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 are paid under the PFS.
Physician Payment Formula

Payment = RVU x Geographic adjustment x 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:

| RVU          | Physician work  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time, skill, &amp; training</td>
</tr>
<tr>
<td>Practice expense</td>
<td>Rent, utilities, equipment, supplies, staff</td>
</tr>
<tr>
<td>Malpractice expense</td>
<td>Liability coverage</td>
</tr>
</tbody>
</table>
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.

• The conversion factor for 2013 is $34.0230.

• The conversion factor is updated each year under the sustainable growth rate (SGR) system.
Office visit, detailed (established patient)
• Procedure code 99213
• Performed by Washington DC physician in a non-facility

RVU x Geographic adjustment x Conversion factor
2.14 x 1.123 x $34.0230
= $81.76

Notes: This example is based on current payment rates effective January 1, 2013. To simplify the calculation, the GPCIs were collapsed into one geographic adjustment factor.
Physician Payment: Example 4

Knee arthroscopy/surgery
  • Procedure code 29850
  • Performed by San Mateo CA physician in a facility

RVU x Geographic adjustment x Conversion factor

\[ 18.56 \times 1.182 \times \$34.0230 \]

\[ = \$746.39 \]

Notes: This example is based on current payment rates effective January 1, 2013. To simplify the calculation, the 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 provides 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.

• **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 plans to 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, 1980-2011

Source: Data from CMS and the Boards of Trustees of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds. Data for 1999 through 2011 are based on the 2012 Annual Report of the Boards of Trustees of the Federal HI and Federal 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 percent above or 7 percent below MEI.
The Fee Update is Determined in Part by Spending Targets and the Medicare Economic Index (MEI)

<table>
<thead>
<tr>
<th>Cumulative Spending Compared to Cumulative Target</th>
<th>Update Compared to the MEI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above</td>
<td>Below</td>
</tr>
<tr>
<td>Equal</td>
<td>Equal</td>
</tr>
<tr>
<td>Below</td>
<td>Above</td>
</tr>
</tbody>
</table>
SGR in Practice
Difference Between Actual Cumulative Spending and Cumulative Allowed Spending, 1996-2012

Cumulative Actual Spending

Cumulative Allowed Spending

Source: CMS, Estimated Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2013.
Note: Data on actual cumulative spending in 2012 represents the first two quarters of the calendar year.
Overriding 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.
Actual Updates Compared to Required Updates, 1998-2013

Source: Data from the Boards of Trustees of the Federal HI and SMI Trust Funds and CMS Office of the Actuary

Notes: Beginning with 2008, required updates are a result of both the SGR formula and legislative changes. The physician updates for 2010 and 2011 reflect the impact of the two different updates that were effective during parts of 2010. For January through May 2010, the physician update was 0 percent. For June through December 2010, the physician update was 2.2 percent.
• 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.
Experience Under the Fee Schedule
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.
Physician Participation and Claims Assignment Rates

Source: CMS Data Compendium 2011
Increased Volume Growth Has Impacted Physician Spending More than Input Prices and Payment Updates, 2000-2010

Note: MEI (Medicare Economic Index).

Source: MedPAC, June 2012 Databook
Increased Volume Growth by Type of Service, 2000-2010

Note: E&M (evaluation and management). Volume growth for E&M and all services is through 2009 only due to change in payment policy for consultations.
Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

Source: MedPAC, June 2012 Databook
Physicians Deriving Increasing Share of Revenue from In-Office Imaging

2000 Medicare Part B imaging spending

- Hospital settings: 35%
- Physician offices: 58%
- Independent Diagnostic Testing Facility: 7%

Total: $6.89 billion

2006 Medicare Part B imaging spending

- Hospital settings: 25%
- Physician offices: 64%
- Independent Diagnostic Testing Facility: 11%

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

<table>
<thead>
<tr>
<th>Provider referral type</th>
<th>Number of providers</th>
<th>Average 2008 referred MRI services</th>
<th>Average 2010 referred MRI services</th>
<th>Percentage change, 2008 to 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switchers</td>
<td>2,803</td>
<td>25.1</td>
<td>42.0</td>
<td>67.3</td>
</tr>
<tr>
<td>Non-self-referrers</td>
<td>199,102</td>
<td>20.6</td>
<td>19.2</td>
<td>-6.8</td>
</tr>
<tr>
<td>Self-referrers</td>
<td>17,753</td>
<td>47.0</td>
<td>45.4</td>
<td>-3.4</td>
</tr>
</tbody>
</table>

Source: [GAO-12-966, MEDICARE: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions](#)
SGR Alternatives/Solutions?
## Common Elements in Previous SGR Reform Proposals

<table>
<thead>
<tr>
<th>Policy</th>
<th>Repeals SGR</th>
<th>Retains SGR with modifications</th>
<th>Statutory updates/transition period</th>
<th>Specialty-based payment differentials</th>
<th>Incentives to move away from FFS</th>
<th>Encourages new models of payment and delivery</th>
<th>Reforms FFS</th>
<th>Incorporates performance on cost and quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Health and Medicare Protection Act of 2007</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Physician Payment Reform Act of 2009</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MedPAC Proposal, 2011</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Physician Payment Innovation Act of 2012</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American College of Surgeons Value-Based Update, 2012</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Medical Association Accountable Payment Models, 2012</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## CBO Estimates of the Cost of Simple SGR Fixes

<table>
<thead>
<tr>
<th>Date of Score</th>
<th>Fee Freeze 10-Year Score (billions of dollars)</th>
<th>MEI Update 10-Year Score (billions of dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2005</td>
<td>$48.6</td>
<td>$154.5</td>
</tr>
<tr>
<td>March 2007</td>
<td>$177.7</td>
<td>$262.1</td>
</tr>
<tr>
<td>May 2009</td>
<td>$285</td>
<td>$344</td>
</tr>
<tr>
<td>June 2011</td>
<td>$297.6</td>
<td>$358.1</td>
</tr>
<tr>
<td>July 2012</td>
<td>$271.0</td>
<td>$362.0</td>
</tr>
<tr>
<td>November 2012</td>
<td>$243.7</td>
<td>(no estimate)</td>
</tr>
<tr>
<td>February 2013</td>
<td>$138.0</td>
<td>(no estimate)</td>
</tr>
</tbody>
</table>

Source: Congressional Budget Office (CBO)
Obstacles

• 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”
Additional SGR Resources

Kent Clemens, F.S.A.
Centers for Medicare & Medicaid Services
Office of the Actuary
kent.clemens@cms.hhs.gov
CMS website:
https://www.cms.gov/SustainableGRatesConFact/

Lori Housman
Congressional Budget Office
Lori.Housman@cbo.gov
CBO website:
http://www.cbo.gov/publication/43502