MedPAC Says SGR Replacement Needed To Fix Health Care

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 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 (CMS).

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 MRIs, CTs, 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. ■

Feds Aim to Coordinate Care, Share Data for 'Dual Eligible' Patients

BY FRANCES CORREA

FROM A BRIEFING BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Sharing information and coordinating care for elderly and disabled patients who qualify for both Medicare and Medicaid could save millions of health care dollars every year, according to Health and Human Services department officials.

To jump-start efforts in this area, the Medicare-Medicaid Coordination Office – which was created by the Affordable Care Act – now seeks to provide state Medicaid agencies with access to Medicare data on these so-called "dual eligible" patients.

Medicare data will now be available on a monthly basis and at no cost to state Medicaid agencies.

MS. SEBELIUS

Data on services paid for by Medicare Parts A, B, and D will now be available on a monthly basis and at no cost to state Medicaid agencies, HHS secretary Kathleen Sebelius said at the briefing.

"With this new data initiative, we're giving states a fuller picture of the health needs of the people they're serving so they can provide the best care possible," Ms. Sebelius said.

For example, she commented, by sharing data on hospitalizations and prescription regimens, physicians and other health care providers can seek to prevent readmissions as well as help to ensure that patients are taking their medications appropriately.

In another effort, the coordination office is seeking input on how to best align Medicare and Medicaid to provide both comprehensive and nonduplicative care for beneficiaries with dual eligibility.

"These are chronically ill individuals who are old enough to qualify for Medicare and usually poor enough to qualify for Medicaid and [are] in very difficult health situations, but the systems have not talked to each other at all," Ms. Sebelius said.

The office has published a notice for public comment in the Federal Register seeking input about how to align care coordination, prescription drugs, cost-sharing, fee-for-service benefits, enrollment, and appeals between the two care payers.

"This is the top priority because it drives the greatest costs, and yet we know if we could work together on this, we could have better health care outcomes for these individuals," Washington Gov. Christine Gregoire (D), said during the news conference.

Even as the federal government works to integrate these programs, some members of Congress are calling for the removal of the Affordable Care Act's Medicaid Maintenance of Effort provision as a cost-saving initiative.

Maintenance of Effort requires states to maintain the same Medicaid coverage for adults pending implementation of health reform provisions that go into effect in January 2014. It also maintains coverage for children in Medicaid and the Children's Health Insurance Program (CHIP) through Sept. 30, 2019.

In response, Ms. Sebelius said Maintenance of Effort and block grants don't hold the greatest potential for savings.

"If the truth be known, the major economic driver for our Medicare costs today … is in the area of dual eligibles," Ms. Sebelius said.

Currently, 9 million Americans are dual eligibles and account for $300 billion in expenditures for Medicare and Medicaid, Dr. Donald Berwick, administrator for the Centers for Medicare and Medicaid Services, said in a statement.

Dual eligibles represented 39% of Medicaid spending in 2007, according to a CMS statement. Medicaid spent about $120 billion on this group that year, or approximately twice as much as the program spent on the 29 million children it covered. ■

CBO Projects Nearly 30% Pay Cut for Physicians Mandated by SGR on Jan. 1

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.

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