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Update on the "SGR fix"

SGR Cliff

As a result of cumulative spending, the Sustainable Growth Rate (SGR) formula "cliff" gets larger and larger each time there is a delay in reforming the funding mechanism. The latest estimate by the Congressional Budget Office (CBO) released on November 14, 2014, estimated that a bipartisan, bicameral "doc fix" plan introduced in February (H.R. 4015, S. 2000) to replace the SGR would cost $144 billion over a decade (fiscal years 2015 to 2024). That is an increase from the roughly $138 billion, 11-year price tag that CBO released in February 2014. If Congress fails to act before February, the overall price tag could increase by as much as $21 billion due to the necessity of extending the 10 year budget estimate to include fiscal year 2025.

SGR at the Close of 2014 – Lame Duck Session

Although the current SGR patch (P.L. 113-93) will prevent cuts to Medicare doctors through March 2015, the desire to harness the progress made during the 113th Congress, upcoming retirements, and the short time window for action next year are all contributing to the push to dispose of the SGR before the end of the year. There is also the historically low price tag, which many are afraid could increase if Congress does not act quickly.

While there is consensus that the payment formula is broken and in need of replacement, there remain several obstacles to action on the SGR in the lame duck session. There is lack of agreement among lawmakers on how to pay for permanently replacing the SGR formula, even though they have reached a bipartisan, bicameral compromise on the policy. This impasse is further complicated by the few remaining days on the congressional calendar in the lame duck. Congress will return to session on December 1, 2014 and is scheduled to complete work on Friday, December 12, 2014. In addition, the Continuing Resolution (CR) expires on December 11th, which will dominate the congressional schedule before adjournment of the 113th Congress. The physician community continues to push for repeal during the lame duck.

Orrin G. Hatch (R-UT), the Ranking Republican on the Senate Finance Committee and chairman of the panel next Congress, said conversations continue about moving a permanent fix in the lame duck, and he mentioned a tax extender package as a potential vehicle. Asked if passing the SGR policy with the tax legislation means it would not need offsets, he replied, "It might not, let me put it that way." He added, "I'm going to solve it one way or the other…I don't know in the lame duck, but we'll see."

Current Finance Committee Chairman Ron Wyden, (D-OR), previously proposed using money saved from winding down the wars in Iraq and Afghanistan (Overseas Contingency Operations, or "OCO" funds) as an offset or not paying for the replacement policy at all. In a March 2014 floor statement, he said he would defer to his colleagues "to decide if it is better to offset the costs of SGR repeal by reducing future war spending or [if it should be] unpaid for, but the bottom line is the same: We ought to act now."

A Senate Democratic aide said Wyden is continuing conversations about the best path forward in the lame duck.

On the House side, in early November, the GOP Doctors Caucus sent a letter to House Republican leadership requesting that "all possible efforts be made" to pass a comprehensive solution to the SGR during the lame duck. That said, House Republicans are generally not comfortable with passing an SGR repeal that is not offset.

Efforts to Repeal and Replace: Bipartisan, Bicameral Combined Committee Proposal

In February 2014, the House Committees on Energy & Commerce and Ways & Means and the Senate Committee on Finance revealed a joint proposal which accomplished the following:

Repealing and Replacing the SGR

- The SGR formula is a budget cap passed into law in 1997 to control physician spending, but it has failed to work.
- Since 2003, Congress has spent nearly $150 billion in short term patches to avoid unsustainable cuts imposed by the flawed SGR.
- Building on bipartisan legislation unanimously reported out of the House Energy & Commerce and Ways & Means Committees and reported out of the Senate Finance Committee, the unified legislation from the three committees repeals the SGR and transitions Medicare away from a volume-based system towards one based on value.

Repeals the SGR and provides stability and 5 years of payment updates

- Repeals the SGR and replaces it with a system focused on quality, value, and accountability.
- Removes the imminent threat of draconian cuts to Medicare providers and ensures a 5-year period of annual updates of 0.5 percent to transition to the new system.

Improves the existing fee-for-service system by rewarding value over volume and ensuring payment accuracy

- Consolidates the three existing quality programs into a streamlined and improved program that improves care for seniors, rewards providers who meet performance thresholds, and provides more certainty for providers.
- Implements a process to improve payment accuracy for individual provider services.
- Incentivizes care coordination efforts for patients with chronic care needs.
- Relies on physician-developed clinical care guidelines to reduce inappropriate care that can harm patients and results in wasteful spending.
- Requires development of quality measures and ensures close collaboration with physicians and other stakeholders regarding the measures used in the performance program.

Incentivizes movement to alternative payment models (APMs)

- Provides a 5 percent bonus to providers who receive a significant portion of their revenue from an APM.
- Participants need to receive at least 25 percent of their Medicare revenue through an APM in 2018-2019, with this threshold increasing over time.
- Also incentivizes participation in private-payer APMs.
- Establishes a Technical Advisory Committee (TAC) to review and recommend physician-developed APMs
  based on criteria developed through an open comment process.
- Creates flexibility around who could qualify as an APM, but would at least include patient-centered medical home (PCMH) and accountable care organization (ACO) concepts.

Expands the use of Medicare data for transparency and quality improvement

- Posts quality and utilization data on the Physician Compare Website to enable patients to make more informed decisions about their care.
- Allows qualified entities (QEs) to provide analysis and underlying data to providers for purposes of quality improvement, subject to relevant privacy and security laws.
- Allows qualified clinical data registries to purchase claims data for purposes of quality improvement and patient safety.

Unfortunately, the draft legislation contained no offsets.

Legislative Activity

The comprehensive "repeal and replace" combined committee bill described above was introduced as H.R. 4015/S. 2000, the "SGR Repeal and Medicare Provider Payment Modernization Act of 2014." On March 14, 2014, the House of Representatives passed H.R. 4015, 238 - 181 (Roll Call Vote no. 135). The Senate did not vote on the comprehensive SGR bill. Therefore, the House introduced H.R. 4302, the "Protecting Access to Medicare Act of 2014," legislation that included a SGR patch through March 31, 2015 and extended other Medicare and health programs. The House passed H.R. 4302 by voice vote on March 27, 2014. The Senate reached agreement to vote on H.R.4302 and passed the bill 64-35 on March 31, 2014. It was signed into law (P.L. 113-93).

History of Physician Payment

Since the Medicare program was created in 1965, several ways of determining how much it pays physicians for each covered service have been used. Initially, the program compensated physicians on the basis of their charges and allowed them to bill beneficiaries for the full amount above what Medicare paid for each service (i.e., balanced billing).

In 1975, in response to the increased costs, Medicare payments were still linked to what physicians charged, but the annual increase in fees was limited by the Medicare economic index, or MEI. Because those changes were not enough to prevent total payments from rising more than desired, from 1984 through 1991 the yearly change in fees was determined by legislation. Congress froze fees from 1984 through 1986; from 1987 through 1991, it raised them by amounts specified in legislation. The effect of those actions was that spending grew at an average annual rate of 15 percent from 1975 to 1991.

Balance billing also prompted Congressional action during the 1980s. According to the Congressional Budget Office, on average, liability for balance billing per beneficiary grew from $56 a year (in nominal terms) in 1980 to a high of $94 in 1986. In effect, beneficiaries contributed to offsetting the constraints on Medicare physician fees. The Congress responded by imposing limits on such billing, which prevented physicians from raising their charges. Total charges by so-called nonparticipating physicians are currently restricted to 109.25 percent of Medicare's fees for participating physicians.

Starting in 1992, the charged-based payment system was replaced by the physician fee schedule. The fee schedule bases payment for individual services on measures of the relative resources used to provide them. The formula for each fee has two parts. One part is a weight--the "relative value"--that indicates the resource costs of each service relative to all others. The other part is a fixed dollar amount known as the conversion factor, which is multiplied by each relative weight to calculate the fee to be paid for each service. Initially, this schedule included distinct conversion factors for various categories of services (e.g., primary care, surgical, and other non-surgical conversion factors).

In an attempt to control volume-driven growth in total spending for physicians' services, policymakers also enacted a mechanism that tied the annual update of fees for services on the physician fee schedule to the trend in total spending for physicians' services relative to a target. Under that approach, the conversion factor was to be updated annually (to reflect increases in physicians' costs for providing care, as measured by the MEI) and adjusted by another factor to counteract changes in the volume of services provided per beneficiary. The introduction of expenditure targets to the update formula initiated the third period in physician payments. Known as the volume performance standard (VPS), it provided a mechanism for adjusting fees to try to keep total spending for physicians' services within budgetary targets.

The VPS led to updates that were unstable. Under that approach, the expenditure target was based on the historical trend in volume. Any excess spending relative to the target triggered a reduction in the update two years later. Medicare's spending for services on the physician fee schedule grew at an average annual rate of 3.2 percent during the 1992-1998 period, but the changes in spending varied substantially from one year to the next, ranging from a reduction of 2.6 percent in 1992 to increases of almost 10 percent in both 1994 and 1995. That volatility led Congress, MedPAC, and the American Medical Association to support a more moderated physician payment schedule – the Sustainable Growth Rate or SGR, which was included as part of the Balanced Budget Act of 1997.

Like the VPS, the SGR method uses a target to adjust future payment rates and to control growth in Medicare's total expenditures for physicians' services. In contrast to the VPS, however, the target under the SGR mechanism is tied to growth in real (inflation-adjusted) GDP per capita--a measure of growth in the resources that society has available for each person. The update under that approach is equal to the MEI adjusted by a factor that reflects cumulative spending relative to the target. Cumulative spending was not part of the VPS method.

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H.R. 4015/S. 2000: Timeline of Implementation

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024 . . .
Base Update	Conversion Factor Update of 0.5% each year					Conversion Factor Update of 0.0% each year					0.5%
Electronic Health Record (EHR) Incentive Program	EHR Incentives continue under current law				EHR Meaningful Use Incorporated into MIPS						
Physician Quality Reporting System (PQRS)	PQRS continues under current law				Quality reporting incorporated into MIPS						
Physician Value-Based Payment Modifier (VBM)	N/A	VBM Continues under current law			Parts of VBM incorporated into MIPS						
"Merit Based" Incentive Payment System (MIPS)*	N/A				(+/-) 4%	(+/-) 5%	(+/-) 7%	(+/-) 9%			
Alternative Payment Models (APM)	N/A				5% lump sum bonus on the previous year's covered professional services for "qualifying APM participants"**						1%
Relative Value Unit (RVU) Adjustments for Misvalued Services	N/A	Secretary determines a net reduction target which if met is redistributed under budget neutrality; if target not met reduced expenditures equal to target recapture amount				N/A					
Identification of Imaging Outlier Ordering Professionals	N/A			The Secretary shall annually identify "outlier ordering professionals" of imaging; beginning in 2020 "outlier ordering professionals" will be subject to prior authorization							

* The Secretary has the authority to create additional MIPS bonuses for "exceptional performers." These exceptional bonuses for 2018-2023 are funded with $500,000,000

** "APM Qualifying Participant": **2018-2019**: 25% of Medicare revenues furnished as part of an eligible APM; **2020-2021**: 50% of Medicare revenues furnished as part of an eligible APM; *or* professionals with at least 25% of Medicare revenues from services furnished as part of an eligible APM *AND* at 50% of all payer revenues (excluding VA and DOD) for services provided as part of an APM (provided that the professional is willing to provide data to CMS to be able to make that determination). **2022-** : 75% of Medicare revenues furnished as part of an eligible APM; *or* professionals with at least 25% of Medicare revenues from services furnished as part of an eligible APM *AND* at 75% of all payer revenues (excluding VA and DOD) for services provided as part of an APM (provided that the professional is willing to provide data to CMS to be able to make that determination).

ADDITIONAL DATES & DEADLINES:

~May 2014:	**CMS** must make public a list of **episode groups** and related descriptive information ("not later than 120 days after the date of enactment") for eventual calculation of **provider resource use**.
~July 2014:	Make appointments to the **Payment Model Technical Advisory Committee** which will provide recommendations on moving providers into alternative payment models ("180 days after date of enactment").
~July 2014:	The **Secretary** and **HHS OIG** shall submit a report to Congress with legislative recommendations to amend fraud and abuse laws (e.g. Stark and Anti-Kickback Statute) in order to allow **gainsharing arrangements** that can improve care and reduce waste and inefficiency.
~December 2014:	The **Secretary** shall post a draft list of patient relationship categories and codes in order to facilitate **patient attribution** to providers ("270 days after date of enactment") for eventual calculation of **provider resource use**.
January 1, 2015:	The **Secretary** shall post a **draft plan for measure development** and accept comments through March 1, 2015. Secretary must post final plan for measure development no later than May 1, 2015.
February 1, 2015:	The **Secretary** shall make publicly available the number and characteristics of **opt-out physicians and practitioners** and update annually.
~March 2015:	The **GAO** shall conduct a study and submit a report to Congress on the RUC process to make recommendations to HHS for the values of specific services. ("not later than 1 year after the date of enactment")
~March 2015:	The **Secretary** shall conduct a study and submit a report to Congress on the feasibility of mechanisms (e.g. a Website) that would allow users to compare the interoperability of EHR products ("not later than 1 year after the date of enactment").
~July 2015:	**GAO Report** on alignment of quality measures between public and private programs with recommendations on how to reduce **administrative burden of reporting** ("not later than 18 months after the date of enactment").
~July 2015:	**GAO Report** shall submit a report to Congress on the extent the appropriate use program can be expanded to services beyond imaging ("not later than 18 months after the date of enactment").
~July 2015:	The **Secretary** shall study and submit a report to Congress on a strategic plan for obtaining data on race and ethnicity for carrying out the MIPS program ("not later than 18 months after the date of enactment.")

July 1, 2015:	**Secretary** must submit a report to Congress on the feasibility of including participation in **Alternative Payment Models into the Medicare Advantage** payment system
July 1, 2015:	The **Secretary** shall make required updates on physicians available on **Physician Compare** (for non-physicians, the Secretary must make the data available by July 1, 2016).
July 1, 2015:	**Qualified Entities (QEs)** may use combined data to conduct additional non-public analyses for the purposes of assisting providers to develop and participate in quality and patient care improvement activities including developing new models of care.
July 1, 2015:	**Qualified Clinical Data Registries (QCDRs)** may request **Medicare claims data** (and in certain circumstances Medicaid data) to link with clinical outcomes data and perform risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety. Costs of providing the data apply.
July 1, 2015:	The **Secretary** shall establish metrics to determine whether the national objective of achieving widespread EHR interoperability is being met.
November 1, 2015:	The **Secretary**, through notice and comment, shall establish criteria for **physician-based payment models** including for specialist physicians.
November 15, 2015:	The **Secretary**, pursuant to rulemaking, shall specify appropriate use criteria for certain imaging services
~March 2016:	The **Secretary** shall conduct a study and send a report to Congress on **fraud and abuse** related to Alternative Payment Models ("two years after enactment").
~March 2016:	The **Secretary** shall conduct a study *using Medicare data* and send a report to Congress that examines the effect of **individuals' socioeconomic status** on quality and resource use outcome measures for individuals under the Medicare program.
~March 2016:	The **GAO** shall submit a report to Congress on studies on **telehealth and remote patient monitoring** ("not later than 24 months after the date of enactment").
April 1, 2016:	The **Secretary** shall publish a list of **qualified clinical decision support mechanisms** for incorporation of appropriate use criteria.
May 1, 2016:	The **Secretary** shall post a report on the **progress made in measure development** (to be conducted annually).
January 1, 2016:	**GAO Report** on whether **entities that pool financial risk** for physician practices (i.e. independent risk managers) can play a role in supporting physician practices

July 1, 2016: The **Secretary** shall make available timely ("such as quarterly") **performance feedback reports** for MIPS participants. The current Physician Feedback Reports requirements will end in 2016.

July 1, 2016: Initial **MedPAC Report** on total and rate of growth of physician and healthcare profession expenditures

January 1, 2017: Related to imaging services, ordering physicians must consult a qualified clinical decision support mechanism and provide information to the furnishing professional. The requirement does not apply in emergency or inpatient services or for services provided in the context of an Alternative Payment Model. There is also a significant hardship exemption.

July 1, 2017: The **Secretary** shall make available to MIPS participants data about items and services that are furnished to that MIPS' patients *by other providers and suppliers.*

December 31, 2017: The **Secretary** shall submit a report to Congress on the use of chronic care management services by individuals living in rural areas and by racial and ethnic minority populations.

December 31, 2017: **Congressional declaration** that it is a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide

July 1, 2018: **MedPAC Report** on spending on professional services from 2014-2018 and its impact on efficiency, economy, quality of care, access, and recommendations for future payment updates

December 31, 2018: The **Secretary** shall submit a report to Congress in the event the Secretary makes a determination that we have not achieved national widespread EHR interoperability identifying the barriers to adoption and making recommendations that the Federal government can take to achieve adoption.

~March 2019: The **Secretary** shall conduct a study *using Federal data and other such data as necessary* and submit a report to Congress that examines the impact of risk factors on quality and resource use outcome measures under the Medicare program ("not later than 5 years after enactment")

October 1, 2019: **GAO Report** on the MIPS program including the distribution of performance and performance scores of participants, recommendations for improvement, and the impact of technical assistance on the ability of professionals to transition to APMs (particularly for practices in HPSAs and MUAs) (Report 1 of 2).

October 1, 2020: **GAO Report** on transition of professionals in rural areas, HPSAs, and MUAs into APMs (Report 1 of 2) (Note: this is mentioned separately from the October 1, 2019 and October 1, 2022 reports which is also to include this information).

October 1, 2022: **GAO Report** on the MIPS program including the distribution of performance and performance scores of participants, recommendations for improvement, and the impact of technical assistance on the ability of professionals to transition to APMs (particularly for practices in HPSAs and MUAs) (Report 2 of 2).

October 1, 2022: **GAO Report** on transition of professionals in rural areas, HPSAs, and MUAs into APMs (Report 2 of 2) (Note: this is mentioned separately from the October 1, 2019 and October 1, 2022 reports which is also to include this information).

July 1, 2020: Final **MedPAC Report** on total and rate of growth of physician and healthcare profession expenditures