

What surgeons should know about...

What's wrong with the SGR

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Following a 5.4 percent reduction in 2002 Medicare reimbursements for physician services, Congress passed two bills last year that blocked similar pay cuts in favor of modest increases in 2003, 2004, and 2005. Nonetheless, when the 109th Congress convenes in January, surgeons will once again face the challenge of convincing their legislators that they need to take action to avert the significant Medicare payment reductions projected for 2006 and subsequent years.

As the College prepares for this effort, many surgeons must wonder why this situation is happening again. Clearly, the current arrangement is unsustainable; after all, general practice costs and liability premiums have been escalating. What problems lie at the root of this dysfunctional payment system? Why has Congress implemented stop-gap measures rather than a permanent solution?

The following questions and answers are intended to help surgeons better understand the Medicare payment system and the obstacles they and their legislators confront in designing effective reforms.

What is the sustainable growth rate (SGR)?

The SGR is a cost-containment mechanism intended to restrain the rate of growth in Medicare spending for physician services. It is a prospectively determined expenditure target that is used, in part, to determine the annual update to the Medicare fee schedule conversion factor.

How does the SGR work?

Normally, payments for goods and services purchased by Medicare are updated annually by an

inflation factor. If the same were true for physicians' services, the conversion factor that translates the relative value units (RVUs) in the Medicare fee schedule into service payment amounts would be updated each year by the Medicare Economic Index, or MEI.

For physicians, however, the aggregate rate of Medicare spending growth under the fee schedule in a given year is compared to the SGR. If spending growth is below the SGR target rate, commensurate "bonus" percentage points are added to the MEI to determine the annual update in a subsequent year. On the other hand, when aggregate spending exceeds the SGR the excessive percentage amount is deducted from the MEI. Regardless of how much actual spending falls short of or exceeds the SGR, Medicare law limits penalty deductions to no more than seven percentage points below the MEI, and bonus increases can be no more than three percentage points above the MEI.

Table 1 on page 9 shows how this system would have worked to determine the 2005 conversion factor, if Congress had not mandated an update of at least 1.5 percent.

What factors are used to set the SGR?

The SGR is calculated according to a formula that accounts for annual changes in the following factors: (1) the cost of providing services, as measured by the MEI; (2) real per capita gross domestic product (GDP) growth; (3) the number of Medicare fee-for-service beneficiaries; and (4) the effect of new laws and regulations (for example, the addition of new congressionally mandated program benefits, such as colorectal cancer screening).

For the past few years, we've heard that the SGR would have mandated negative fee schedule updates—with resulting across-the-board payment reductions—if Congress had not intervened. What is causing this downward spiral in payments?

The structure of the SGR itself and current trends in spending and economic growth are causing the system to produce negative updates. More specifically:

- *Service volume is growing.* After being relatively stable for a number of years, growth in the volume and the intensity of services covered by the SGR have been increasing rapidly, exceeding the annual targets. While rates of spending growth for most surgical services are comparatively low (and even declining for some), the volume of many other invasive and imaging procedures is growing rapidly (see Figure 1 on this page).

- *Lower rates of GDP growth.* The problem is exacerbated by lower rates of GDP growth in recent years. Under the SGR formula, if Medicare service volume and intensity grow faster than the national economy on a per capita basis, the annual fee schedule update will be less than the estimated increase in the cost of providing services. Currently, the national economy is growing at a rate of about 2 percent each year. In comparison, the Centers for Medicare & Medicaid Services (CMS) actuaries estimate that the rate of spending growth for Medicare physician services in 2004 will be nearly 9 percent.

- *Cumulative spending.* The SGR is cumulative in nature. In other words, SGR adjustments

are determined by how much the cumulative amount of actual spending on physician services since the base year of 1996 differs from the cumulative spending target since that year. As a result, the system requires that excess spending in any

Table 1

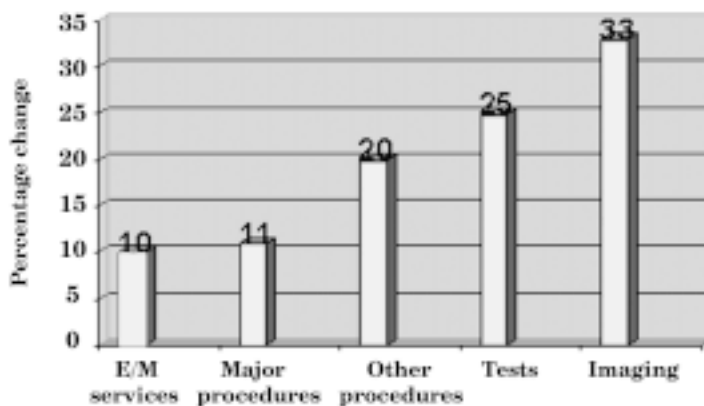
Current estimate of 2005 fee schedule conversion factor

CY 2004 conversion factor	\$37.3374
MEI	2% (1.028)
SGR performance adjustment	-7.0% (0.930)
Other factors	0.8% (0.964)
Calculated increase	-3.6%
Calculated 2005 conversion factor	\$35.9934
Actual increase mandated by law	1.5%
Estimated 2005 conversion factor	\$37.8975

Source: Centers for Medicare & Medicaid Services, "Estimated Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2005." Available online at: <http://www.cms.hhs.gov/providers/sgr/sgr2005p.pdf>

Figure 1

Cumulative growth in volume per beneficiary, by type of service, 1999-2002



Source: Medicare Payment Advisory Commission: *Report to Congress: New Approaches to Medicare*. Washington, DC: MPAC, June 2004, p. 114.

single year be recouped in future years. The only way to achieve this objective is to reduce the fee schedule updates enough to offset the excess spending. With a “floor” on payment updates of MEI -7 percent, it can take quite a few years to offset a period of high spending growth.

- *“Incident to” services.* Spending growth rates are extraordinarily high for items and services that are provided “incident to” a physician visit, such as diagnostic laboratory services performed in the office and physician-administered drugs. Arguably, rates of spending growth for these items do not belong under the spending target because their costs are not paid under the fee schedule and their prices are not influenced by the SGR. While these items do not account for the majority of Part B spending under the SGR, their rate of expenditure growth far outpaces the growth in physician services.

- *Site of service shifts.* The trend toward providing more services in outpatient and office settings is increasing fee schedule costs covered by the SGR to a degree that is underappreciated and difficult to quantify. This trend is probably most noticeable for those services that are experiencing the most rapid rates of growth, such as diagnostic imaging. Medicare pays more for services when they are provided in a physician’s office to reflect the fact that the physician personally incurs greater overhead costs (see Table 2, this page).

Interestingly, services formerly provided in a hospital or other facility no longer result in a separate facility payment when they are provided in a physician’s office setting. As a result, higher physician payments for office-based services should be offset to a significant degree by foregone facility payments covered elsewhere by Medicare Part A (for former inpatient services) or Part B (for hospital outpatient and ambulatory surgical center services). Unfortunately, the current physician payment system lacks a mechanism for “transferring” such savings into a larger spending allow-

Table 2

2004 facility and nonfacility payments for a sample surgical service (Chicago, IL)

CPT 19120—*Removal of Breast Lesion*

2004 facility payment:	\$385.12
2004 nonfacility (office) payment:	446.28
Difference	61.16 (15.9%)

Source: Centers for Medicare & Medicaid Services, “Medicare Physician Fee Schedule Look-up.” Available online at: <http://www.cms.hhs.gov/physicians/mpfsapp/default.asp>

ance under the SGR. Consequently, existing trends (and incentives) to provide more services in the office setting contribute to the fee schedule spending increases that are producing the downward spiral in payments for physician services across the board.

How long is this series of cuts expected to last and how bad is it going to get?

CMS currently estimates that without a change in law the current system will produce negative payment updates annually through 2013. For the first several years, these reductions will reach the maximum threshold of MEI less seven percentage points.

Didn’t the College support expenditure targets in the early 1990s when the Medicare fee schedule was first implemented? What has happened since then?

When the law was written that established the Medicare fee schedule in 1992, the College en-

dorsed the concept of Medicare volume performance standards, or MVPSs. Although these, too, were expenditure targets, they differed from the SGR in significant ways. For example, separate MVPS targets were ultimately established for three service categories—surgery, primary care, and other physician services. This minimized the impact that service volume growth in one service area would have on payments for completely unrelated services.

Other ways in which the MVPSs differed from the SGR were as follows: (1) cumulative spending was not a factor in determining the impact of the MVPSs on annual updates because they covered only a single year; (2) recent trends in actual Medicare spending on physician services were used instead of GDP growth as a gauge of health care needs; and (3) the Secretary of Health and Human Services had discretion to modify the targets to reflect changes in technology, costs, and so forth.

As a result, the MVPS system was not only more flexible, but, because of relatively slow service volume growth in surgical services, it produced far more favorable fee schedule updates for surgeons. Between 1992 and 1997, when the separate MVPSs were in effect, the conversion factor for surgical services grew from \$31 to \$40.96 (compared to the current 2004 conversion factor of \$37.34).

What is the solution to our current problems with the Medicare payment system?

Clearly, the SGR is a blunt instrument for controlling Medicare physician expenditures. Over the years, it has produced relatively low rates of spending growth for physician expenditures and, hence, some budget watchers consider it “successful.” However, the indiscriminate nature of the reductions produced by the SGR certainly argues against its utility from a policy perspective. And, as a practical matter, it stands to reason physicians can only

absorb so many annual payment reductions before they simply cannot afford to provide some important health care services. The optimal solution is to establish an update system that is based on the actual changes in the cost of providing physician services, so that those physicians who provide needed care are spared any penalties. The challenge, of course, is to address questions about inappropriate payment incentives and ineffective patterns of care that are driving service volume and program costs to levels the federal government (and other payors) can no longer afford.

What stands in the way?

Eliminating the SGR is an expensive proposition. Because of the “baseline” spending trends, it was estimated last year that replacing the current payment system with one based on the MEI (annual Medicare inflation rate) alone would cost nearly \$100 billion over 10 years. More recent estimates set the price tag at closer to \$200 billion. Given the size of the federal budget deficit, Congress will need to make some difficult choices before it can make this amount of money available for a physician payment fix. CMS and the Administration could help by making certain regulatory changes that will lower the cost of a congressional solution. Finally, organizations like the College can contribute by devising sound proposals that incorporate principles that promise to achieve needed cost controls by improving the value and effectiveness of the care that patients receive, such as evidence-based medicine. □