projected.<sup>2</sup> Although still a lot of money, this bright spot has breathed new life into the potential to permanently fix the SGR this year before the window of opportunity closes.<sup>6</sup>

## Obstacles Remain

There is universal agreement among policymakers that the fee-for-service (FFS) payment model for physicians is inflationary and would continue to

From Dermatology Associates of Lancaster, Pennsylvania.  
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Correspondence not available.

lead to increased Medicare costs with or without the SGR. Many believe that the SGR enhanced rather than limited some of the worst aspects of the current FFS system, such as rewarding physicians for providing more tests, more procedures, and more visits, rather than for better, more effective care.<sup>4</sup> In an October 2011 letter, the Medicare Payment Advisory Commission, which advises lawmakers on Medicare payments, called the formula “fundamentally flawed” and said it “has failed to restrain volume growth and, in fact, may have exacerbated it.”<sup>3</sup>

Congress realizes that it cannot simply eliminate the SGR and allow continued unfettered FFS payments to physicians. It appears that any potential legislation will need to include alternative reimbursement models under Medicare that may or may not include a modified FFS payment system. Representative Joe Pitts, chairman of the Subcommittee on Health for the House Energy and Commerce Committee, stated, “There is also no disagreement that the SGR needs to be replaced with something that actually is ‘sustainable’ and reimburses for outcomes and quality, instead of just volume of services.”<sup>7</sup>

### **A Look at Recommendations and Proposals**

As early as October 2011, the Medicare Payment Advisory Commission recommended elimination of the SGR without increasing the deficit by cutting fees for specialists and imposing a 10-year freeze on rates for primary care physicians.<sup>3</sup> This proposal was strongly opposed by health industry groups as well as the American Medical Association, which in turn has recommended a 5-year transition fee scale that allows time to test new payment approaches, including several being tested as part of the Patient Protection and Affordable Care Act.<sup>8</sup>

Two of the most intriguing proposals have come from the House of Representatives. In February 2013, Representatives Allyson Schwartz and Joe Heck, DO, introduced a bill—the Medicare Physician Payment Innovation Act of 2013—that would repeal the SGR, maintain current payment levels through the end of 2014, increase payments to physicians for 4 years, and test new payment and delivery models.<sup>9</sup> A key feature of this bill is that it aims to transition Medicare from its traditional FFS model to new payment and delivery models that are more rooted in quality and value, with the intent of having them in place by 2016.<sup>2</sup>

Some Republicans in the House of Representatives proposed an SGR repeal as well as a payment reform plan for Medicare physicians. In April 2013, the Energy and Commerce Committee and the Committee on Ways and Means unveiled a reform package that would freeze physician payment rates at their current levels for up to 10 years, with future increases based on

individual physicians’ quality of care and efficiency.<sup>10</sup> This approach would involve 3 phases. Phase 1 would include repealing the SGR and providing a period of predictable, statutorily defined payment rates, which would enable physicians to prepare for and participate in payment reform by maintaining FFS payment schedules for up to 10 years. Phase 2 would include reform for Medicare’s FFS payment system to better reflect the quality of care provided; after the period of stability during which FFS payment would dominate, physician fee schedule payment updates would be based on performance relating to meaningful, physician-endorsed measures of quality care. Phase 3 would include further reform for Medicare’s FFS payment system that would account for efficiency of care. After several years of risk-adjusted, quality-based payments, physicians who perform well on quality measurements would be afforded opportunities to earn additional payments based on the efficiency of care.<sup>10</sup>

On July 31, 2013, the Energy and Commerce Committee passed a bill—the Medicare Patient Access and Quality Improvement Act of 2013<sup>11</sup>—unanimously (51 to 0). The bill provides for a 5-year period of stability and transition while a new quality reporting program is developed. Within that 5-year period, there will be annual statutory updates of 0.5% per year. Furthermore, this bill would insure a pathway for the implementation of new and innovative delivery and payment models, stressing value and quality of care while leaving the opportunity open for physician practices and specialties that do not fit into alternative payment models to continue to participate within the FFS system.<sup>11</sup>

### **Comment**

The physician’s struggle for adequate payment for Medicare services has been an ongoing battle. The flawed SGR system has increased physician pay rates by only 4% since 2001, even though the cost of operating a practice has risen by more than 20%.<sup>12</sup> The vast majority of health care parties participating in Medicare agree that the SGR is severely flawed and must be repealed. Most policymakers seem to agree that if SGR is repealed, it must be replaced with a physician payment and delivery system that is different from FFS; the policymakers’ argument has been that the volume produced by FFS drives costs upward without increasing the quality or efficiency of health care. It appears that Congress also has bought into this approach.

This year, it has been encouraging to see Congress unveil serious proposals for repealing the SGR. Physician organizations generally have reacted favorably to the latest reform draft and most recent legislation from the House of Representatives, and

they are largely in agreement that Medicare payment reform is inevitable and can stabilize physician payment and improve the value of health care if addressed properly.<sup>13</sup>

However, the Medicare Patient Access and Quality Improvement Act of 2013 is not without controversy. The American Medical Association and many other specialty societies are in strong disagreement with the provision that would cut 1% per year from the pool of physicians' pay for 3 years to offset a part of the cost of repealing the SGR. They argue that budget neutrality must be retained to avoid diminishing the barely adequate funding of the physician payment pool further.<sup>14</sup> There also is concern among health care organizations that the so-called updates will not keep up with inflation.

As we all know, the devil is in the details, and SGR reform will not be an easy task. Although the reform draft from the House of Representatives empowers physicians, not bureaucrats, to determine the quality and efficiency measures that are clinically meaningful for Medicare beneficiaries, the urge for Congress to micromanage and allow government bureaucrats to dictate the practice of medicine through programs with impractical government-imposed standards could easily derail and undermine the process as this piece of legislation moves through the House and then onto the Senate.<sup>15</sup> Let us hope that by the end of 2013 we will have meaningful legislation for physician payment under Medicare that will be a win-win situation for both health care professionals and policymakers in Washington.

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