

SGR: What Is It, Why Is It Important, and What Does It Mean for Ophthalmology?

AN INTERVIEW WITH MICHAEL X. REPKA, MD

The prospect of the sustainable growth rate (SGR) formula being enforced by Congress has loomed for well over a decade. The SGR threatens to drastically affect physician reimbursement through Medicare, yet Congress has refused to allow the modifier to come into play. No alternate solutions have made it to federal legislative floors for a vote, and doctors have been forced to practice medicine under a certain uncertainty whether they will be able to afford to provide care for patients.

To gain insight into just how ominous the threat of the SGR is for physicians—and for ophthalmologists in particular—*Retina Today* interviewed Michael X. Repka, MD, who serves as Medical Director for Governmental Affairs with the American Academy of Ophthalmology (AAO).

Retina Today: What is the SGR and why is it an important factor in conversations about reimbursement?

Michael X. Repka, MD: The SGR is a formula created by Congress, designed to try to control the growth of Medicare spending. Historically, it is the second such formula created for this purpose, the first being the Medicare Volume Performance Standard (MVPS), which was created at the institution of the Resource-Based Relative Value System (RBRVS). That mechanism did not really work, so Congress came up with the SGR.

Basically, the SGR is a modifier placed on reimbursement based on prior year expenditure. It is an artificial device to control spending growth. If the SGR were to come into play and the expenditures per beneficiary exceeded the rate of growth in gross domestic product for a given year, then a

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modifier would be placed the following year on Medicare reimbursement to cap the rate of growth. Within the formula, there are adjustments for the number of beneficiaries and for technology growth. However, the rate of growth in expenditure per beneficiary has far exceeded what was expected when the SGR was envisioned, and, as a result, the modifier would severely and dramatically slash reimbursement levels, probably to a level at which providers might deem it unsustainable to participate in Medicare. Congress has sort of kicked the can down the road on the SGR for a number of years, in effect delaying its institution while it searches for a new mechanism to control costs.

RT: Why is it important for ophthalmologists to be aware of the SGR and its potential to modify reimbursement?

Dr. Repka: Because ophthalmology is second only to geriatrics in the percent of average office income, or revenue, dependent upon Medicare. And Medicare is controlled by the SGR, so we ophthalmologists are a particularly vulnerable specialty to the SGR.

HOUSE PASSES SGR REFORM BILL, SENATE TO VOTE FOLLOWING RECESS

In a move anticipated for over a decade, the House of Representatives has approved legislation that would repeal the Standard Growth Rate (SGR) formula, replacing the spending cap measure with a new algorithm that ties compensation to quality improvement initiatives to counteract the rising cost of health care delivery.

H.R. 2 Medicare Access and CHIP Reauthorization Act of 2015, which would also extend Children's Health Insurance Program (CHIP) for two years, passed the House by an overwhelming 392 to 97 vote on March 27. The measure, which raises reimbursement rates 0.5% in the last half of 2015 and annually through 2019, gained bipartisan support in the House; however, the Senate adjourned for recess before voting on the bill. The Senate is scheduled to reconvene on April 13.

According to the Congressional Budget Office, the new formula could add as much as \$141 billion to the nation's deficit between 2015 and 2025. As well, some of the expense associated with rising costs of health care would be offset by higher premiums based on beneficiaries' modified gross income. Under the measure, individuals making between \$133 501 and \$160 000 would see a 50% to 65% rise in premiums; individuals with annual incomes of \$160 001 or greater and couples with an annual income of at least \$320 001 would see an 80% rise in premiums.

The bill would limit Medigap coverage only to costs that exceed the Part D deductible starting in 2020. Currently, Medicare beneficiaries are eligible to have deductibles and copayments covered by Medigap so as to limit out-of-pocket expenditures.

The nonvote by the Senate effectively triggers the scheduled cuts to reimbursement effective April 1. However, if the Senate votes when it returns to sessions on April 13, and if the measure receives the President's signature by April 14, physicians would avoid the 21% reimbursement cut mandated by the technically still active SGR: The Centers for Medicare and Medicaid Services (CMS) cannot pay electronic claims sooner than 14 calendar days after receipt (29 days for hard copy claims), and so prompt action would allow CMS to cancel the 21% rate reduction for services performed after March 31.

RT: Have there been any projections on how much potential impact the SGR might have on pay structures at the individual level, or even at the macro level?

Dr. Repka: If the SGR had been implemented, we would have payment rates about 25% less than we have today. What has happened, of course, is that Congress has not let the SGR impact go into effect over the past decade. But

the SGR and the prospect of its implementation have been influential on medicine. Although the economy has not slowed down, and although the cost of living and doing business has not decreased, doctors have basically had to accept no change in payments for more than a decade. Important in all of this is that hospitals and institutional medicine have seen increases. There has been an increase in reimbursement for medical devices. Nursing or extended care facilities have gotten increases. But individual physicians have been affected by this peculiar cost-containment maneuver.

RT: What exactly do you mean when you say that Congress has not let the SGR be enforced?

Dr. Repka: The SGR and whether it is enforced are legislative branch issues. In its annual funding bills over the past decade, Congress has written in provisions to halt the implementation of the SGR. They have mostly offered "no update," meaning no pay increase, or they may offer a modest increase, as they did last year in according a 0.5% increase. But these are all patches and do not serve to fix, modify, or replace the SGR formula.

RT: Realistically speaking, what is the potential for the SGR to take effect?

Dr. Repka: We are facing about a 25% reduction in fees if the Centers for Medicare and Medicaid Services (CMS) is forced to reduce the fee structure on April 1. Based on historical precedent, it seems unlikely that it will happen, and we can hope that holds true because this would be a huge percentage decrease. But we ultimately do not know what will happen, whether there will finally be a proposal to fix the formula or replace it, whether Congress might adopt part of the cuts, or something else altogether.

RT: Have there been any alternative structures or economic models for capping expenditures proposed by Congress or other interested parties?

Dr. Repka: I am sure there are many economic models, but none of them has been thoroughly tested. However, one of the trends of health care reform has been an interest in what has been termed alternative payment models, which includes incentives to spur investments in accountable care organizations, bundled payments, episode groupers, medical homes, and the like. However, that is a move that winds up putting the onus for cost containment on the provider, when what we really need is a way to put that responsibility on not just doctor, the patient, and the

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