

*Medicare's Physician Payment System and the Sustainable Growth Rate (SGR)*

**Jessica Farb**

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# Roadmap

- Basics of Medicare physician payment
- Mechanics of the Sustainable Growth Rate (SGR)
- Implications of SGR
- Alternative approaches to SGR

# Physician Payment Basics

# Medicare Pays Physicians for Each Service Provided According to a Fee Schedule

- The physician fee schedule (PFS) replaced the previous reasonable charge method in 1992.
- The fee schedule is based on a resource-based relative value scale (RBRVS).
- Over 7,000 services including office visits, surgical procedures and diagnostic tests, are covered by the fee schedule.
- For most services, Medicare pays 80 percent and the beneficiary (or the beneficiary's supplementary insurance) pays 20 percent.
- Non-physician providers such as nurse practitioners, physician assistants, physical therapists, and psychologists also bill Medicare for Part B services under the PFS.

# Physician Payment Formula

$$\text{Payment} = \text{RVU} \times \text{Geographic adjustment} \times \text{Conversion factor}^*$$

**Relative Value Unit (RVU)** Reflects relative cost of physician service

**Geographic adjustment** Accounts for geographic variation in the cost of providing physician services

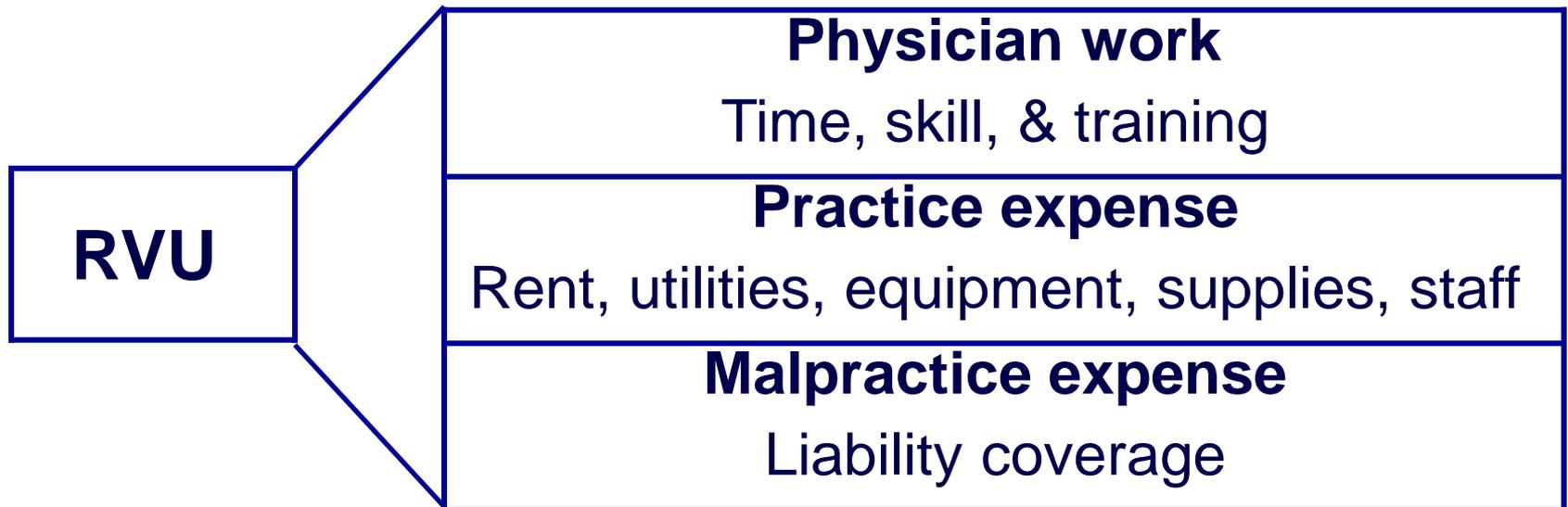
**Conversion factor** Converts adjusted RVUs into dollar amounts

**\*Other adjustments** e.g., Non-physician providers, Health Professional Shortage Areas

Note: The formula shown is a simplified version of the payment formula.

# Nationally Uniform Relative Value Units

- Under the RBRVS, each physician service is given a weight that measures its relative costliness
- The weights, known as relative value units (RVUs), have 3 components:



# Geographic Adjustment

- Geographic Practice Cost Indices (GPCIs) adjust fees for geographic variation in practice costs.
- GPCIs have the same three elements as RVUs—physician work, practice expense, and malpractice.
- There are 89 separate geographic areas with their own GPCIs.
- These areas can consist of an entire state, large urban areas, or portions of states.

# Conversion Factor

- A single conversion factor is applied to all services covered by the fee schedule.
- From January 1, 2015 – March 31st, the conversion factor is \$35.7547.
- From April 1, 2015 – December 31st, the conversion factor is scheduled to be \$28.2239.
- The conversion factor is updated each year under the sustainable growth rate (SGR) system.

# Physician Payment: Example 1

## Office visit, detailed (established patient)

- Procedure code 99213
- Performed by Washington DC physician in a non-facility setting

**RVU x Geographic adjustment x Conversion factor**

$$2.04 \times 1.134 \times \$35.7547$$
$$= \underline{\underline{\$82.71}}$$

Notes: This example is based on current payment rates effective January 1, 2015. To simplify the calculation, the work, practice expense, and malpractice GPCIs were collapsed into one geographic adjustment factor.

# Physician Payment: Example 2

## Office visit, detailed (established patient)

- Procedure code 99213
- Performed by Washington DC physician in a facility setting

**RVU x Geographic adjustment x Conversion factor**

$$1.43 \times 1.134 \times \$35.7547$$
$$= \underline{\underline{\$57.98}}$$

Notes: This example is based on current payment rates effective January 1, 2015. To simplify the calculation, the work, practice expense, and malpractice GPCIs were collapsed into one geographic adjustment factor.

# Physician Payment: Example 3

## Knee arthroscopy/surgery

- Procedure code 29850
- Performed by Washington DC physician in a facility setting

**RVU x Geographic adjustment x Conversion factor**

$$18.01 \times 1.134 \times \$35.7547 \\ = \underline{\underline{\$730.23}}$$

Notes: This example is based on current payment rates effective January 1, 2015. To simplify the calculation, the work, practice expense, and malpractice GPCIs were collapsed into one geographic adjustment factor.

# Physician Payment: Example 4

## Knee arthroscopy/surgery

- Procedure code 29850
- Performed by West Virginia physician in a facility setting

**RVU x Geographic adjustment x Conversion factor**

$$18.01 \times 0.954 \times \$35.7547$$
$$= \underline{\underline{\$614.42}}$$

Notes: This example is based on current payment rates effective January 1, 2015. To simplify the calculation, the work, practice expense, and malpractice GPCIs were collapsed into one geographic adjustment factor.

# Other Fee Schedule Adjustments

- **Participation**
  - **Participating physicians** agree to accept Medicare's fee schedule payment as payment in full.
  - **Non-participating physicians** are paid 95 percent of the fee schedule, but may charge beneficiaries a limited additional amount—this practice is called balance billing.
- **Non-physician providers**
  - Generally paid 85 percent of the physician fee schedule.
  - Not permitted to balance bill.

# Medicare Physician Bonus Programs

- **Shortage Areas**

- Physicians providing Medicare-covered services in a designated Health Professional Shortage Area (HPSA) are eligible for a 10 percent bonus payment on a quarterly basis.
- General surgeons providing major surgical services in a HPSA are eligible for both a 10 percent HPSA bonus and a 10 percent HPSA Surgical Incentive Payment (HSIP).

- **Primary Care**

- Physicians practicing family, internal, geriatric, or pediatric medicine and clinical nurse specialists, nurse practitioners, and physician assistants who provide a majority of designated primary care services are eligible for a 10 percent bonus on a quarterly basis.

# Medicare Incentive Programs

- **Physician Quality Reporting System (PQRS) program**
  - From 2011 to 2014, provided incentive payments of 0.5 to 1 percent of allowed charges to physicians (and other practitioners) for satisfactorily reporting on quality measures.
  - Starting in 2015, eligible professionals who do not satisfactorily report quality measures will be subject to a penalty starting at 1.5 percent of their Medicare payments.
- **Electronic Health Record (EHR) program**
  - From 2011 to 2014, provided incentive payments of up to a maximum over the 5 years of \$44,000 to physicians when they adopt EHRs and demonstrate “meaningful use.”
  - Starting in 2015, eligible physicians who do not satisfy the EHR criteria are subject to a penalty starting at 1 percent of their Medicare payments.
- **Electronic Prescribing (eRx) program**
  - From 2009 to 2011, provided incentive payments of 1 percent of allowed charges to prescribing physicians and other professionals who used a qualifying eRx system and did not receive incentive payments under the EHR program.
  - Starting in 2012, eligible professionals who have not met the eRx criteria and who cannot demonstrate “hardship” were subject to a penalty starting at 1 percent of their Medicare payments.
- **Value-Based Modifier (VBM) program**
  - Will adjust Medicare payments to some physicians in 2015 and to all physicians in 2017 on the basis of the quality and cost of care provided.
  - CMS will use performance information on quality metrics submitted under PQRS and cost metrics derived from Medicare claims.
  - The law requires the program to be budget neutral so the size of upward adjustments depend on the total sum of negative adjustments in a given year.

# Why Physician Spending Targets?

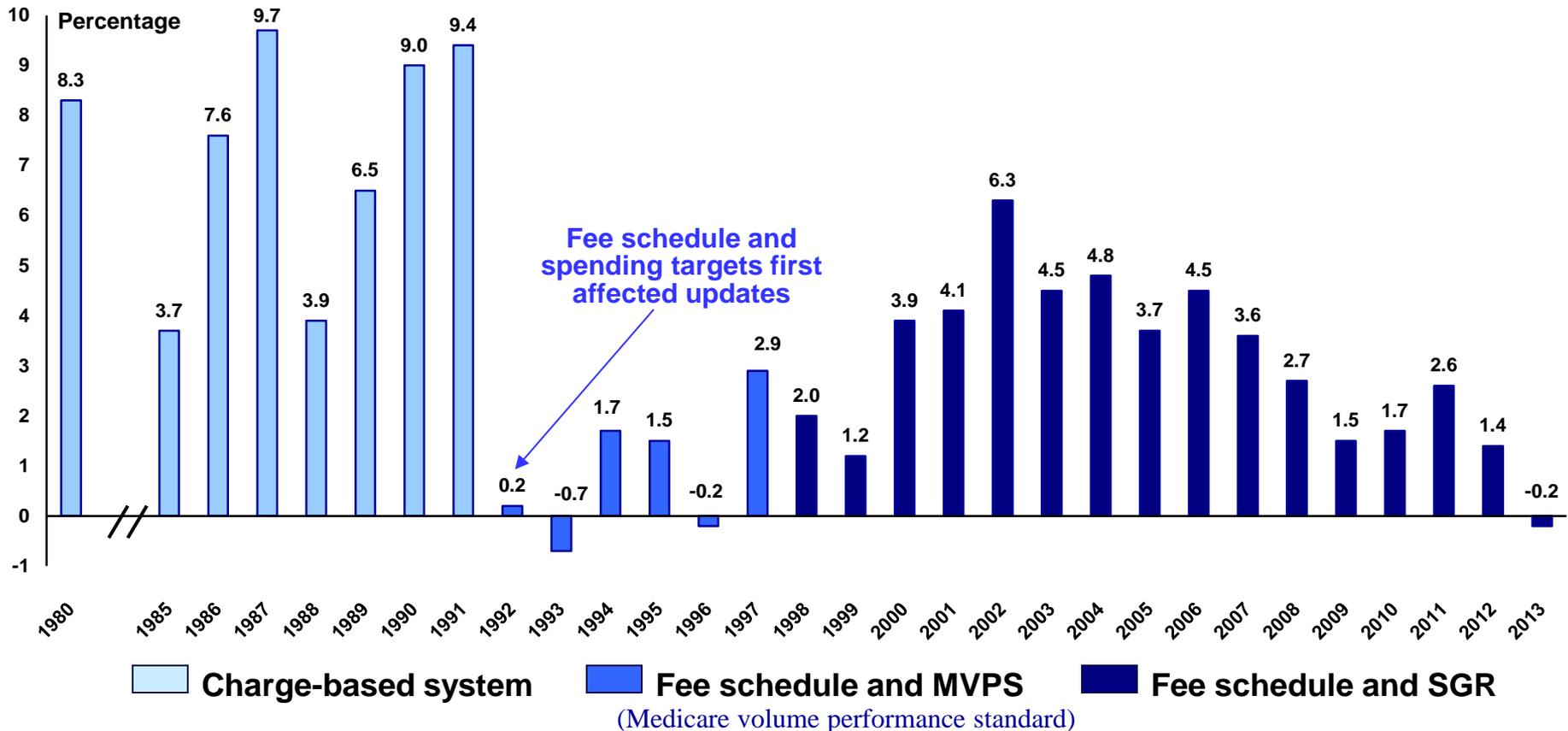
# The Case for SGR

- Total Medicare spending for physician services grew rapidly from 1980 through 1990 at an average annual rate of 13.4 percent.
- Much of the spending growth in the 1980s resulted from increases in the volume (or number) and intensity (or complexity) of services provided per beneficiary.
- Congress created SGR (and its predecessor) to constrain this rapid physician spending growth.

# The Case for SGR

- In 1989, the Secretary of HHS cited the need for spending targets to constrain spending growth for physician services. He noted that:
  - past efforts to control such spending had not been successful;
  - an RBRVS system alone would not control volume and may exacerbate the current spending trajectory; and
  - the administration opposed implementation of the RBRVS-based fee schedule unless it was linked to an expenditure target.

# Growth in Volume and Intensity of Medicare Physician Services Per FFS Beneficiary, 1980-2013



Source: Data from CMS and the Boards of Trustees of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds.

# SGR in Theory

# SGR's Four Factors

- SGR accounts for factors that one would expect to affect spending growth:
  - increases in input prices
  - changes in FFS enrollment, and
  - changes in spending due to laws and regulation.
- In addition, SGR allows spending to grow with the economy—real GDP per capita.
- This additional factor was intended to allow for some growth in the volume and intensity of services.

# Normal Update Process

- The Medicare Economic Index or MEI (which measures the estimated increase in the average costs physicians incur to provide services) serves as the baseline for each year's payment calculation.
- To arrive at a fee update, the MEI is adjusted based on the relationship between cumulative actual spending and a cumulative target.
  - If cumulative actual spending is equal to the cumulative target, the fee update will be equal to the MEI.
  - If cumulative actual spending is not equal to the cumulative target, then an update adjustment factor (UAF) is used to increase or decrease the fee update relative to MEI.
- The UAF is constrained so that the update cannot be set more than 3 percentage points above or 7 percentage points below MEI.

# The Fee Update is Determined in Part by Spending Targets and the Medicare Economic Index (MEI)

Spending Compared to Target	Update Compared to the MEI	
Above		Below
Equal		Equal
Below		Above

## SGR Compares Actual Spending to Allowed Spending Target

Time Period	Actual Spending <sup>a</sup> (\$ billions)	Allowed Spending <sup>a</sup> (\$ billions)	Actual Compared to Allowed Spending <sup>a</sup> (\$ billions)
1996-2014 <sup>b</sup>	\$1,443.8	\$1,447.4	\$3.6
2014	\$103.3	\$108.3	\$5.0

<sup>a</sup>CMS Office of the Actuary estimate as of November 2014.

<sup>b</sup>April 1, 1996 through December 31, 2014.

Source: CMS

# SGR in Practice

# Trends in the Updates

- The SGR was permitted to work per statute from 1998-2002.
- Congress has overridden reductions in fees every year beginning in 2003.
- To try to maintain budget neutrality over a 10-year window for these overrides Congress has used either a “clawback” or “cliff” approach.

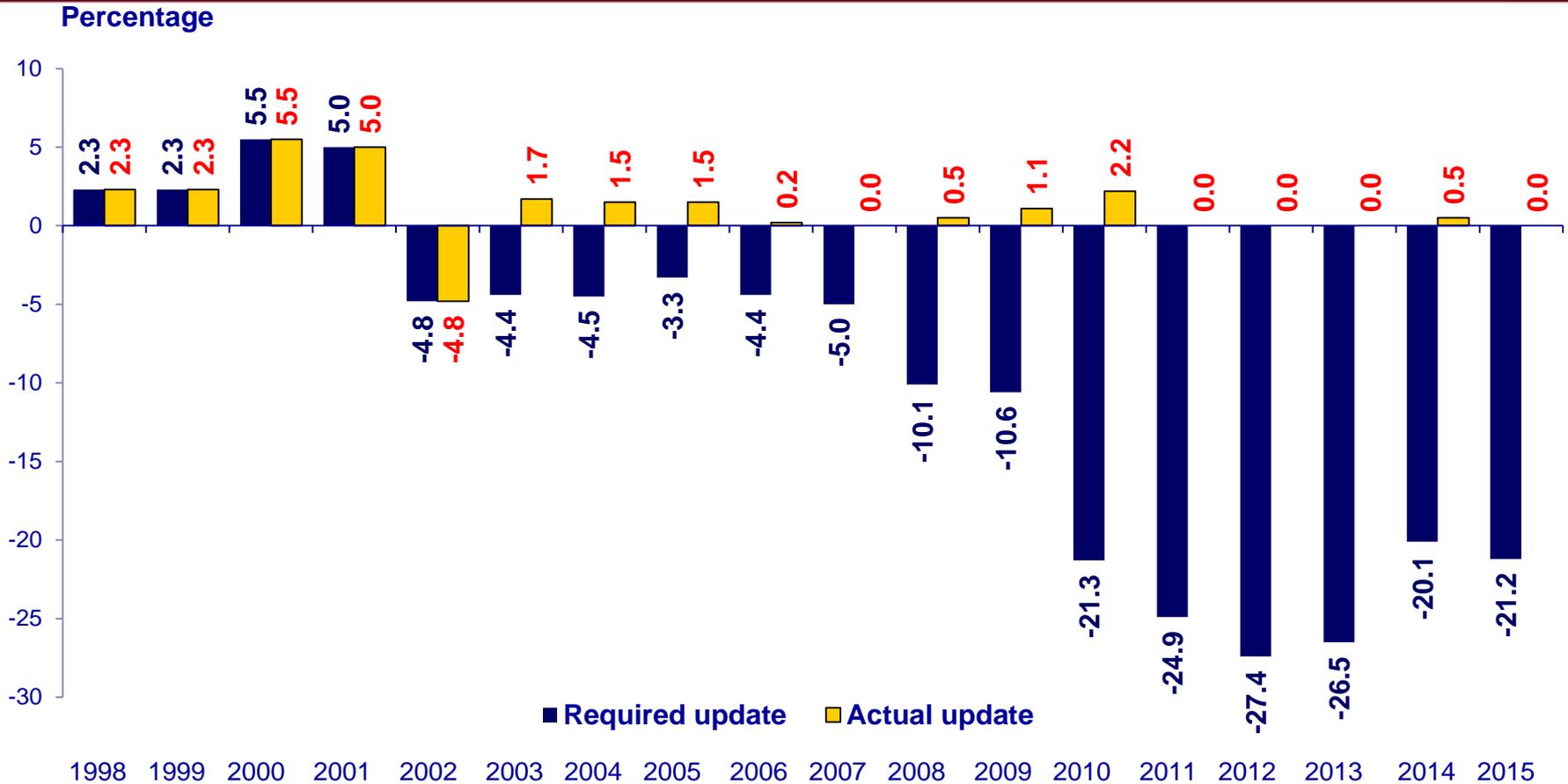
# Clawback Approach (2004-2006)

- The clawback mechanism temporarily overrides the SGR determined update and recoups the associated additional spending within the 10-year budget window.
- Under this approach:
  - spending grew faster in the short run relative to the baseline than it otherwise would have
  - more and more of the subsequent years after the temporary override were subject to the maximum reduction of MEI minus 7 percentage points (about a -5 percent update each year)
  - eventually the cost of a one-year patch could not be recouped within the 10-year budget window, even with 9 years of negative 5 percent updates

# Cliff Approach (2007-2014)

- The cliff mechanism overrides SGR's maximum payment reduction (MEI minus 7 percentage points) in the year following a temporary payment increase or freeze and specifies that the next payment rate update is calculated as if that temporary patch had not been enacted.
- Under this approach:
  - Very large reductions in the year following the short-term adjustment have been projected.
  - The recent annual projections of negative updates greater than 20 percent reflect the cumulative effect of all reductions called for under the SGR formula since 2007.
  - Annual targets and payment rates for the cliff year differ from the amounts called for under current law and reflected in the CBO baseline.

# Actual Updates Compared to Required Updates, 1998-2015



Source: Data from the Boards of Trustees of the Federal HI and SMI Trust Funds, CMS Office of the Actuary, and Congressional Research Service.

Notes: Beginning with 2008, required updates are a result of both the SGR formula and legislative changes. In 2003 and 2010, the increase became effective on March 1st and June 1st, respectively. In 2015, the 0 percent update is in effect through March 31st; After that, a 21.2 percent cut is set to take effect.

# Paying for Temporary Patches: Example of 2013 Override

- In November 2012, CBO estimated that replacing the 26.5 reduction in physician payment rates with a freeze or 0 percent update for 2013 would “cost” **\$25.2 billion** over 10 years.
- Through the American Taxpayer Relief Act (Public Law 112–240) Congress replaced the fee reduction and “paid for” the policy change through several health-care related offsets.
- As with previous years, significant savings were derived from changes to Medicare payment policies affecting hospitals.

# Examples of Potential SGR Pay-fors in the American Tax Relief Act of 2013

Provision	Affects physicians	Estimated 10-year savings (billions)
Documentation and coding adjustment for inpatient hospitals	No	10.5
Revisions to the Medicare End-Stage Renal Disease (ESRD) payment bundle	No	4.9
Payment for certain radiology services furnished in hospital outpatient departments	No	0.4
Adjustment of equipment utilization rate for advanced imaging services	Yes	0.8
Medicare payment of competitive prices for diabetic supplies	No	0.6
Medicare payment adjustment for non-emergency ambulance transports for ESRD beneficiaries	No	0.4
Medicare Advantage Coding and Intensity Adjustment	No	2.5
Elimination of the Medicare Improvement Fund	Maybe	1.7
Rebasing of State Disproportionate Share Hospital (DSH) allotments	No	4.2
<b>Total</b>		<b>26.0</b>

Source: CBO, January 9, 2013

# Implications of SGR

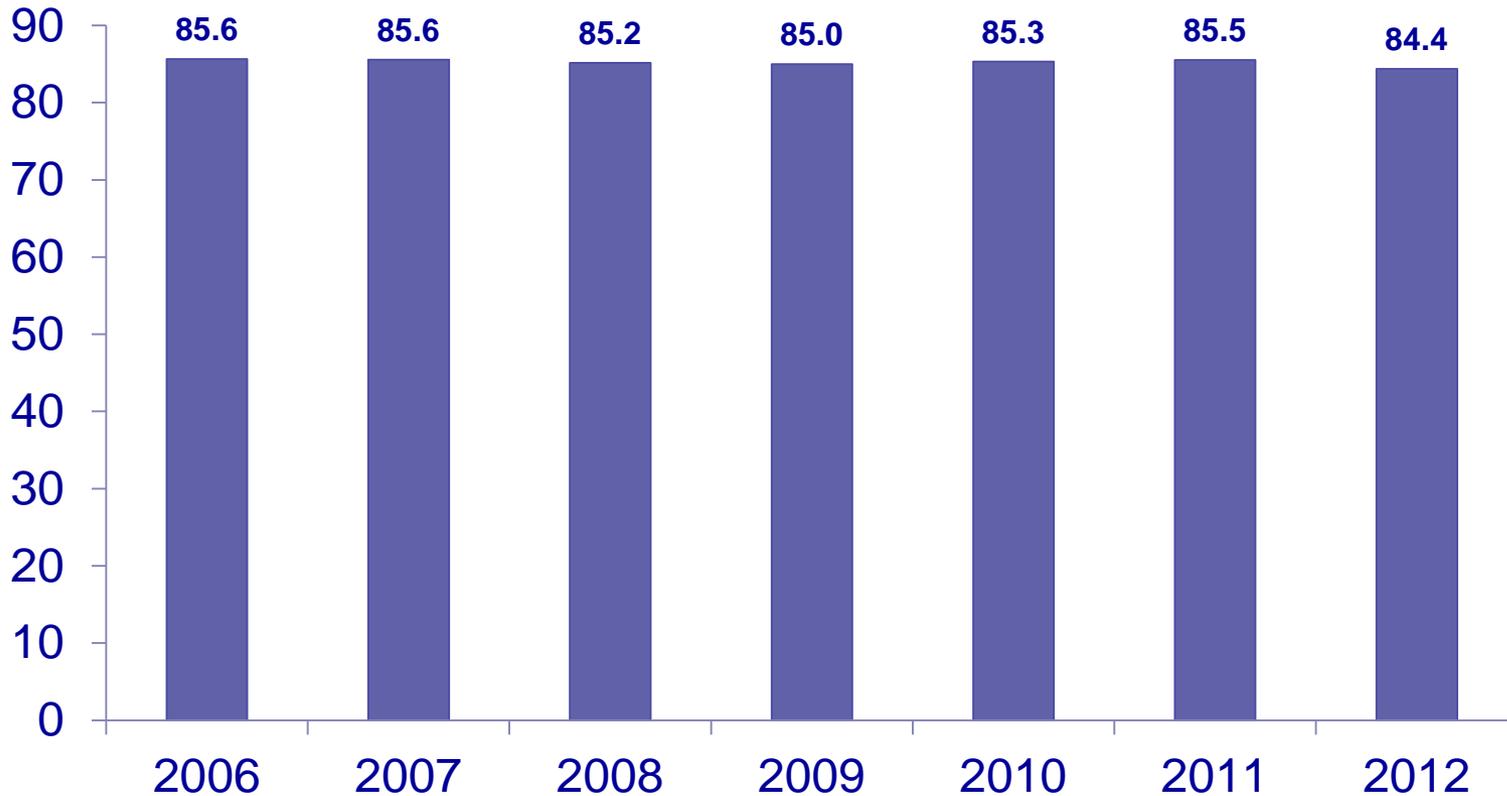
# How has beneficiary access been affected?

## Measures of access to physician services are positive:

- GAO found that from 2000 through 2008:
  - the proportion of beneficiaries receiving services generally increased in the aggregate and in both urban and rural areas;
  - the number of services provided per beneficiary generally increased in the aggregate and in both urban and rural areas; and
  - physicians appeared willing to accept Medicare patients.
- Since 2008, MedPAC has consistently reported that most Medicare beneficiaries have reliable access to care, including:
  - the ability to schedule timely appointments;
  - the ability to find a new physician; and
  - provider willingness to accept new Medicare patients.
- Results from national patient surveys—the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Medicare Current Beneficiary Survey (MCBS)—demonstrate that most beneficiaries:
  - have access to a usual source of care;
  - face few difficulties obtaining care; and
  - can get timely access to routine care.

# Percentage of Medicare Beneficiaries Reporting a Doctor's Office/Clinic as Their Usual Source of Care

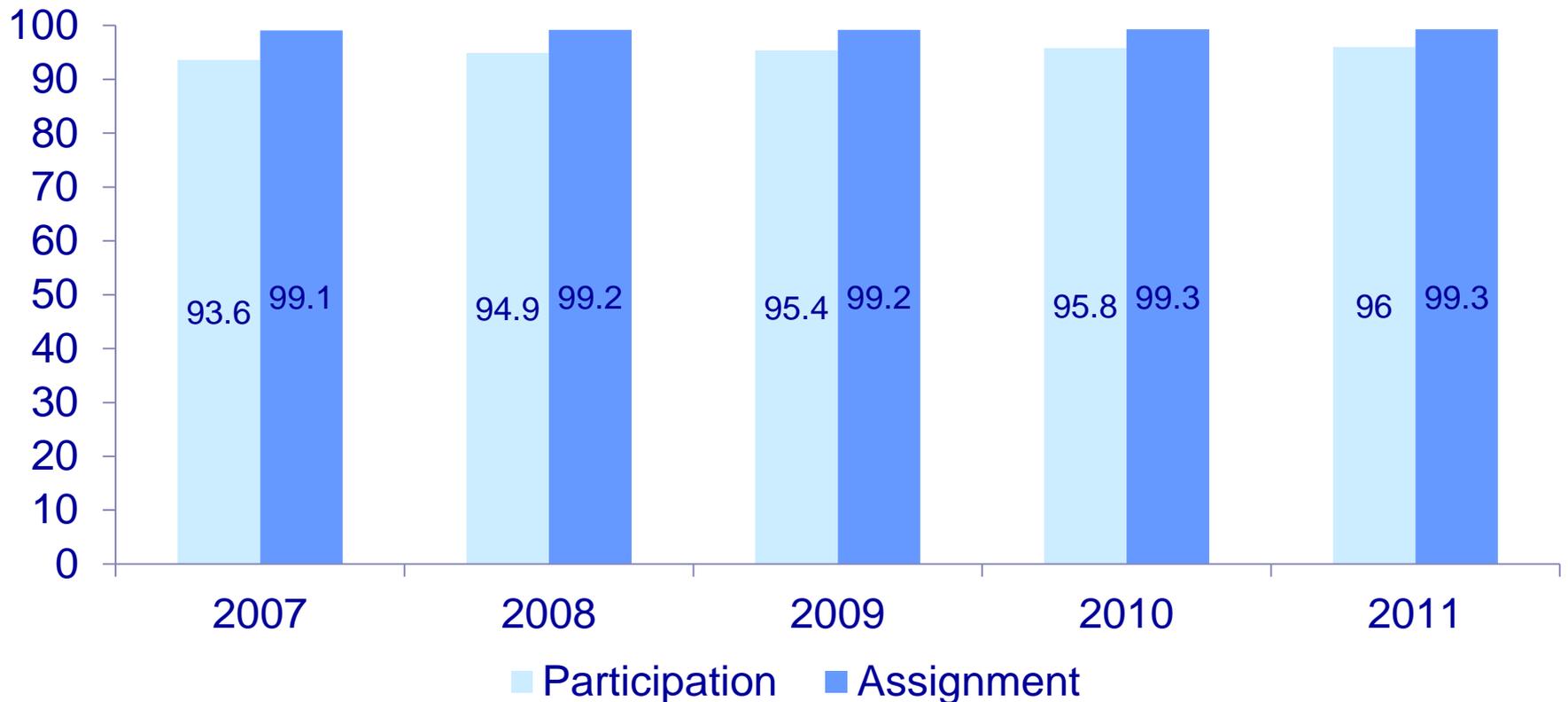
Percentage



Source: Medicare Current Beneficiary Survey Data Tables 2006-2012

# Physician Participation and Claims Assignment Rates

Percentage

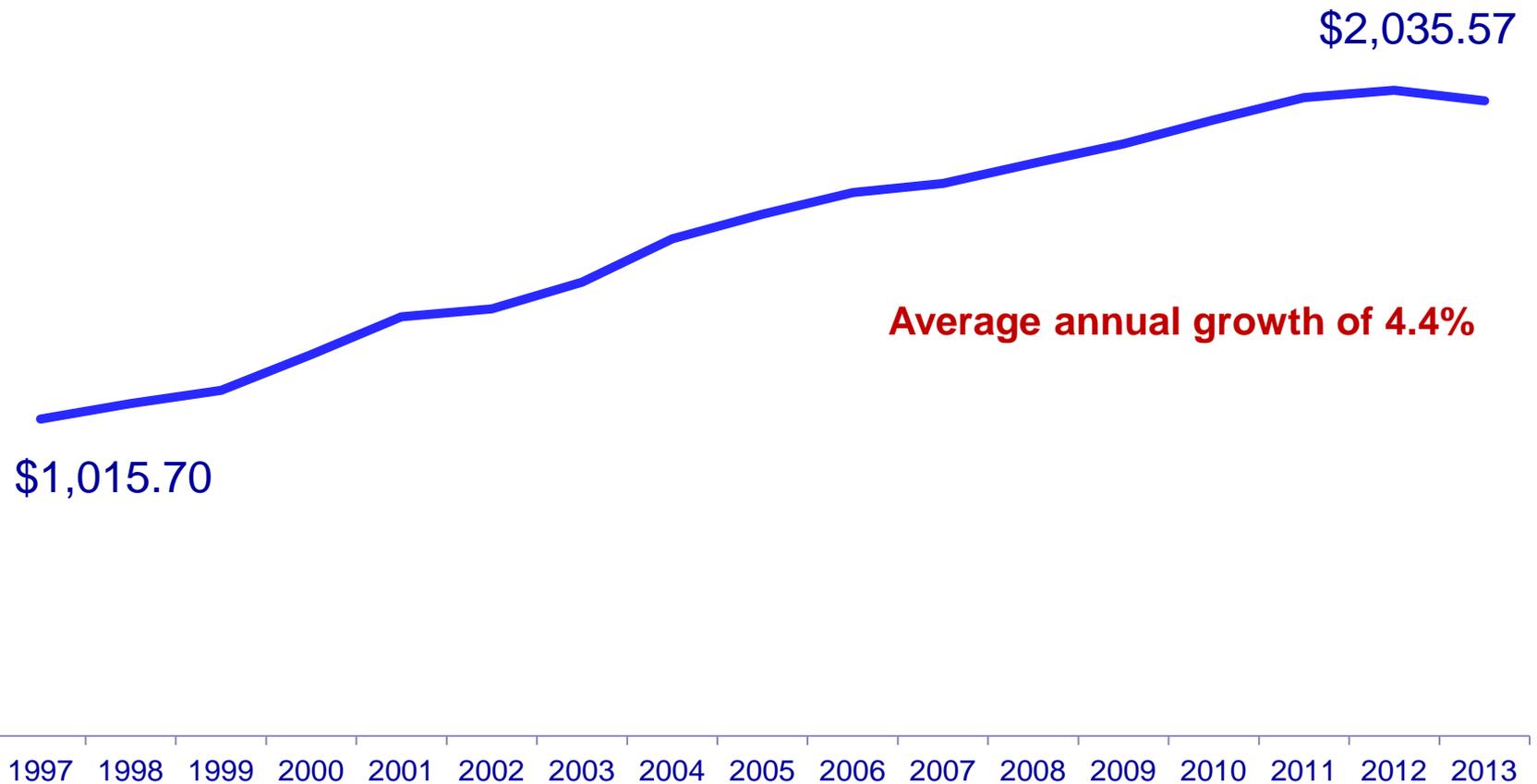


Source: CMS Data Compendium 2011

# How has physician spending been affected?

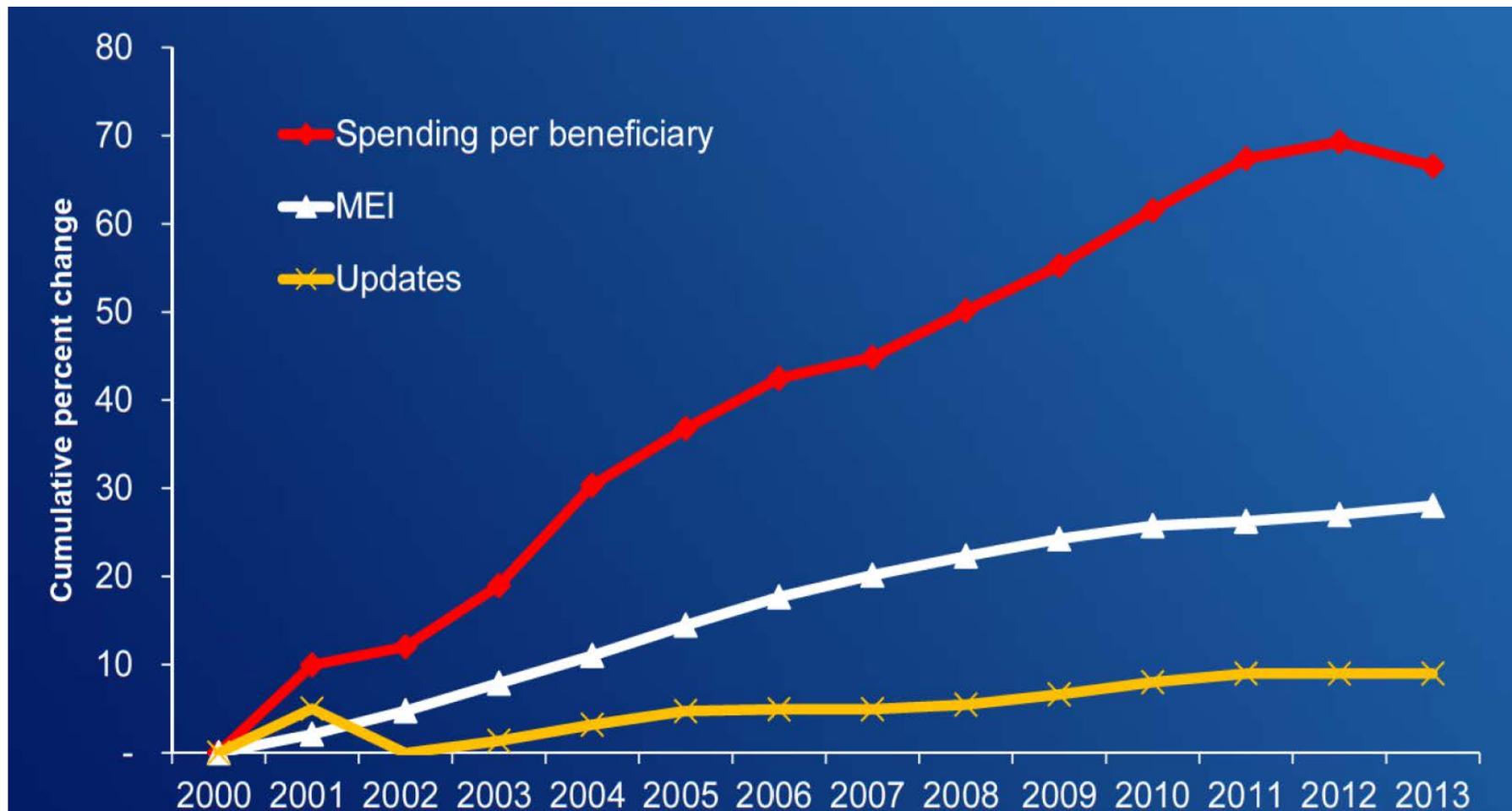
- Since implementation of the SGR, spending per beneficiary has grown on average by 4.4 percent annually.
- According to the Medicare Trustees, much of this spending growth is due to increased volume and intensity, greater use of specialists, the aging of the Medicare population, and certain administrative actions.

# Average Annual Spending Per Beneficiary on Physician Services Slowing



Source: Data from the Boards of Trustees of the Federal HI and SMI Trust Funds.

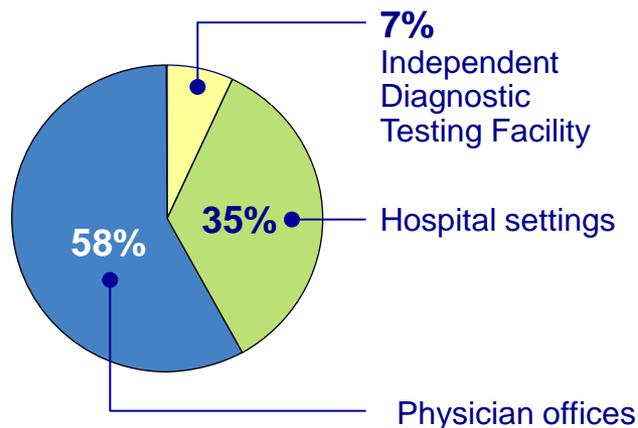
# Increased Volume Growth Has Impacted Physician Spending More than Input Prices and Payment Updates, 2000-2013



Source: MedPAC, December 18, 2014 presentation (data are preliminary)

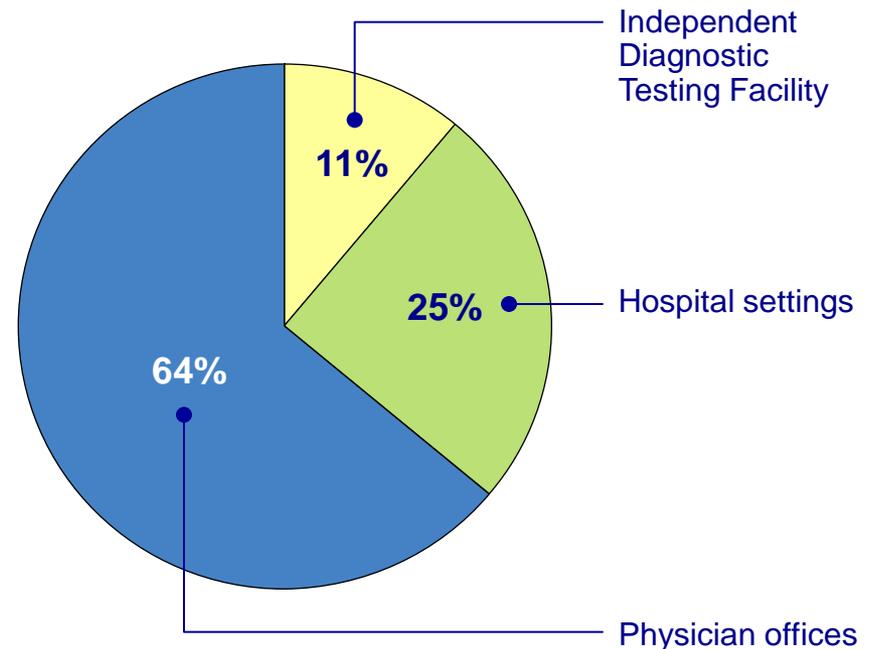
# Physicians Deriving Increasing Share of Revenue from In-Office Imaging

2000 Medicare Part B imaging spending



Total: \$6.89 billion

2006 Medicare Part B imaging spending



Total: \$14.11 billion

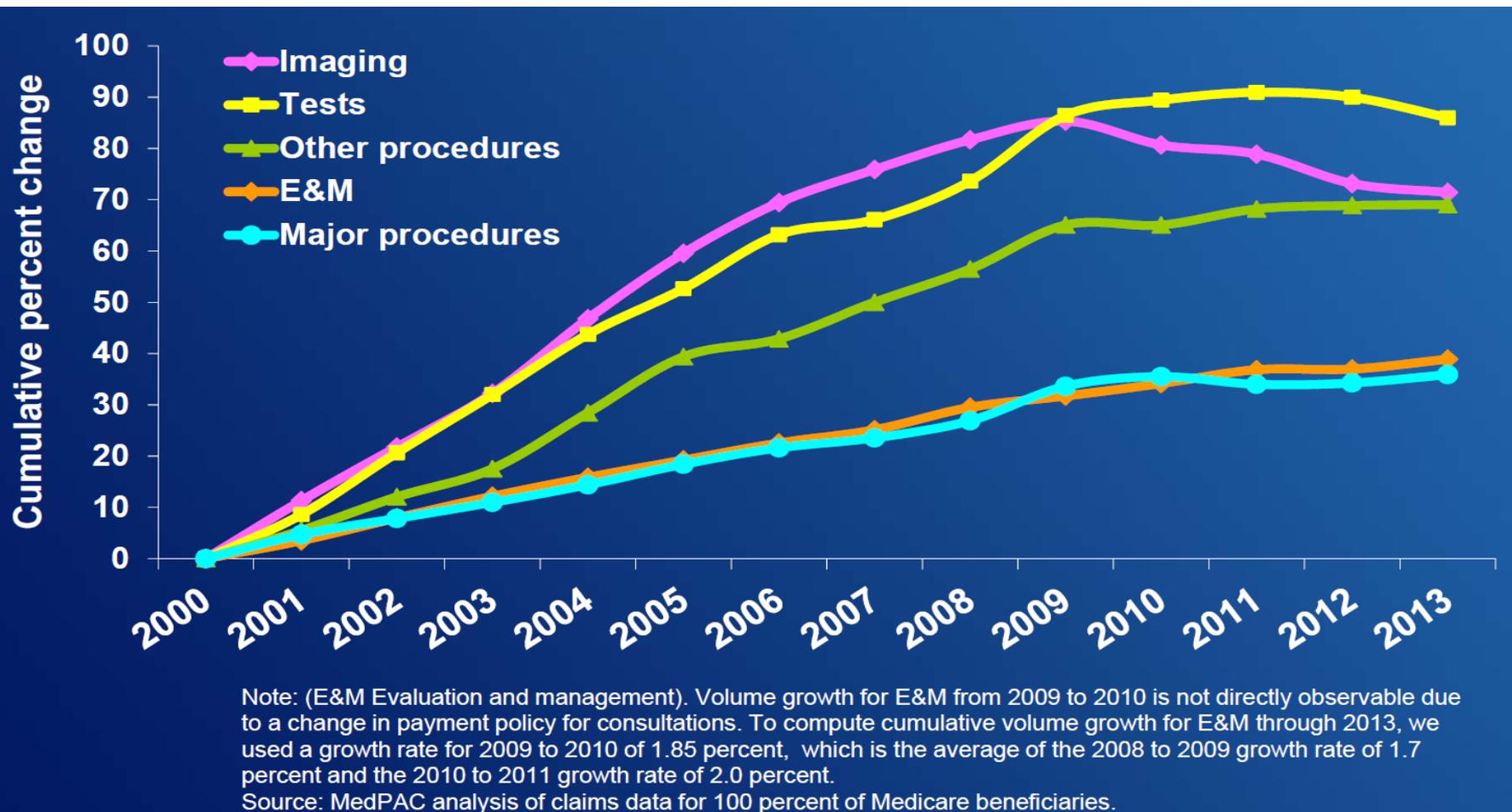
Source: **GAO-08-452** *MEDICARE PART B IMAGING SERVICES: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices*

# Trends in Physician Self-Referral for Advanced Imaging

Change in the Average Number of MRI and CT Services Referred, 2008 and 2010				
Provider referral type	Number of providers	Average 2008 referred MRI services	Average 2010 referred MRI services	Percentage change, 2008 to 2010
Switchers	2,803	25.1	42.0	67.3
Non-self-referrers	199,102	20.6	19.2	-6.8
Self-referrers	17,753	47.0	45.4	-3.4

Source: [GAO-12-966](#), *MEDICARE: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions*

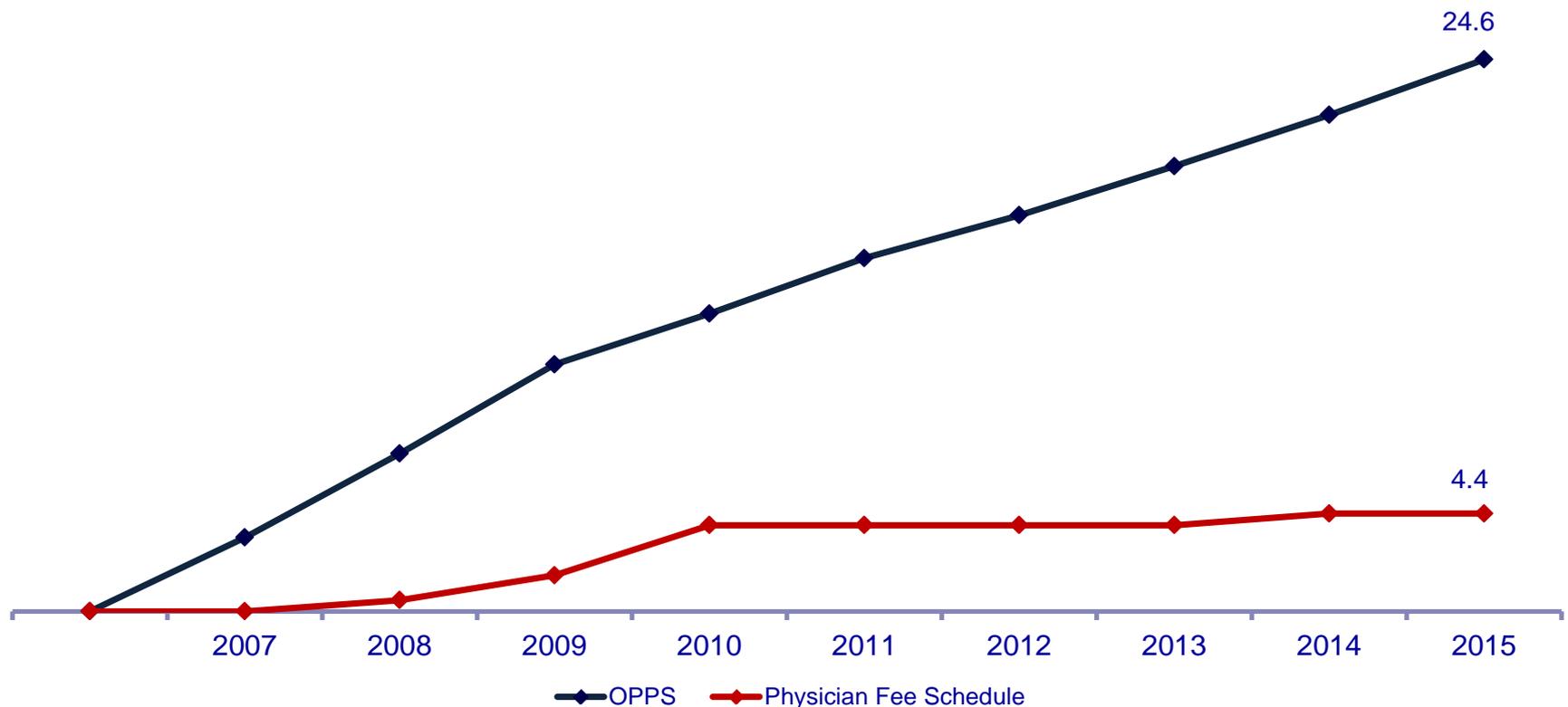
# Increased Volume Growth by Type of Service, 2000-2013



Source: MedPAC, December 18, 2014 presentation (data are preliminary)

# OPPS Payment Updates Have Outpaced PFS Updates

Cumulative Percentage Increase



Sources: OPPS Final Rules (2007-2015) and *Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2015*.

# SGR on Balance

## Positives:

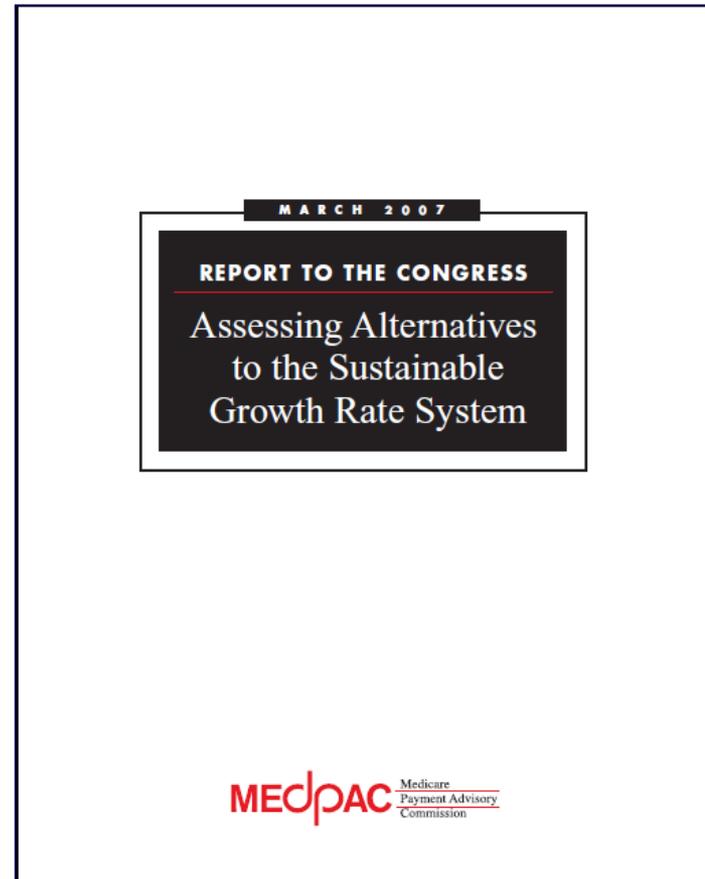
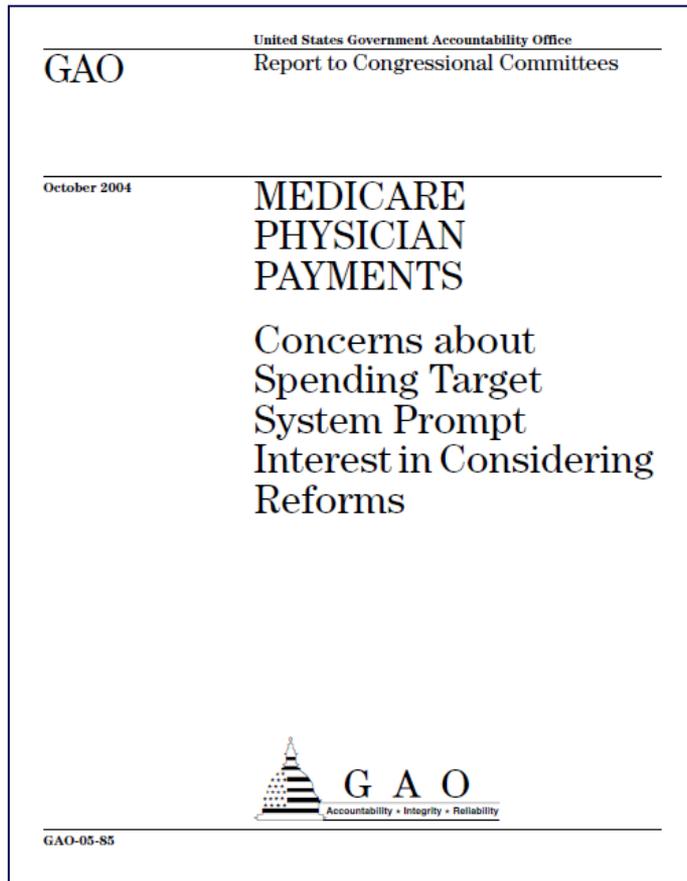
- Experience of 1990s was hopeful
- Without SGR, Medicare spending would have been higher
- SGR has kept Medicare (and larger health care) spending problem in full view

## Negatives:

- Limited effect on volume and intensity (no incentives for individual physicians to control spending growth)
- Blunt instrument (SGR doesn't differentiate between "good" and "bad" actors)
- System has been difficult for Congress to "live with" and has created annual uncertainty for physicians and beneficiaries

# SGR Alternatives/Solutions?

# Reports to Congress: GAO and MedPAC



# MedPAC Proposal, October 2011 (updated in April 2013)

The Commission recommended that Congress:

- Repeal SGR
- Replace it with statutorily specified differential updates:
  - 10-year freeze in payment updates for primary care providers
  - 3 years of -3.0 percent updates followed by a 7 year freeze for all other providers
- Require the Secretary to make refinements to the fee-schedule to increase accuracy through targeted data collection and reductions in payments for overpriced services
- Create additional incentives for participation in alternative payment models

The Commission also recommended a list of potential offsets to cover the cost of repealing and replacing SGR.

# Past Attempts

## **110<sup>th</sup> Congress:**

[Children's Health and Medicare Protection Act of 2007 \[H.R.3162\]](#)

## **111<sup>th</sup> Congress:**

[Medicare Physician Payment Reform Act of 2009 \[H.R.3961\]](#)

## **112<sup>th</sup> Congress:**

[Medicare Physician Payment Innovation Act of 2012 \[H.R.5707\]](#)

## **113<sup>th</sup> Congress:**

[The Medicare Patient Access and Quality Improvement Act of 2013 \[H.R.2810\]](#)

[The SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013 \[S.1871\]](#)

[The SGR Repeal and Medicare Provider Payment Modernization Act of 2014 \[H.R.4015/S.2000\]](#)

# Tri-Committee Bill

## The SGR Repeal and Medicare Provider Payment Modernization Act of 2014 [H.R.4015/S.2000]

- Repeals SGR and replaces with transitional annual updates of 0.5 percent for 5 years (2014-2018) followed by a fee freeze from 2019-2023
- Implements Merit-Based Incentive Payment System (MIPS) for fee schedule providers beginning in 2018
  - MIPS streamlines and improves on the three distinct current law incentive programs
  - performance on cost, quality, and other metrics could reduce or increase eligible professionals' payment updates substantially
- Encourages Alternative Payment Model (APM) participation either through existing or future provider-developed models that aren't reliant on FFS (e.g., ACOs, bundled payment demos, etc...)
- Other provisions include: expanded data availability for care improvement activities, additional care coordination activities, and data collection of practice costs for improving payment accuracy

# Common Elements in Previous SGR Reform Proposals

	Children's Health and Medicare Protection Act of 2007	Medicare Physician Payment Reform Act of 2009	MedPAC Proposal, 2011	Medicare Physician Payment Innovation Act of 2012	American College of Surgeons Value-Based Update, 2012	American Medical Association Accountable Payment Models, 2012	The SGR Repeal and Medicare Provider Payment Modernization Act of 2014 [Tri-Committee]
Repeals SGR			✓	✓	✓	✓	✓
Retains SGR with modifications	✓	✓					
Statutory updates/transition period			✓	✓	✓	✓	✓
Specialty-based payment differentials	✓	✓	✓	✓			
Incentives to move away from FFS				✓	✓	✓	✓
Encourages new models of payment and delivery				✓	✓	✓	✓
Reforms FFS			✓	✓			✓
Incorporates performance on cost and quality				✓	✓	✓	✓

Change is on the Horizon?

# Previous Obstacles to Reform

- How to pay for any repeal or replace
- How to overcome inherent FFS incentives
- How to develop a policy that various stakeholders can “live with”

# What's Different Now?

- Lower CBO score
- Committees of jurisdiction worked together on broad agreement
- Specialty societies generally supported bipartisan, bicameral, tri-committee bill
- Resulting legislation passed House

# CBO Estimates of the Cost of Simple SGR Fixes

<b>Date of Score</b>	<b>Fee Freeze 10-Year Score (billions of dollars)</b>	<b>MEI Update 10-Year Score (billions of dollars)</b>
March 2005	\$48.6	\$154.5
March 2007	\$177.7	\$262.1
May 2009	\$285	\$344
June 2011	\$297.6	\$358.1
July 2012	\$271.0	\$362.0
November 2012	\$243.7	(no estimate)
February 2013	\$138.0	(no estimate)
May 2013	\$139.1	\$224.8
November 2014	\$118.9	\$204.3
January 2015	\$137	(no estimate)

Source: Congressional Budget Office (CBO)

# Uncertainty Remains

- Tri-Committee legislation does not include:
  - Pay-fors
  - Direct volume/spending controls
- CBO score of previous legislation has already increased from \$138.4 billion in February 2014 to \$144 billion in November 2014
- Special interests and specialty societies
- Legislative priorities/2016 Election

# Takeaways

- No reason to believe that volume and intensity growth in the long run will remain below real GDP growth under FFS.
- So far beneficiary access not affected.
- Need to distinguish between fee stability, spending, and budgetary issues.
- Need to look outside of Part B spending to achieve savings to help offset budgetary costs.

# Additional SGR Resources

M. Kent Clemens, F.S.A.  
Centers for Medicare & Medicaid Services  
Office of the Actuary  
N3-26-04  
Baltimore, MD 21244  
[kent.clemens@cms.hhs.gov](mailto:kent.clemens@cms.hhs.gov)

Also CMS Website:

<https://www.cms.gov/SustainableGRatesConFact/>