Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System

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Summary

Each year since 2002, the statutory method for determining the annual updates to the Medicare physician fee schedule, known as the sustainable growth rate (SGR) system, has resulted in a reduction in the reimbursement rates (or a "negative update"). With the exception of 2002, when a 4.8% decrease was applied, Congress has passed a series of bills to override the reductions. The SGR system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services. While the fee schedule limits the amount that Medicare will pay for each service, there are no limits on the volume or mix of services. The SGR system was intended to serve as a restraint on aggregate spending. If expenditures over a period are less than the cumulative spending target for the period, the update is increased. However, if spending exceeds the cumulative spending target over a certain period, future updates are reduced to bring spending back in line with the target.

In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were close to the Medicare economic index (MEI, a price index of inputs required to produce physician services) in the first two years (2.3% in 1998 and 1999, compared with a MEI of 2.2% in 1998 and 2.3% in 1999). For the next two years, in 2000 and 2001, the actual physician fee schedule update was more than twice the MEI for those years (5.5% update vs. MEI of 2.4% in 2000, 5.0% update vs. MEI of 2.1% in 2001). However, beginning in 2002, the actual expenditure exceeded allowed targets and the discrepancy has grown with each year, resulting in a series of ever-larger cuts under the formula.

Some criticisms of the SGR system point to purported flaws in the technical details behind the formula, while others have just expressed displeasure with the resultant outcome. Although modifications have been proposed to replace the SGR system, no proposal has garnered sufficient support and almost all proposals would be expensive to implement compared against the current baseline, which necessarily assumes that significant cuts to the fee schedule will occur.

Legislative activity in the 111th Congress included several bills that addressed the SGR system. The FY2010 Defense Appropriations Act delayed the implementation of the reductions for two months, from January 1 through February 28, 2010. The Statutory Pay-As-You-Go Act of 2010 (P.L. 111-139) exempts the amount it would cost to freeze payments for five years from PAYGO rules. H.R. 4691, which became law on March 2, 2010, delayed the payment cuts through March 31, 2010. On April 15, the Senate passed an amended version of H.R. 4851 that extended the payment cut delay through May 31, 2010. The House passed the amended bill, and the President signed P.L. 111-157 into law that day. On June 25, 2010, several weeks after the expiration of the extension created by the Continuing Extension Act, an amended version of H.R. 3962 was signed into law that increases fee schedule payments 2.2% retroactive to June 1 and continuing through November 30, 2010. On November 30, 2010, the President signed the Physician Payment and Therapy Relief Act of 2010 into law (P.L. 111-286), which extended the 2.2% increase for an additional month through December 31, 2010. The Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309) preserves the payments at this level through December 31, 2011.

At its September 15, 2011, public meeting, MedPAC presented a draft proposal for addressing the SGR and Medicare physician payments as well as a preliminary list of Medicare policy changes to partially offset the cost of its SGR override proposal. MedPAC plans to continue to deliberate on the proposal and the offsets and to vote on final recommendations at its October 2011 meeting.

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Introduction

Each year since 2002, the statutory method for determining the annual updates to the Medicare physician fee schedule, known as the sustainable growth rate (SGR) system, has resulted in a reduction in the reimbursement rates (or a "negative update").[1] With the exception of 2002, when a 4.8% decrease was applied, Congress has passed a series of bills to override the reductions. However, these actions have required almost yearly attention from the Congress. This report provides a background on the Medicare fee schedule, the SGR system and the annual updates, and discusses recent proposals to address this issue.

Background on the Medicare Fee Schedule Updates

Medicare payments for Part B services[2] provided by physicians and certain non-physician practitioners are made on the basis of a fee schedule, a list of over 7,000 tasks and services for which physicians bill Medicare.[3] From the inception of the program until 1992 and the introduction of the resource-based relative value scale (RB-RVS) fee schedule, Medicare paid physicians based on "usual, customary, and reasonable" charges.[4]

The Omnibus Budget Reconciliation Act (OBRA 89, P.L. 101-239) created the RB-RVS-based Medicare fee schedule, which went into effect January 1, 1992. Under the RB-RVS fee schedule, the Center for Medicare and Medicaid Services (CMS) assigns relative values that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs.[5] The adjusted relative values are then multiplied by a conversion factor to derive the actual payment amount in dollars. Medicare pays providers the lesser of the actual charge for the service or the allowed amount under the fee schedule.

Updates and the Sustainable Growth Rate (SGR) System

The SGR system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services. While the fee schedule limits the amount that Medicare will pay for each service, there are no limits on the

[1] 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds, p. 22. http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf.

[2] For detail on fee-for-service Medicare and other Medicare background information, see CRS Report R40425, *Medicare Primer*.

[3] Social Security Act, Sec. 1848. [42 U.S.C. 1395w–4]. In some instances, special rules apply to the calculation of Medicare fees for some services, including anesthesia, radiology, and nuclear medicine.

[4] Also called "customary, prevailing and reasonable charges," this method based physician payments on charges commonly used by physicians in a local community. The payment for a service was the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charge for that service in the community. For further discussion, see Physician Payment Review Commission, "Annual Report to Congress, 1997."

[5] The determination of the relative value units affects all payments under the fee schedule. Refinements in existing values and establishment of values for new services have been included in the annual fee schedule updates. This refinement and update process is based in part on recommendations made by the American Medical Association's Specialty Society Relative Value Update Committee (RUC) which receives input from approximately 100 specialty societies. The law requires a review every five years.

volume or mix of services. The SGR system was intended to serve as a restraint on aggregate spending. While the SGR targets are not limits on expenditures, they represent a "sustainable" trajectory for cumulative spending on Medicare physician services from April 1996 forward. The annual fee schedule update thus reflects the success or failure in meeting the goal. If expenditures over a period are less than the cumulative spending target for the period, the update is increased. However, if spending exceeds the cumulative spending target over a certain period, the update for a future year is reduced, with the goal to bring spending back in line with the target.

Expenditure targets have been a factor in the calculation of Medicare physician payment updates since the current fee schedule was first implemented in 1992. In the first year, one overall conversion factor was used to calculated the update. Then, two (surgical and non-surgical services) and eventually three conversion factors were used for different categories of services (surgical, primary care, and other nonsurgical services). However, under the Medicare Volume Performance Standard (MVPS) method, targets were set (and typically exceeded) each year; there was no cumulative goal and no significant consequence to exceeding the expenditure target. The current SGR method for calculating annual updates was created partly in response to the shortcomings of the prior method.

The Balanced Budget Act of 1997 (BBA97, P.L. 105-33) replaced the MVPS with the SGR, with the objective of creating a *sustainable* growth path for Part B expenditures. First, BBA97 added a cumulative spending criteria that resulted in actual consequences for failing to meet expenditure targets; beginning with April 1, 1996, as the starting point, actual program expenditures are compared to growth targets to determine annual updates. Second, BBA 97 introduced the rate of growth in the per capita amount of the gross domestic product (GDP) into the SGR calculation and also provided for the use of a single conversion factor instead of three.[6] By tying the expenditure targets to the growth in GDP per capita, this system attempted to hold Medicare physician expenditures to a level that would not consume an ever-increasing share of national income.

Since the conversion factor applies to all services, the update to the conversion factor is the key component for determining how reimbursements change from year to year.

Conversion Factor Calculation

The annual update to the conversion factor calculation is based on (1) the Medicare Economic Index (MEI), which measures the weighted average annual price changes in the inputs needed to produce physician services;[7] (2) the Update Adjustment Factor (UAF), used to equate actual and target (allowed) expenditures; and (3) allowed expenditures, equal to the actual expenditures updated by the SGR.

[6] The Balanced Budget Refinement Act of 1999 (BBRA 99, P.L. P.L. 106-113) incorporated an adjustment for the prior year into the UAF update calculation; it also moved from a fiscal year to a calendar year system.

[7] For more information on the components used to calculate the MEI and quarterly historical data, see http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/mktbskt-economic-index.pdf.

Sustainable Growth Rate (SGR)

The SGR sets both the cumulative and allowed expenditures under the UAF formula and consists of the following components:

- the estimated percentage changes in physicians fees,
- the estimated percentage changes in the number of fee-for-service beneficiaries,
- the estimated percentage growth in real gross domestic product (GDP) per capita (10-year moving average), and
- the estimated percentage changes resulting from changes in laws and regulations.

One important implication of the way this formula was constructed is that sustainable growth in Medicare physician expenditures should be equivalent to the rate of growth in the economy (i.e., the growth in GDP per capita). In addition, the formula implies that increases in managed care enrollment relative to fee-for-service Medicare would result in a slightly lower SGR.

Update Adjustment Factor

The update adjustment sets the conversion factor at a level so that projected spending for the year will meet allowed spending by the end of the year. The adjustment factor is the sum of (1) the prior year adjustment component; and (2) the cumulative adjustment component. Use of both the prior year adjustment component and the cumulative adjustment component allows any deviation between cumulative actual expenditures and cumulative allowed expenditures to be corrected over several years rather than a single year. As originally established, the adjustment factor can not be less than minus 7% or more than plus 3%. Thus, despite calculations which would have led to larger reductions, the UAF adjustment has been minus 7% for the last several years. The caps on the adjustment limit the annual reduction or increase. Thus, the gap between cumulative actual spending and cumulative allowed spending grows larger each year and is exacerbated whenever Congress overrides the reductions, since the targets are never modified under current law.

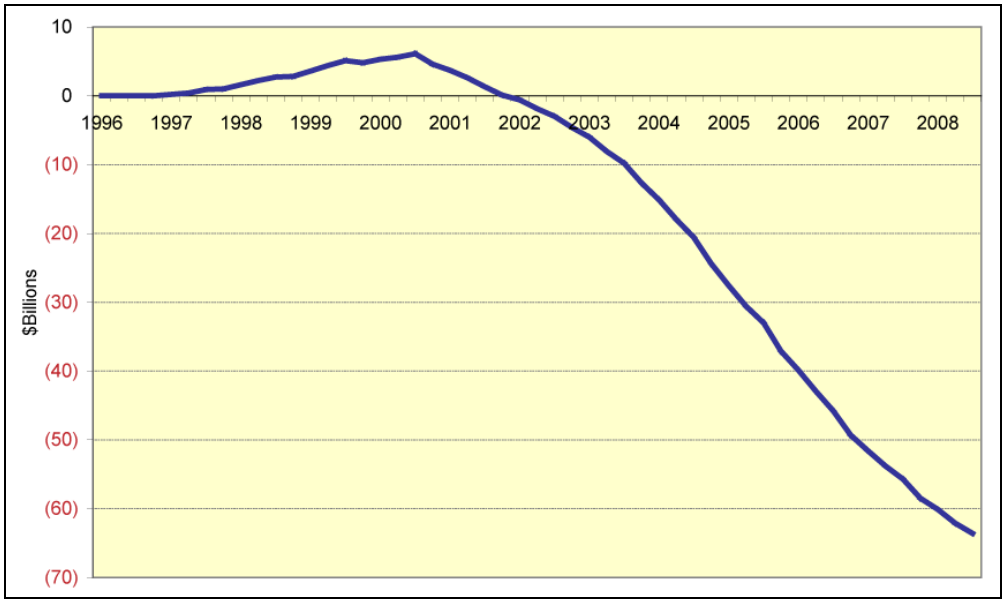
Historical Updates and Legislative Overrides

Under the update formula, if actual expenditures do not exceed target expenditures, the update generally would be positive and payments would increase for all services under the fee schedule subject to the single conversion factor. In the first few years of the SGR system, the actual expenditures did not exceed the targets. (See **Figure 1**.) As a consequence, the updates to the physician fee schedule were close to the MEI in the first two years (2.3% in 1998 and 1999, compared with MEI of 2.2% in 1998 and 2.3% in 1999).[8] For the next two years, in 2000 and 2001, the actual physician fee schedule update was more than twice the MEI for those years (5.5% update vs. MEI of 2.4% in 2000, 5.0% update vs. MEI of 2.1% in 2001). However, beginning in 2002, the actual expenditure exceeded allowed targets and the discrepancy has grown with each year.

[8] See Table 6, Actual Past Medicare Economic Index Increases and Physician Updates for 1992−2009, and Estimated Values for 2010, in CMS publication, "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010."

Figure 1. Difference Between Cumulative Allowed and Actual Expenditures for Physician Services Under the SGR System

1996-2008



Source: CRS figure from CMS data contained in "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010." Available at http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2010p.pdf

Notes: This graph shows the difference between *cumulative* allowed expenditures and actual expenditures for physician services. The 2008 figures for both allowed and actual expenditures are CMS estimates.

As a consequence of exceeding the target, the formula dictated a reduction in the fee schedule in 2002. Although reductions have been called for every year since, Congress has passed legislation that has overridden the cuts each year since. (See **Table 1**.)

Table 1. Summary of Updates and Legislative Activity

2002-2009

Year	Formula update	Actual update	Legislation	Notes
2002	−4.8%	−4.8%		
2003	−4.4%	1.4%	Consolidated Appropriations Resolution of 2003 (CAR)	The update was 1.7% but was effective on March 1, 2003, so the average update for the year was 1.4%.
2004	−4.5%	1.5%	Medicare Modernization Act of 2003 (MMA, P.L. 108-173)	
2005	−3.3%	1.5%	MMA	
2006	−4.4%	0.2%	Deficit Reduction Act of 2005 (DRA, P.L. 109-171)	Although the DRA froze the conversion factor update, refinements to the RVUs resulted in a 0.2% update for the year.

Year	Formula update	Actual update	Legislation	Notes
2007	−5.0%	0%	Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432)	
Jan–Jun 2008	−10.1%	0.5%	Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173)	Physicians who voluntarily reported on certain quality measures during July 1, 2007-December 31, 2007, were eligible for a bonus payment of 1.5% in 2008 per TRHCA.
Jul–Dec 2008	−10.6% reduction from June 2008 level	0% (0.5% from 2007 level)	Medicare Improvement for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)	See above.
2009		1.1%	MIPPA	Physicians who voluntarily reported on certain quality measures during 2008 were eligible for a bonus payment of 1.5% in 2009 per MMSEA.
Jan 1–Feb 28, 2010	−21.3%	0%	Department of Defense Appropriations Act (P.L. 111-118)	
Mar 1–Mar 31, 2010		0%	Temporary Extension Act (P.L. 111-144)	Signed into law on Mar 2, 2010.
Apr 1–May 31, 2010		0%	Continuing Extension Act (P.L. 111-157)	Signed into law on Apr 15, 2010.
June 1–November 30, 2010		2.2%	Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (P.L. 111-192)	Signed into law on June 25, 2010. (increase was retroactive to June 1.)
December 1 – 31, 2010.		0% (2.2% from Jan – May, 2010 level)	Physician Payment and Therapy Relief Act of 2010 (P.L. 111-286P.L. 111-286)	
2011		0%	Medicare and Medicaid Extenders Act (P.L. 111-309)	

Source: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds, http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2010.pdf, and CMS, Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2011, http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2011f.pdf.

In addition to overriding the payment reductions, Congress has also included provisions in several of the laws to increase Medicare physician payments in other ways. For example, the Congress has altered the geographic adjustment factor for physician work, one component used in making regional adjustments to payments under the physician fee schedule. MMA set a floor on the work geographic adjustment index at 1.0 for 2004-2006, thereby slightly increasing the payment amounts in some areas. TRHCA extended this provision through 2007, MMSEA extended it through June 30, 2008, and MIPPA extends it through December 2009. In addition, beginning January 1, 2009, MIPPA also raised the work geographic adjustment in Alaska to 1.5.

Some of the bills also modified the cap on the conversion factor, which has led to the current situation where the consequence of not overriding the reduction would lead to cuts in excess of the 7% cap. TRHCA specified that the override of the reduction that would have been implemented under the statutory formula was to be treated as if it did not occur. Therefore, the starting base for the 2008 calculation was 5% below the actual 2007 conversion factor. MMSEA overrode the reduction for the first six months of 2008 and provided for a 0.5% increase for that period. However, the legislation again specified that the override of the statutory formula was to be treated as if it did not occur. MIPPA again specified that the override of the statutory formula was to be treated as if it did not occur. As a result, CMS estimates that a reduction of 21.2% will be necessary in 2010 unless Congress acts again to override the current situation.[9]

Analysis and Criticisms of SGR System

The experience in recent years has been that the volume and the intensity of physician services provided to Medicare beneficiaries are growing at more than double the rate allowed under the SGR system.[10] Payment reductions as called for under the update formula have required almost annual interventions by Congress and the SGR system has been criticized (and defended) amid calls for its repeal. While some of the criticisms of the SGR system point to purported flaws in the technical details behind the formula, others have just expressed general displeasure with the outcome.

General and Conceptual Concerns

One commonly asserted criticism is that the SGR system treats all services and physicians equally in the calculation of the annual payment update to the detriment of physicians who are "unduly" penalized. The expenditure target is a nationwide aggregate and the annual updates are applied uniformly; there is no direct link between individual behavior and the subsequent update. Thus, actions might be individually rational (physicians provide and bill for additional services and collect greater reimbursement) yet collectively detrimental (the annual update is reduced).[11] An

[9] CMS press release, "CMS Announces Payment, Policy Changes For Physicians Services To Medicare Beneficiaries In 2010," October 30, 2009. http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3539&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

[10] U.S. Government Accountability Office (GAO), *Medicare Physician Payments: Trends in Utilization, Spending and Fees Prompt Consideration of Alternative Payment Approaches*, testimony of Bruce Steinwald before House Energy and Commerce Committee, July 25, 2006.

[11] Often referred to as the tragedy of the commons: while it may be individually rational for each herder to let livestock graze on the common field (to preserve his own), the collective consequence of many such individual decisions is that (continued...)

individual physician who controls or reduces volume does not see a resulting increase in payments.

Others point out that there is no ability to distinguish between appropriate volume increases (for instance, due to changes in disease conditions that increase demand) and inappropriate volume increases (for instance, when tests or procedures are provided that are not necessary).

Technical Concerns

The inclusion of some items and services in the expenditure targets has also been called into question. Specifically, physicians have argued that Part B drug spending should be excluded from the calculation because physicians have no control or influence on the price of these drugs, although CMS is preparing to address this in its implementation of the 2010 proposed rule changes.[12]

Additionally, the targets may not be not adequately modified to reflect scientific and technological innovations or site-of-service shifts, and providers have often stated that actual increases in practice costs exceed those allowed under the system. The impact of legislative and regulatory changes also may not be fully reflected in the SGR calculation.

Per Capita Gross Domestic Product (GDP) and the Annual Update

The SGR is based on a number of factors, including the changes in the price of inputs required to produce physician services (such as rent, staff and supplies), the change in the number of Medicare fee-for-service beneficiaries, the effect of laws and regulations on part B expenditures, and the rate of growth in the per capita gross domestic product, calculated as a 10-year moving average.

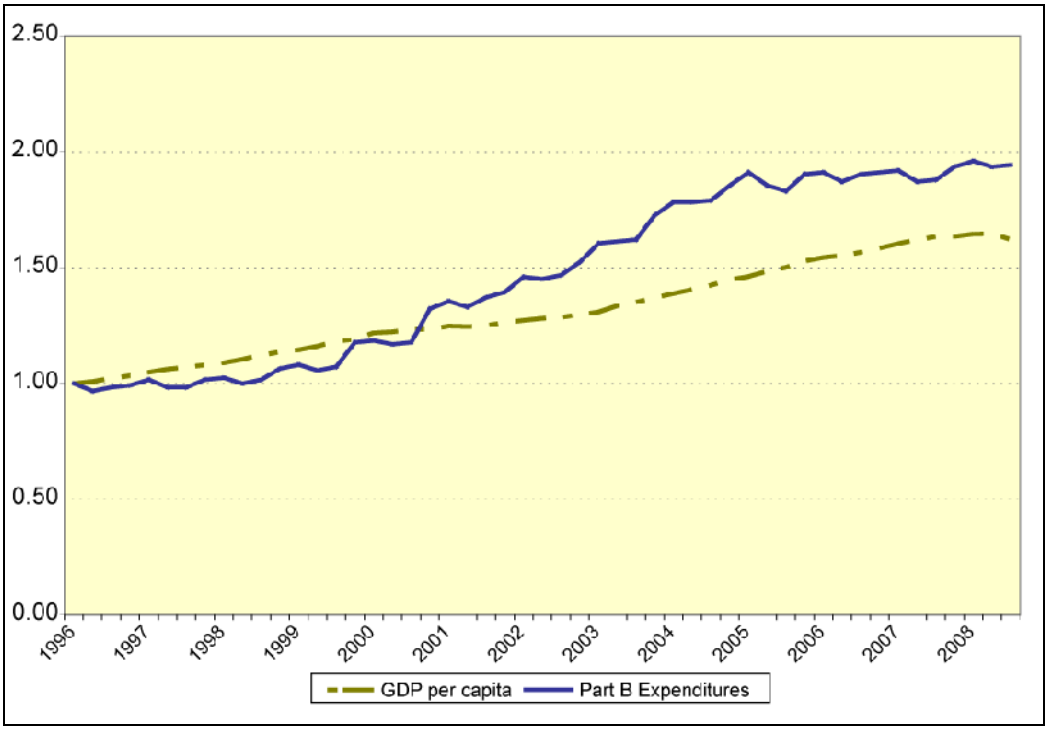
(...continued)

the common fields are overgrazed and all herders suffer from the degradation or depletion of the common good.

[12] See CMS Final Rule, *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010*, to be published in the *Federal Register* on November 25, 2009.

Figure 2. Relative Increase in Part B Expenditures vs. per Capita GDP

1996-2008



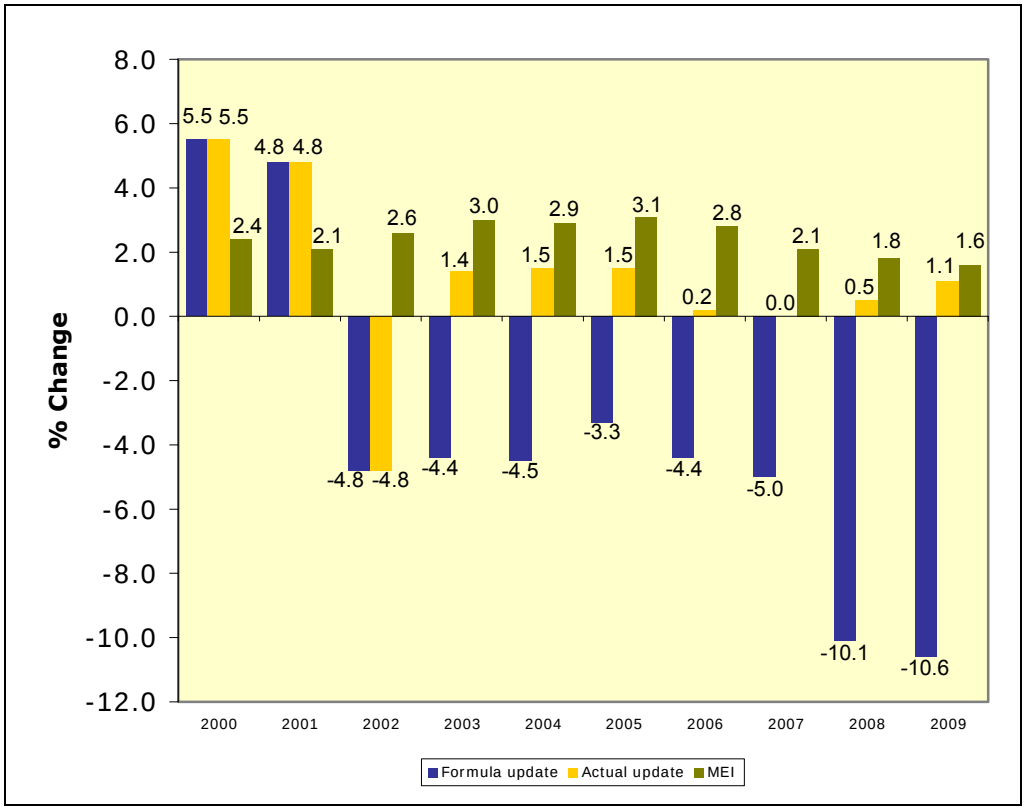
Source: CMS, "Estimated Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2010" http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2010p.pdf and U.S. Department of Commerce, Bureau of Economic Analysis, *National Income and Product Accounts*, Table 7.1. "Selected Per Capita Product and Income Series in Current and Chained Dollars" (http://www.bea.gov/national/nipaweb/IndexP.htm#P).

Notes: The lines are based on quarterly data that are not seasonally adjusted. The uneven pattern of Medicare Part B expenditures reflects typical seasonal variation in health care use, which tends to increase with colder temperatures.

The rate of growth in per capita GDP has a significant impact on the determination of the annual update. As can be seen in **Figure 2**, from 1997 through 2000, per capita GDP grew faster than part B expenditures, at more than 4% annually; part B expenditures were relatively stable from 1996 to 1998 and then started to increase in 1999 and 2000. However, economic growth slowed at the turn of the century (as can be seen in the flatter slope in the growth of per capita GDP during the period from 2000-2003), while part B expenditures grew at a faster rate from 2000 on. Because the comparison of actual to target expenditures includes a significant component that is cumulative (rather than just a comparison of the current period), the updates were positive during the early years of the SGR system but then became negative as a result of this imbalance. (See **Figure 3**.)

Figure 3. Formula Updates, Actual Updates, and the Medicare Economic Index

2000-2009



Source: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds, p. 22. http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf, and CMS, Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010, http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2010p.pdf.

Notes: MMSEA included a six-month override of the SGR update (−10.1%) for the first half of 2008. MIPPA provided for an 18-month override of the SGR update that would have taken effect on July 1, 2008 (−10.6%) that included the second half of 2008 and all of 2009. See also **Table 1**.

Thus, the relative health of the economy effectively masked the increases in total part B expenditures for the first few years under the SGR system, but as the economy slowed and expenditures continued to increase, the updates as determined under the SGR system have turned negative in order to bring projected actual expenditures back in line with target expenditures.

Potential Modifications and Alternatives

Although a number of modifications to the SGR system have been proposed, there is no consensus around a long-run alternative. In addition, any permanent change would likely be quite costly because the Congressional Budget Office (CBO) baseline must assume that a reduction in the conversion factor will occur for the next several years as required under current law. In addition to the impact on federal outlays, any change in the update formula will also have

implications for beneficiaries; because Part B beneficiary premiums must cover 25% of Part B program costs, any overall increase in spending results in a proportional increase in premiums.[13]

Suggested modifications have ranged from modifying the current formula to replacing the formula and linking updates to payment adequacy and/or quality measures. While a change in the formula would require legislation, some observers have suggested that there are things CMS could do administratively to ease the impact of the current formula. Proponents argue that these changes, such as removing Part B drugs from the calculation, could somewhat moderate the negative updates that are predicted.

The Medicare Modernization Act of 2003 (MMA) required that GAO study "the appropriateness of the sustainable growth rate formula" and "the stability and predictability of such updates and rate and alternatives."[14] In a 2005 report, the GAO categorized options for alternatives around two themes: (1) proposals that end the use of spending targets and separate fee updates from explicit efforts to moderate spending growth; and (2) proposals that retain spending targets but modify the current SGR system to address perceived shortcomings.[15] The first approach emphasizes stable fee updates, while the second automatically adjusts fee updates if spending growth deviates from a predetermined target. GAO stated that "the choice between the two approaches may hinge on whether primary consideration should be given to stable fee increases or to the need for fiscal discipline within the Medicare program." The second approach would end targets as an explicit measure for moderating spending growth. Updates would be based on cost increases with the possibility of specifically addressing high volume service categories such as medical imaging.

The Deficit Reduction Act of 2005 (DRA) required MedPAC to submit a report to Congress on mechanisms that could be used to replace the SGR system, including "such recommendations on alternative mechanisms to replace the sustainable growth rate system as the Medicare Payment Advisory Commission determines appropriate."[16] In its March 2007 report, MedPAC described two possible paths: one path would eliminate the SGR and emphasize the development and adoption of approaches for improving incentives for physicians and other providers to furnish lower cost and higher quality care, while the second path would add a new system of expenditure targets in addition to these approaches.[17] However, MedPAC did not make any recommendations in favor of any single alternative to the SGR, citing "significant disagreement … within the Commission about the utility of expenditure targets" and stating that the complexity of the issues made it difficult to recommend any option with confidence. MedPAC did stress in the report that "a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity." Examples cited by MedPAC include pay-for-performance programs for quality, improving payment accuracy, and bundling payments to reduce overutilization.

[13] For details on Medicare Part B premiums see CRS Report R40082, *Medicare: Part B Premiums*, by Jim Hahn.

[14] P.L. 108-173, Section 953(a).

[15] U.S. Government Accountability Office, Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms, GAO-05-85, October 8, 2004.

[16] P.L. 109-171, Section 5104(c).

[17] Medicare Payment Advisory Commission, Assessing Alternatives to the Sustainable Growth Rate System, March 2007.

MedPAC has also recommended updating payments for physicians' services based on the estimated change in input prices for the coming year less an adjustment for savings attributable to increased productivity. Specifically, input prices would be measured using the MEI (without regard to the CMS adjustment for productivity increases). The recommended productivity adjustment would be that used across all provider services.[18]

In March 2008, CBO issued cost estimates for a variety of approaches for dealing with the physician payment issue.[19] Proposals with modest costs assumed a freeze for the second half of 2008 (as opposed to a 10.6% reduction), with reductions in future years to hold future rates at current law levels. More costly alternatives would freeze or increase payments over the 10-year budget window. For example, increasing payments by the MEI each year through 2018 would increase federal spending by $288.1 billion for the FY2008-FY2018 period. Coupling this with a provision excluding this change from beneficiary premium calculations ("premium hold-harmless") would increase federal spending by $364.3 billion over the same period.

Figure 3 shows that in each year since 2002, the MEI has been greater than the update as determined under the SGR formula and the actual update that physicians have received as a result of congressional intervention.

Recent Legislative Activity: Not Passed

H.R. 3162 (110th Congress)

Summary

The Children's Health and Medicare Protection Act of 2007 (CHAMP, H.R. 3162) was introduced on July 24, 2007. Section 301 of Title III would have modified the SGR system by eliminating the single conversion factor currently applied to all physician services and would have established separate target growth rates and conversion factors for each of six newly created service categories.[20] The six categories of physician services would have been the following: evaluation and management services for primary care and for preventive services; other evaluation and management services; imaging services and diagnostic tests; major procedures; anesthesia services; and minor procedures and other services.

The provision would have replaced the single SGR computation with separate target growth rates for each of the service categories created above. Beginning with 2008, the target growth rate for each service category would have been computed and applied separately using the same method for computing the sustainable growth rate under current law except that (1) "physicians' services" would refer to the physicians' services included in the appropriate service category, (2) the estimate of the annual average percentage growth in real gross domestic product per capita for the applicable period would have been increased by 0.03, and (3) a national coverage determination would be treated as a change in regulation and thus incorporated into the Secretary's estimate of

[18] MedPAC, Report to the Congress, Medicare Payment Policy, March 2008.

[19] http://www.cbo.gov/ftpdocs/90xx/doc9055/03-14-SGR_Options.pdf.

[20] This summary and discussion includes only the proposed modifications to the Medicare physician update methodology in the CHAMP Act relevant to the ongoing discussions regarding proposed solutions.

the percentage change in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) resulting from changes in law and regulations.

Beginning with 2008, the conversion factors would be computed and updated separately for each service category. In 2008, the conversion factors would have been based on the single 2007 conversion factor multiplied by the appropriate update for the category. In subsequent years, the conversion factor for each category would have been based on the conversion factor for the service category adjusted by the appropriate update. The provision would have established a floor for updates so that the conversion factors for each service category would be no less than 0.5% for 2008 and 2009.

The Committee on Ways and Means amended and reported the bill on August 1, 2007, and the House passed the bill the same day by a vote of 225-204.[21] The bill was never taken up by the Senate.

Brief Analysis

The approach to modifying the SGR as proposed in H.R. 3162 attempted to address, among other things, the criticism that the current update calculation penalized (or rewarded) all physicians identically regardless of the individual's or the specialty's contribution towards meeting or exceeding the aggregate expenditure target. Thus, even though imaging services have grown faster than other types of physician services (including evaluation and management services, tests, major procedures, and other procedures) the resulting impact on the annual update factor applies to all services across all specialties. However, others have countered that this delineation may not be appropriate and the CHAMP approach went too far. For example, some of the increase in imaging services may have allowed for the earlier detection of disease conditions such as cancer, which may have produced savings for other services and specialties (e.g., nuclear medicine and oncology services).

H.R. 3961 (111th Congress)

Summary

H.R. 3961, the Medicare Physician Payment Reform Act of 2009 was introduced on October 20, 2009. The proposals in this bill share some of the same approaches and objectives as Section 301 of the CHAMP Act, but also differ significantly in a few important ways. First, rather than creating six different categories of physician services, the bill would create two categories of service beginning in 2011, each with its own separate target growth rate and conversion factor update. The two categories of service would be (1) evaluation, management, and preventive services, and (2) all other services. Target expenditures for the E&M and preventive services category would be allowed to grow at the rate of growth of per capita GDP plus 2%, while the target expenditures for the all other category would be allowed to grow at the rate of growth of per capita GDP plus 1%. Second, the year 2009 would be established as the new baseline year for calculating expenditure targets (rather than 1996 under current law) for each of the two categories of services. Third, only physician services would be included in the calculation of actual and

[21] http://clerk.house.gov/cgi-bin/vote.asp?year=2007&rollnumber=787.

target growth expenditures; services provided incident to the physician visit (such as laboratory services), would not be included. Fourth, during the transition to the calculations required for the new method of calculating targets and updates, the 2010 update would be the percentage increase in the Medicare economic index (MEI). In its final rule for 2010 Medicare physician payments, CMS specified that the MEI will be 1.2%.[22]

On November 19, 2009, the House passed H.R. 3961 by a vote of 243-183.[23] However, on February 24, 2010, the Senate amended the bill by replacing everything after the enacting clause and renamed the bill "An Act to extend expiring provisions of the USA PATRIOT Improvement and Reauthorization Act of 2005 and Intelligence Reform and Terrorism Prevention Act of 2004 until February 28, 2011."[24]

Brief Analysis

The impact of this bill would be felt not only by physicians but also by other parts of the Medicare program, the Department of Defense TRICARE program, and beneficiaries under Medicare Part B. CBO estimates that enacting H.R. 3961 would increase direct spending by about $210 billion over the 2010-2019 period.[25] Not only would physician reimbursements under the Medicare physician fee schedule increase, but expenditures under the Medicare Advantage (MA) program would increase because per beneficiary spending for fee-for-service beneficiaries would increase as a result of the bill, raising the "benchmarks" that Medicare uses to determine the capitation payments for beneficiaries enrolled in Medicare Advantage plans. TRICARE expenditures would rise because its physician reimbursements are based on Medicare's physician fee schedule. Furthermore, since Medicare Part B beneficiary premiums are required to cover 25% of total Part B expenditures, the increases in physician reimbursements as a result of changing the update calculation would put pressure on future Part B premiums to rise.

The proposed modification might reduce the likelihood that future expenditures exceed the target expenditures, since the growth rates would be more generous under this bill than under current law, but this might lead to an increase in the total expenditures of the Medicare Part B program. While the SGR has been heavily criticized, a fundamental assumption was that tying physician expenditure growth to the rate of growth in GDP per capita could lead to a sustainable growth path. By allowing the two categories to grow at GDP per capita plus 1% or 2%, this bill would appear to allow for a situation where physician expenditures grow and consume a greater percentage of the national income.

[22] The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The calculation of the 2010 MEI is given in Table 33 of the final 2010 Medicare physician payment rule issued by CMS. http://www.federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf.

[23] http://clerk.house.gov/evs/2009/roll909.xml.

[24] The Senate passed the amended bill by voice vote on February 24, 2010. The House passed the Senate-amended version on February 25, 2010, by 315-97 and the bill became P.L. 111-141.

[25] CBO Cost Estimate, "H.R. 3961—Medicare Physician Payment Reform Act of 2009," November 4, 2009, http://www.cbo.gov/ftpdocs/107xx/doc10704/hr3961.pdf.

A Senate Amendment in the form of a Substitute to H.R. 3590 (111th Congress)

Summary

Section 3101 of the Senate health care reform bill, an amendment in the form of a substitute to H.R. 3590, would have overridden the reduction in the annual update to the conversion factor used in the determination of the Medicare fee schedule and provided an increase of 0.5% in 2010. The conversion factor for 2011 and for subsequent years would have been computed as if the increase in 2010 had never applied. CBO estimates that this provision would have cost $7.2 billion in 2010 and $4.1 billion in 2011, with no other budgetary impact in subsequent years. However, the manager's amendment contained several additions and modifications to the bill, including Section 10310, which repealed Section 3101. On December 24, 2009, the Senate passed the amended bill by a vote of 60-39.[26]

Brief Analysis

Much as other recent overrides have done, the original provision (Section 3101) would have increased Medicare physician payments slightly in the short term while increasing the cost of addressing this problem in the future because another year's worth of actual expenditures that exceed target expenditures would have contributed to the total amounts that would have to be recouped under the current SGR system. However, the manager's amendment struck this section, and thus the health care reform bill as passed by the Senate does not include any provisions that address the SGR situation.

Recent Legislative Activity: Enacted into Law

Department of Defense Appropriations Act, 2010 (P.L. 111-118)

Summary

On December 16, 2009, the House passed H.R. 3326, the FY2010 Defense Appropriations bill. One of the provisions in Section 1011 of the bill delayed the application of the update to the conversion factor until February 28, 2010.[27] Another provision in the same section reduced the amount of monies available in the Medicare Improvement Fund by $1.55 billion.[28] The Senate passed the bill on December 19, 2009,[29] and the bill was signed into law[30] that day.

[26] http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396.

[27] For roll call details, see http://clerk.house.gov/cgi-bin/vote.asp?year=2009&rollnumber=985.

[28] Section 188 of MIPPA established the Medicare Improvement Fund (MIF), available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries.

[29] For roll call details, see http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00384.

[30] P.L. 111-118.

Brief analysis

The bill delayed the payment reductions from taking effect for two months while maintaining fee schedule reimbursements at 2009 levels.

Increasing the Statutory Limit on the Public Debt (P.L. 111-139)

Summary

Section 7 of Title I of this bill (H.J.Res. 45, the Statutory Pay-As-You-Go Act of 2010), which was signed into law on February 12, 2010 (P.L. 111-139), provides a limited exception to the "pay-as-you-go (PAYGO)" rules for addressing the Medicare physician payment situation as a result of the SGR system (as well as additional exceptions). The maximum amount of the exception is to be the difference between estimated net outlays if 2009 Medicare fee schedule payment rates were to be in effect for the next five years (i.e., a "freeze" through December 31, 2014) and what the payments would have been had fees reverted to levels as dictated under the SGR system. Furthermore, any future legislation that reforms or replaces the SGR system would be scored for PAYGO purposes only if the modification were to cost more than the cost of the five-year freeze at 2009 levels. If legislation changing the SGR system were to be enacted that costs less than the five-year freeze through 2014, any remaining amount in the adjustment could be used to offset costs after 2014 as a result of the change, but the total adjustment could not exceed the maximum adjustment amount.

Brief Analysis

The provision exempts the equivalent of a five-year freeze of Medicare reimbursement at 2009 levels from PAYGO—an amount the CBO estimates to be $88.5 billion.[31] Congress would still have to pass legislation that would override the cuts as directed by the SGR system.

Temporary Extension Act of 2010 (P.L. 111-144)

Summary

On February 25, 2010, the House passed H.R. 4691, the Temporary Extension Act of 2010, by voice vote. This bill extended a number of expiring programs, including unemployment insurance benefits, premium assistance for COBRA benefits, and the Medicare therapy caps, in addition to forestalling the Medicare physician payment cuts. Section 5 modified the Defense Appropriations Act, 2010, by delaying the payment reduction for another month, through March 31, 2010. The CBO score for this section is $ 1.04 billion in additional outlays.[32] Although a motion to pass the bill by unanimous consent failed in the Senate that evening,[33] the bill eventually passed the Senate by a vote of 78-19[34] and was signed into law (P.L. 111-144) on March 2, 2010.

[31] http://www.cbo.gov/budget/factsheets/2010b/SGR-menu.pdf.

[32]CBO score available at http://www.cq.com/displayfile.do?docid=3299370.

[33]See the Congressional Record at http://www.congress.gov/cgi-lis/query/D?r111:2:./temp/~r111LpI3Lx.

[34] http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=2&vote=
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Brief Analysis

This bill delayed the payment reductions from taking effect until April 1, 2010, while maintaining fee schedule reimbursements at 2009 levels through March 31, 2010.

Continuing Extension Act of 2010 (P.L. 111-157)

Summary

On March 17, 2010, by voice vote, the House passed H.R. 4851, as amended (striking all after the enacting clause and inserting new text). The bill includes extensions for several programs, including certain unemployment insurance provisions, premium assistance for COBRA benefits, and the Medicare therapy caps exceptions process in addition to forestalling the SGR payment reductions for another month, until May 1, 2010. The Senate amended Section 4 of the bill by lengthening the Medicare physician payment cut extension until May 31, 2010, and both houses of Congress passed the bill on April 15, 2010. The President signed the bill into law (P.L. 111-157) that day.

Brief Analysis

The bill delayed the physician payment reductions from taking effect until June 1, 2010, while maintaining fee schedule reimbursements at 2009 levels through May 31, 2010.

Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (P.L. 111-192)

Summary

On June 18, 2010, more than two weeks after the May 31, 2010, expiration of the extension under the Continuing Extension Act of 2010,[35] the Senate passed an amended version of H.R. 3962 by voice vote that would avert the SGR-determined payment reduction and increase the conversion factor by 2.2% retroactive to June 1, 2010, and continuing through November 30, 2010. CBO scored this provision as adding $6.3 billion to direct spending over the 5- and 10-year budget window, with all spending occurring in fiscal years 2010 and 2011. The cost is offset (1) by imposing a three-day prohibition on hospital provision that would bar Medicare contractors from reopening or adjusting claims by hospitals during the three days preceding a patient's inpatient admission, and (2) from savings resulting from modifications that allow firms to spread out their

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[35] CMS issued two instructions to its contractors regarding claims affected by the expiration. The first, on May 27, instructed contractors to hold claims for services dated June 1 and later and paid under the Medicare physician fee schedule for the first 10 business days of June (i.e., through June 14, 2010). The second, on June 18, 2010, instructed contractors to begin lifting the hold and to begin processing June 1 and later Medicare physician fee schedule claims under the law's negative update requirement on a first-in/first-out basis.

pension fund obligations over a longer period, resulting in fewer tax-preferred contributions to pension plans and creating more taxable income for the firms.

The House passed the Senate-amended bill on June 24, 2010.[36] The President signed the bill into law (P.L. 111-192) the next day.

Brief Analysis

The act increases the Medicare physician fee schedule payments by 2.2% for six months. A substantial payment reduction (about 23%) would have been required beginning December 1, 2010, and an additional reduction (about 6%) would have been applied beginning January 1, 2011, in the absence of further congressional action.

The Physician Payment and Therapy Relief Act of 2010 (P.L. 111-286)

Summary

On November 18, 2010, by unanimous consent, the Senate passed H.R. 5712,[37] which extended the 2.2% increase established by H.R. 3962 for an additional month through December 31, 2010. The House passed the amended bill on November 29, 2010, by voice vote, and the President signed the bill into law (P.L. 111-286) on November 30, 2010.

The cost of the override was to be offset by reductions to payments to providers for the second and for additional services when multiple therapy procedures are performed on the same patient on the same day.[38]

Brief Analysis

While this extension maintained provider payments at the existing level, additional legislative action was required to forestall the reduction to payments under the Medicare fee schedule that would have taken effect beginning January 1, 2011.

[36] The vote was 417-1, with 14 members not voting. See http://clerk.house.gov/evs/2010/roll393.xml.

[37] Originally introduced in the House in July, 2010 as the Veterans', Seniors', and Children's Health Technical Corrections Act of 2010, the version passed by the Senate struck and substituted everything after the enacting clause. in addition to the physician payment modification, the bill also modified the discount applied to payments for therapy services when multiple procedures are performed on a beneficiary on the same day.

[38] See Congressional Budget Office, Estimate of the Statutory Pay-As-You-Go Effects for the Physician Payment and Therapy Relief Act of 2010, November 18, 2010, http://cbo.gov/ftpdocs/119xx/doc11969/PhysicianPaymentandTherapyReliefAct.pdf.

Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309)

Summary

The Medicare and Medicaid Extenders Act of 2010 (H.R. 4994) extended many Medicare provisions that were due to expire on December 31, 2010, and made other changes to the Medicare and Medicaid program, including a one-year override of the payment reductions required under the SGR system. This act provided for a 0% update adjustment factor in 2011 compared to the (end-of-year) 2010 payments. These provisions were fully offset.[39]

Brief Analysis

Following the one-year override, the legislation states that "the conversion factor ... shall be computed ... for 2012 and subsequent years as if [the override] had never applied." CMS's March 2011 estimate of the 2012 SGR[40] is that a 29.5% reduction will be required beginning January 1, 2012, in the absence of further legislative action.[41] In its March 2011 report, MedPAC recommended a 1% update to the Medicare physician fee schedule for 2012.[42]

MedPAC Proposal

At its September 15, 2011, public meeting, MedPAC presented a draft[43] proposal for addressing the SGR and Medicare physician payments. Among the objectives of its proposal is to replace uncertain payment updates under the SGR system with "a stable, predictable 10-year path of legislated fee-schedule updates," [44] and to eliminate the almost 30% reduction beginning January 1, 2012, that would occur under current law. The draft proposal acknowledges the criticisms of the SGR system as well as the concern that beneficiary access to providers willing to accept Medicare patients may be affected in coming years should the uncertainty about fee schedule reimbursements continue. Further, MedPAC is concerned about reducing the discrepancy in payment between primary care services (mostly cognitive, evaluation, and management activities) and specialty care and procedure-oriented services.

[39] The one-year override was offset by increasing the penalties collected from individuals who improperly receive health insurance tax credits (under health care reform), replacing the two fixed penalty amounts ($250 for individuals and $400 for families at or below 400% of the federal poverty level) with a scaled penalty related to income. The CBO score is available at http://cbo.gov/ftpdocs/120xx/doc12008/hr4994.pdf

[40] The Secretary is required (Section 1848(d)(1)(E) of the Social Security Act) to make public an estimate of the Sustainable Growth Rate (SGR) and the conversion factor applicable to Medicare payments for physicians' services for the following year by March 1 of each year.

[41] See CMS, "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2012" available at https://www.cms.gov/SustainableGRatesConFact/Downloads/sgr2012p.pdf.

[42] MedPAC, *Report to the Congress: Medicare Payment Policy*, MedPAC, Washington, DC, March 2011, http://www.medpac.gov/documents/mar11_entirereport.pdf.http://www.medpac.gov/documents/mar11_entirereport.pdf.

[43] The SGR proposals and recommendations presented at the September meeting are preliminary. The Commission expects to revise the list following discussion and to vote on the final proposals and recommendations at the October meeting.

[44] http://www.medpac.gov/transcripts/SGR%20sept%202011%20handout.pdf.

MedPAC's draft proposals are to (1) freeze the Medicare physician fee schedule reimbursement rates for primary care services for 10 years, (2) reduce other fee schedule reimbursements by 5.9% each year for 3 years, then freeze the rates at that level for 7 additional years, and (3) offset over $200 billion of the cost of the override through a combination of other modifications to the Medicare program.

The primary care services would be determined in a manner similar to the eligibility criteria for the primary care bonus introduced by PPACA:[45] providers would have to (1) be a physician whose self-declared specialty is in one of the primary care specialties (family medicine, internal medicine, geriatric medicine, or pediatric medicine) or be a nurse practitioner, clinical nurse specialist, or physician assistant, and (2) furnish 60% of their services in the primary care service codes (office visits, home visits, and visits to patients in nursing facilities, domiciliaries, and rest homes). The freeze on reimbursement rates for primary care services would apply only to those service codes. Thus, a primary care provider could provide some services where the reimbursement rates would be frozen as a result of the MedPAC proposal and other services where the reimbursement rates would be subject to a decrease. Similarly, two different physicians could bill for the same code, yet one could be paid at the frozen reimbursement rate while the other would be paid at a reduced rate. MedPAC projects that with this combination of freezes and reductions to the fee schedule reimbursements, total Medicare revenue to practitioners under the physician fee schedule, as well as revenue per beneficiary for fee schedule services, will continue to rise in each of the next 10 years.

MedPAC is also considering recommendations that would attempt to improve the accuracy of the Medicare physician fee schedule. These would include initiatives to (1) collect and use data to validate and adjust the RVUs (beyond what was required in PPACA), and (2) encourage and accelerate the development of and transition to payment systems that are not based on fee-for-service.

MedPAC also developed a preliminary list of Medicare policy changes to partially offset the cost of its SGR override proposal.[46] These modifications include prior MedPAC recommendations that have yet to be adopted (about $50 billion) as well as "proposals informed by outside groups (e.g., HHS OIG, CBO options) and MedPAC staff analysis" (about $180 billion). The cost of these offsets would be "shared by physicians, other health professionals, providers in other sectors, and beneficiaries."

The estimated "approximately $200 billion" cost of the proposed fee schedule changes to override the SGR-mandated 30% reduction in reimbursement rates would be countered by the proposed offsets package. MedPAC notes that there is uncertainty in the figures it presents because these offsets "have not been scored by CBO, and they are not official estimates" and as such, "the cost ... could be higher and the savings could be lower."[47]

MedPAC plans to continue to deliberate on the proposal and the offsets and to vote on final recommendations at its October 2011 meeting.

[45] See Sec. 5501 of the Patient Protection and Affordable Care Act (P.L. P.L. 111-148).

[46] The detailed list is available at http://www.medpac.gov/transcripts/Draft%20Offset%20List%20for%20Public.pdf.

[47] See the transcript of the September 15, 2011, meeting, available at http://www.medpac.gov/transcripts/09150916MedPAC.pdf.

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