MedPAC Calls SGR Flawed, Urges Replacement

BY ALICIA AULT

FROM A BRIEFING HELD BY THE MEDICARE PAYMENT ADVISORY COMMISSION

WASHINGTON – The Sustainable Growth Rate is "flawed in many ways," according to the Medicare Payment Advisory Commission, which presented several possible alternatives in its semiannual report to Congress.

Reform of the Sustainable Growth Rate formula (SGR) is essential to fixing the American health care system, MedPAC chairman Glenn M. Hackbarth said in a statement. "The Commission believes payment reform is a necessary, although not sufficient, condition for reform of the health care delivery system."

It is not the first time that the MedPAC commissioners have expressed their concern about the SGR and its continuing threat to both physicians and patients. Under the SGR, Medicare is on track to cut physician pay by 30% in 2012.

To eliminate the cuts that have mounted over the years is an expensive proposition – about $300 billion, according to estimates by MedPAC and others.

Thus, the commission has suggested several alternatives as well as potential ways to create Medicare savings to cover the cost of replacing the SGR.

One idea that has garnered strong support from the commission is overhauling the fee-for-service system by rewarding primary care physicians and encouraging a medical home model of care. Under that scenario, payments essentially would be shifted away from specialty care and procedure-based medicine to primary care, said MedPAC executive director Mark Miller.

The SGR proposals are just a small facet of MedPAC's goal to move Medicare away from a fee-for-service system. MedPAC commissioners are aiming for a more global payment model.

The report also called for possible short-term fixes to the SGR to last for at least 2 years. In 2010, updates were so short-lived that they were often applied retroactively. The lack of predictability was difficult for physician practices, according to the report, which added that "the most disturbing outcome resulting from the short-term fixes was damage to patients' and providers' confidence in Medicare."

Mr. Miller said that the SGR proposals are just a small facet of MedPAC's goal to move Medicare away from its fee-for-service payment system. MedPAC commissioners have been discussing how to move Medicare toward a more global payment model, such as the accountable care organizations (ACOs) that are being proposed by the Centers for Medicare and Medicaid Services.

The report also made a series of recommendations to reduce the ever-rising cost of ancillary services provided by physicians, particularly imaging services. The commission is not anti-imaging, said Mr. Miller. But there has been such a spike in volume in the last decade – 6% growth per beneficiary per year for 2004-2008 and 2% per year for 2008-2009 – that commissioners felt it was imperative to suggest ways to curb the growth.

Among the suggestions: Disallow multiple payments for imaging of multiple body parts that are carried out simultaneously, and reduce fees for physicians who order a procedure and then perform it themselves.

The report also recommended that Medicare require prior authorization of magnetic resonance imaging, computed tomography, and nuclear imaging for physicians who order more of these tests than do their peers. This change would likely take an act of Congress, however.

The commission outlined a process whereby physicians who are found to order more – but within appropriate bounds – would merely be subject to a prior notification process.

The commissioners did not embrace outright the radiology benefits management (RBM) model that's used in the private sector, but Mr. Miller said that ultimately a Medicare contractor would administer the process, and that an RBM might be eligible.

The report also contained recommendations on improving how Medicare can support physicians and other health care providers interested in improving the quality of care they deliver. Among the biggest changes: Take some payments that would go to Quality Improvement Organizations, and funnel them directly to providers or communities that want to band together to create their own quality improvement programs.

The report can be viewed online at http://medpac.gov/documents/Jun11_EntireReport.pdf. ■

CBO Projects Nearly 30% Physician Pay Cut in 2012

Medicare payments to physicians will be slashed by 29.4% on Jan. 1 unless Congress acts to avert the scheduled cut, according to an estimate from the Congressional Budget Office.

Last year, Congress passed a 1-year pay fix that kept Medicare fees to physicians at 2010 rates through the end of 2011. Come January, though, physicians will be faced with paying the bill on years of accumulated pay cuts.

If Congress were to throw out the SGR and freeze Medicare payments to physicians at current rates, the cost to the government would be almost $298 billion over 10 years.

The new report from the nonpartisan Congressional Budget Office (CBO) also outlines the costs of various proposals to replace or revamp Medicare's Sustainable Growth Rate (SGR), the formula that requires annual cuts to physician pay whenever actual spending on physician services exceeds spending targets. For example, if Congress were to throw out the SGR and simply freeze Medicare payments to physicians at current rates, the cost to the federal government would be almost $298 billion over 10 years. Offering physicians a 2% pay bump in each year through 2021 would raise the price of the fix to $389 billion over the decade.

A somewhat less expensive option would be to reset the SGR instead of replacing it. Under that option, Congress would forgive all spending above the cumulative targets as of the end of 2010. Going forward, 2011 would be the baseline period for the application of the SGR and in 2012 physicians would receive an increase equal to the Medicare Economic Index. That option would cost about $195 billion over 10 years.

Lawmakers on the House Energy and Commerce Committee are considering the options for replacing the SGR. They recently held a hearing in which they solicited ideas from several of the major professional medical societies on what could replace the SGR. Rep. Michael Burgess (R-Tex.), a member of the committee, said that the goal was to enact a permanent solution to the Medicare physician payment problem this year.

–Mary Ellen Schneider

Insurers Are Paying More Quickly, But Accuracy Is Still an Issue

FROM THE ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION'S HOUSE OF DELEGATES

CHICAGO – A sampling of claims payments from some of the nation's top insurers shows that although they are paying much more quickly, some 23% of claims were denied and almost a fifth were paid incorrectly.

The study was conducted for the American Medical Association and issued at the meeting.

The 2011 National Health Insurer Report Card showed that the error rate of 19.3% represented an extra $3.6 million in erroneous claims, a 2% increase from the previous year. The AMA estimated that these faulty payouts and the hassles associated with them added $1.5 billion in administrative costs to the health care system.

"This report card conveys that the current state of the health care claims process is untenable," AMA board member Dr. Barbara L. McAneny said at the meeting.

She said that 10%-14% of a physician's revenue goes to dealing with administrative issues. The AMA is working with insurers and physicians to get that down to 1% of revenue.

The report card tracked a number of performance measures at Medicare and seven private insurers: Aetna, Anthem Blue Cross/Blue Shield, Cigna, Health Care Services, Humana, Regence, and UnitedHealthcare.

UnitedHealthcare (UHC) was the only insurer that improved its claims-processing accuracy from 2010, paying 90% of claims in an accurate manner. Anthem, on the other hand, paid only 61% of claims accurately.

The outright denial rate (in which no payment is made) ranged from a low of 17% of claims at Regence to 25% at Anthem and Cigna.

Prior authorization is a growing problem for physicians and constitutes one of the top eight reasons for denial of claims, according to Mark Rieger, CEO of National Healthcare Exchange Services, the company that conducted the analysis for the AMA. Coping with prior authorization is the second-largest administrative task for physicians, consuming at least 20 hours a week of physician and staff time, he said at the meeting.

Cigna had highest rate (6%) of claims requiring prior authorization; Regence had the lowest (0.04%).

There were some bright spots in the report. The vast majority of claims are now being paid within the first 15 days, with the remainder coming largely within 16-30 days of submission. Humana and Medicare were the fastest, paying some 95% of claims within 15 days. Cigna and Health Care Services were close behind.

The data were compiled by National Healthcare Exchange Services. The company analyzed claims submitted between Feb. 1 and March 31, 2011. Claims came from 42 states, and included 4 million services billed on 2.4 million claims made by 400 practices covering 80 specialties.

–Alicia Ault