

Health Policy Opinion

The Tragedy Of The Sustained Growth Rate Formula Continues Into 2014: Is There Hope For Repeal?

Laxmaiah Manchikanti, MD¹, Frank J.E. Falco, MD², Hans Hansen, MD³, and Joshua A. Hirsch, MD⁴

A recent health care policy article describes the sustained growth rate (SGR) as a mythical sword of Damocles hanging over the physicians (1). The SGR formula is an approach to restrain the growth of Medicare spending on physician services. It threatens to impose a 24.4% decrease in the Medicare physician fee schedule on April 1, 2014, if not fixed. The Bipartisan Budget Act of 2013 (2), which was signed into law by President Obama on December 26, 2013, provided a reprieve for 3 months, delaying the cuts to April 1, 2014, included the pathway for SGR Reform Act of 2013. The Bipartisan Budget Act of 2013 establishing the federal budget targets for fiscal years 2014 and 2015 includes a number of provisions impacting Medicare and Medicaid programs (3). While the act provides a short-term reprieve from a looming Medicare physician fee schedule cut, it also extended Medicare provider payment cuts under existing sequestration authority for 2 years and it makes a variety of other policy changes.

It is expected that the 3-month payment patch will give Congress time to repeal the SGR with a 0.5% increase for services provided. Congress has been focusing on permanent repeal of the dysfunctional SGR formula throughout 2013; however, it failed to happen in 2013.

After numerous attempts to fix the physician payment system with multiple modifications which have been judged to be failures, in 1998, the physician payment updates were replaced by a new mechanism – the SGR formula (4). The consequences of this formula have been problematic from soon after its enactment. The dual goals of policy makers in creating the SGR mechanism was to ensure adequate access to physician services and to control federal spending in a more predictable way than previous mechanisms allowed, continues to fail and create new problems each year. Recently, Wilensky (5) has described that the use of a relative-value scale with fees adjusted according to the SGR is inconsistent with a renewed interest in value creation in health care. She described that a fee schedule that reimburses physicians on the basis of billing for approximately 8,000 discrete service codes makes it very difficult to hold physicians responsible or accountable for the health outcomes of their patients or for the costs of treating them (5). In addition, the incentives that the SGR presents to the individual physician are incompatible with the formula's objective of controlling aggregate physician spending. While the aggregate spending of all physicians' drives the SGR, no one physician or physician group is large enough to affect aggregate spending. Thus, stellar performance can't be rewarded and poor performance can't be penalized at the level of the physician or the group associated with the good or bad behavior (5). An increase in the volume of services that are provided has accounted for most of the increases in physician spending over the past decade (Fig. 1) (5). While the Medicare Economic Index (MEI) increased moderately, spending for

From: ¹Pain Management Center of Paducah, Paducah, KY and University of Louisville, Louisville, KY; ²Mid Atlantic Spine & Pain Physicians, Newark, DE and Temple University Hospital, Philadelphia, PA; ³Pain Relief Centers, Conover, NC; and ⁴Massachusetts General Hospital and Harvard Medical School, Boston, MA.

Additional author affiliation and disclaimer information on Page E24:

Address Correspondence:
Laxmaiah Manchikanti, MD
2831 Lone Oak Road
Paducah, Kentucky 42003
E-mail: drlm@thepainmd.com

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beneficiary increased substantially with lackluster payment updates. However, the MEI also lags behind cost inflation in real life. Thus, in spite of the prevention of negative updates, with rising practice cost inflation or medical expenditure index, a wide gap continues to grow between projected payment updates and increasing expenses (4).

MedPAC, the administration, and Congress now realize that the SGR is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. MedPAC has recommended that Congress should repeal the SGR system citing multiple reasons. The SGR system, which ties annual updates to cumulative expenditures, has failed not only to restrain volume growth, but may even be exacerbating it (6). In fact, MedPAC, while laying out its findings and recommendations for moving away from the SGR system in its October 2011 report to Congress indicated that repeal was rather urgent (6). Historically, the SGR negative updates have been corrected each year since its inception.

Wilensky (5) describes that Medicare value will be improved with an SGR fix. However, with the experience over the last 15 years, many are worried that the administration and Congress may just kick the proverbial SGR can down the road for another year or so (5).

In 2013 for the first time there has been bipartisan, bicameral attention being directed toward developing an alternative reimbursement system that rewards physicians who improve the quality and efficiency of care.

Past legislative efforts to reform the SGR relied primarily on applying the formula to different subgroups of physicians, as in both children's health and the Medicare Protection Act of 2007 and the Medicare Physician Payment Reform Act of 2009. However, these efforts never became law. In 2013, very different types of legislative bills were considered and will be considered in 2014. In 2013, a bipartisan bill was passed unanimously by the House Energy and Commerce Committee (7), and toward the end of the year, a bipartisan legislative framework was released by the Senate Finance Committee and the House Ways and Means Committee (8).

These 3 bills considered in 2013 will hopefully become legislation in 2014 have many elements in common displaying congressional bipartisan agreement. Some of the agreements include a short period of stability for physician reimbursement, with zero to small updates; larger updates made available for physicians who participate in alternate delivery systems that can demonstrate improved value; and finally, reductions in payments made to physicians who do not demonstrate success in improving value or efficiency.

The cost of repealing the SGR has been the major factor since a few years after its inception. The SGR targets the product of the growth in the fee-for-service (FFS) enrollment: inflation update factors, real gross domestic product (GDP) per capita, and changes in law or regulation. Actual growth and spending on physician services are compared with a cumulative target growth rate

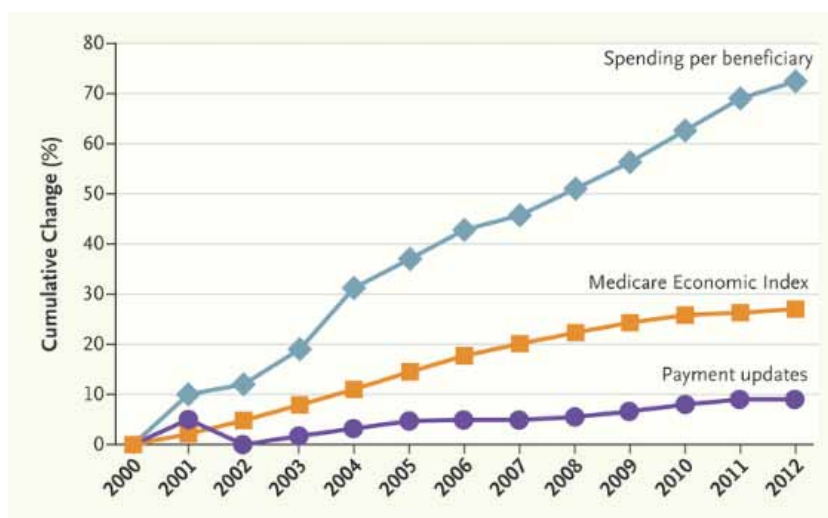


Fig. 1. Cumulative changes in payment updates, in the medicare economic index, and in spending per medicare beneficiary (2000–2012).

Source: Wilensky GR. Improving value in Medicare with an SGR Fix. N Engl J Med 2014; 370:1-3 (5).

linked to GDP using 1996 as the base year. In addition, the formula limits the amount of an increase in payment rates to inflation plus 10% and it also limits a decrease in payment rates to inflation minus 7%, with inflation being measured by MEI. The MEI measures changes in the cost of a physician's time and operating expenses which is weighted to some of the prices of inputs in those 2 categories. The changes in the cost of physician's time are measured using changes in the non-farm labor cost and changes in "all factor" productivity (9).

MedPAC analysis over the years has demonstrated that some physicians and other health professionals contribute to the inappropriate volume growth that has resulted in larger payment adjustments through the SGR, even though others have restricted volume. Since the SGR does not differentiate between physicians who restrain volume and those who do not, all physicians are affected, irrespective of their actions. As an example that SGR failed to restrain volume growth and even may have exacerbated it is that the physician fee schedule services grew by 88% from \$37 billion to \$69.6 billion from 2000 to 2012, which is more related to the growth in the volume and intensity of services than because of the fee increases (10-15). Critics also claim that in spite of congressional interventions to set aside steep SGR mandated physician payment cuts, utilization growth in recent years has been relatively low even though it is quite unpredictable. The growth accelerated in 2001, reaching a plateau during 2001 to 2004 with annual growth ranging between 4.6% and 5.8%. The deceleration of the growth rate started in 2005 ranging from 3% to 3.7%, falling to 3.1% in 2012 (11-15).

Whenever Congress blocks a fee reduction, it compounds the difference between actual and SGR driven fees, making the eventual adjustment that much larger. This is against principles of business management as no industry could function with this type of correction possible pending congressional action. Hence, the Damocles sword reference cited above. Consequently, if Congress continues to enact temporary fixes, prior estimates suggest that cost of permanent reform, already over \$250 billion would have escalated to approximately \$300 billion for 10 years based on June 2011 estimates (16). However, the Congressional Budget Office (CBO) in a 2011 report showed a steep drop in eliminating the Medicare SGR formula as shown in Fig. 2. The cost of replacing the Medicare SGR formula has ranged from almost \$50 billion to nearly \$300 billion. The 2011 estimates from the CBO cut by nearly half its cost estimate for freezing physician reimbursement over a decade. This has helped to create renewed interest in Congress and the administration to find a formula to fix the SGR and find a more permanent Medicare payment solution for less.

However, rather unfortunately, as everything changes in Washington, the CBO has estimated that the bill passed by the Energy and Commerce Committee would cost \$175 billion over a period of 10 years (17,18). The draft strategy from the Senate Finance and House Ways and Means committees has not yet been given a cost estimate by the CBO.

The House committee on Ways and Means and the Senate committee on Finance released the SGR repeal proposal in early November, and the 2 committees



Fig. 2. Ten-year freeze estimate (in billions).
Source: Congressional Budget Office cost reports.

have since met to revise their respective bills (8). The original proposal called for a 10-year freeze on Medicare physician payments; however, the House bill now would provide a 0.5% positive update for 2014 to 2016. In contrast, the Senate bill retains the full 10-year payment freeze. Other inclusive principles apart from repeal of the SGR are as follows:

- Provide funding to shift emphasis toward new payment models that focus on quality of care rather than fee-for-service;
- Provide \$125 million to help small physician practices transform to payment models based on the quality of care;
- Consolidate existing quality improvement programs, such as meaningful use, the physician quality reporting system and the value-based modifier, into a single Value-Based Performance Payment program that would reward high performing practices and that also would decrease penalties assessed on physicians who do not participate in quality programs;
- Create a Medicare payment for complex chronic care services, which also will compensate physicians for services provided remotely; and
- Create a process to identify misvalued services and redistribute savings on those services within the physician fee schedule.

While these 2 bills need to be reconciled through debate, the bill from the House Energy and Commerce Committee is somewhat different from the Senate Finance and House Ways and Means committee propos-

als (7). However, none of the bills have produced any policy for how to pay for the repeal of the SGR which now is estimated to cost \$116.5 billion for the next 10 years as per CBO without any increases and only payment freezes.

The House Energy and Commerce Committee bill, which passed unanimously on a bipartisan basis, also known as Medicare Patient Access and Quality Improvement Act of 2013, has the following principles for the reform:

1. Stabilizing the fee updates, the provision would repeal the SGR and replace it with a 5-year period of stable payments with annual inflationary baseline adjustments of 0.5%.
2. Quality Update Incentive Program (QUIP). The period of transition from 2014 to 2018 would end with implementation of an enhanced Physician Quality Reporting System (PQRS) which would link payments to provider excellence in the delivery of high quality care. All providers who meet or exceed their specialty specific benchmark could receive a positive update of 1.5% per year.

The Energy Commerce Committee draft also includes an advance in alternate payment models by choice. Eligible professionals at any time could choose to opt out of the FFS program and participate in alternative payment models. These alternative payment models would include, but would not be limited to, the following: patient-centered medical homes, specialty models, and bundles or episodes of care.

All 3 proposals contain many elements similar as shown in Table 1. Thus, one might think that there is

Table 1. Comparison of 3 legislations proposed to repeal SGR.

	SGR Repeal and Medicare Beneficiary House Ways and Means Committee	Medicare Patient Access and Quality Improvement Act of 2013 H.R. 2810 House Energy and Commerce Committee	SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013 Senate Committee Finance
Repeal	Yes	Yes	Yes
Freeze Payments	Yes	Yes	Yes
Positive Updates	0.5% 2014 to 2016	0.5% 2014 to 2018	None
Alternate Payment Models	Yes	Yes	Yes
Funding	\$125 million	\$150 million	\$125 million
Value-Based Performance Payment Program Which Includes Meaningful Use	Physical Quality Reporting System and Value-Based Modifier	Physical Quality Reporting System and Value-Based Modifier	Physical Quality Reporting System and Value-Based Modifier
Complex Chronic Care Services	Yes	Yes	Yes
Identification of Misvalued Services and Redistribution of Savings	Yes	Yes by improving accuracy of relative values	Yes

more unity in thinking about how best to reform physician reimbursement than has existed in a long time. However, there still may be multiple hurdles including the payment which is a fiscal matter to reconcile between conservative republican house and relatively moderate democratic senate. Other issues revolve around alternative payment systems to receive increased reimbursement. However, this appears to be redundant as the ACA incorporates many regulations in it. Consequently, Congress may look into eliminating alternative payment care options. There may be more promise for repeal of the SGR in 2014 than there has been in the last decade during which Congress has engaged each year in the year-end ritual. However, when considering numerous factors always at work in Washington, nothing can be assumed.

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AUTHOR AFFILIATIONS

Dr. Manchikanti is Medical Director of the Pain Management Center of Paducah, Paducah, KY, and Clinical Professor, Anesthesiology and Perioperative Medicine, University of Louisville, Louisville, KY.

Dr. Falco is Medical Director of Mid Atlantic Spine & Pain Physicians, Newark, DE; Director, Pain Medicine Fellowship Program, Temple University Hospital, Philadelphia, PA; and Adjunct Associate Professor, Department of PM&R, Temple University Medical School, Philadelphia, PA.

Dr. Hansen is Medical Director, Pain Relief Centers, Conover, NC.

Dr. Hirsch is Vice Chief of Interventional Care, Chief of Minimally Invasive Spine Surgery, Service Line Chief of Interventional Radiology, Director of Endovascular Neurosurgery and Neuroendovascular Program, Massachusetts General Hospital; and Associate Professor, Harvard Medical School, Boston, MA.

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Conflict of Interest

Dr. Falco is a consultant for St. Jude Medical Inc. and Joimax Inc.

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