

Updating Medicare's Physician Fees: The Sustainable Growth Rate Methodology

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OVERVIEW — Medicare's method to annually update the fees it pays physicians has been under fire for some time—specifically, since the method determined that physician fees should be reduced rather than increased. The update method, called the sustainable growth rate (SGR), was implemented to control the growth in Medicare physician spending. Yet Congress, in response to physician concerns about beneficiary access to care, has acted to avert physician fee cuts since 2003. Although this signals dissatisfaction with the SGR methodology, there is yet to be a widely accepted physician fee update proposal that balances federal budgetary realities with the need to ensure beneficiary access. And the cost of changing the update method continues to mount, adding to the difficulties of developing a solution that meets the needs of all stakeholders. This issue brief describes the SGR methodology, the reasons why projected physician fee updates are negative, and some options that have been proposed to remedy the current situation.

This issue brief is the second of two related papers on physician spending and Medicare's sustainable growth rate methodology. The companion paper was published on October 9, 2006 (see Issue Brief 815, available at www.nhpf.org/pdfs_ib/IB815_PhysicianSpending_10-09-06.pdf).

Updating Medicare's Physician Fees: The Sustainable Growth Rate Methodology

Implemented in 1998, the sustainable growth rate (SGR) methodology was designed to annually adjust Medicare's physician fees to bring Medicare physician spending in line with a spending target. Until 2002, total physician spending was below the target, so the fees were increased annually. Spending on physician services exceeded the target in 2002, however, so Medicare physician fees were reduced by 4.8 percent. Since then, spending has continued to grow faster than the target, triggering negative SGR-determined updates. In response to concerns that lower fees would impede beneficiary access to services, however, Congress acted to prevent the negative updates from occurring from 2003 to 2006.

The SGR methodology continues to be the law and physician spending continues to be above the target. As a result, Medicare physician fees are scheduled to be reduced by about 5 percent in 2007. Although Congress may avert a fee cut for 2007, without addressing the high growth in physician spending, physician fee updates are expected to be negative through 2012. Each year that the SGR methodology remains the law and spending growth remains high, the budget pressures increase. The search for a way to update physician fees that balances beneficiary access and budgetary concerns continues.¹

This issue brief explains Medicare's physician payment approach, the SGR methodology, and the difference between actual spending and the spending target. It discusses why the gap between the target and actual spending continues to widen, including the effect of initial estimation and forecasting errors and more recent escalation in the volume and intensity of physician services. These and other technical concerns with the SGR methodology, philosophical arguments about this update approach, and some widely discussed SGR "fixes" are also presented.

PAYING FOR PHYSICIAN SERVICES

Medicare's physician fee schedule, designed to promote payment equity across services and physician specialties, determines payments for over 7,000 physician services using the resource-based relative value scale or RBRVS. The fees are the product of a relative value assigned to each service and a conversion factor that translates the relative value

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into dollars (Table 1). The relative values are based on estimates of the resources used to deliver each service to a typical patient compared with the average resources required for all other physician services. Three types of resources are accounted for: the physician’s time, effort, and expertise, called the work component; practice expenses, that is, office space, nurse’s time, equipment, and other expenses associated with the office; and malpractice premiums.

The Medicare fee for an intermediate office visit, for example, was \$120.14 in 2006. This is based on its relative value of 3.17 and the 2006 conversion factor of \$37.8975. The fee is the same for a particular service, regardless of the specialty of the physician delivering the care. The fee is adjusted, however, for geographic differences in resource costs because it is more expensive to practice medicine in some areas than in others.

The fee schedule replaced a system in which payments were based on historical physician charges in an area, subject to various limits. The former system, generally viewed as inequitable, resulted in vastly different fees for the same service across individual physicians, medical specialties, and geographic areas. In addition, fees for different services did not necessarily vary according to the resources used to provide them. For example, evaluation and management services, which include office visits, were believed by many to be undervalued relative to procedural services such as surgeries.

Recognizing that Medicare’s physician fee schedule did not provide incentives for physicians to control the volume and intensity of services, Congress mandated that updates to the fees depend on achieving an overall spending target. Linking the update to the growth in overall physician

TABLE 1
Medicare Physician Fees, Selected Examples, 2006

SERVICE	Relative Value	×	Conversion Factor	=	Fee*
Initial Inpatient Consultation	3.75				\$ 142.12
Office Visit (minor problem)	1.02				38.66
Office Visit (intermediate)	3.17		\$ 37.8975 <i>for all services</i>		120.14
Radiologic Exam (chest – two views)	0.96				36.38
Echocardiogram Exam (heart – complete)	5.40				204.65

* This does not reflect Medicare’s adjustment for geographic cost differences.

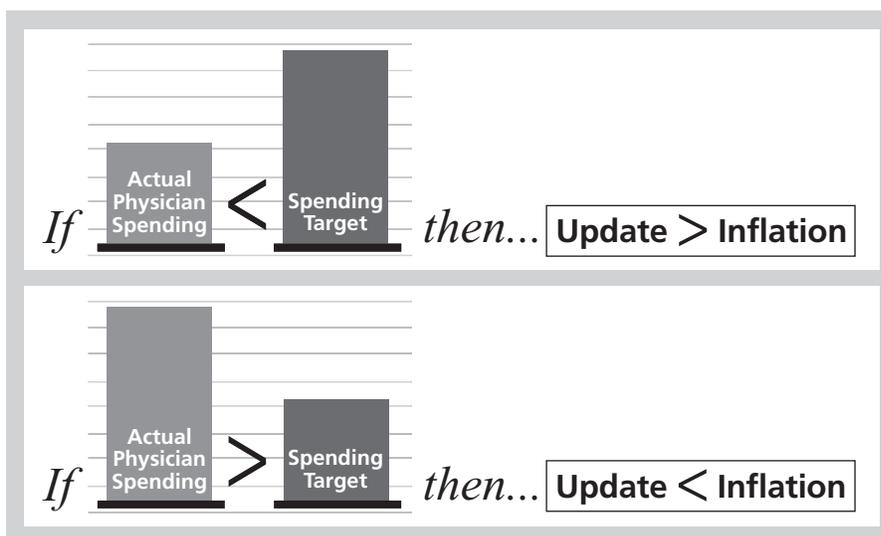
Source: American Medical Association (AMA), “Conversion Factor and Payment Schedule,” February 15, 2006; relative weights determined through search on AMA Web site, “CPT (Current Procedural Terminology,” available at www.ama-assn.org/ama/pub/category/3113.html.

spending is a unique approach to controlling spending, reflecting the unique role of the physician in health care delivery as well as the absence of effective means to assess the volume and types of physician services that are provided.² As the gatekeeper to most medical care, physicians prescribe and recommend not only physician services, but other health care services as well. Thus, they have more control than institutional providers, such as hospitals and home health agencies, over the quantity and types of health care services delivered and, ultimately, their own Medicare revenues. The target spending concept incorporated in the SGR methodology takes the place of volume control incentives and utilization checks that are incorporated in Medicare's payment approaches for institutional providers.

The SGR methodology incorporates a spending target that substitutes for volume control incentives and utilization checks in Medicare's payment approaches for institutional providers.

By linking fee updates to spending, the SGR methodology is intended to provide physicians a collective incentive to control the volume and intensity of physician services. Spending on physician services is the product of the fee for each service; the number, or volume, of services provided; and the mix, or intensity, of services delivered. The SGR methodology determines the annual change in the conversion factor—the piece of the equation controlled by the Medicare program—based on a comparison of prior years' total physician spending with a spending target. Physicians, as a group, are rewarded by larger increases in fees when actual spending per beneficiary, adjusted for inflation, is less than the target (Figure 1). Conversely, they are penalized with a lower update to fees when spending is

**FIGURE 1
Physician Fee Update**



Source: Federal Register, vol. 70, no. 223, November 21, 2005, p. 70304.

above the target. Policymakers believed that, under the SGR methodology, physician specialty societies or other physician groups would develop practice guidelines that would influence the volume and intensity of physician services—the other parts of the spending equation.

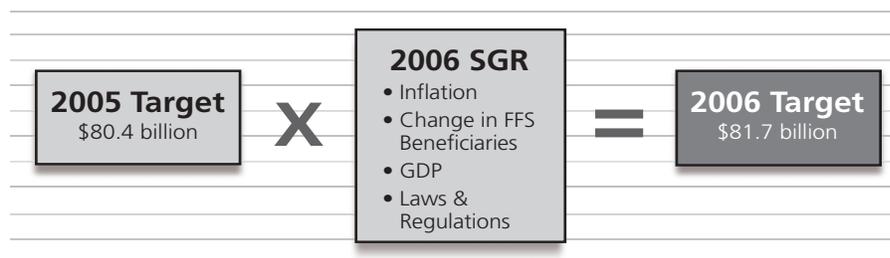
All of the components of determining a physician fee—the relative values, the conversion factor, and the geographic adjustment—have been controversial, but probably none are as contentious as the SGR methodology. In the early years of the SGR methodology, when physician fee updates were large and positive, this was not true. But as projected updates have become negative, concerns about other components of the payment system have taken a back seat.

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CALCULATING THE UPDATE

The annual update to physician fees determined through the SGR methodology involves several concepts. The starting point for the calculation is the annual inflation in the costs of providing physician services, as measured by the Medicare economic index (MEI). The MEI then is adjusted up or down to reflect how far actual Medicare spending on physician services is from the spending target. For any year, the target is the previous year’s target, adjusted by the SGR (Figure 2). The original target was Medicare’s physician spending in 1996, the first year that this type of update methodology was used.

FIGURE 2
Annual Physician Spending Target, 2006



Source: Federal Register, vol. 70, no. 223, November 21, 2005, p. 70304.

The MEI

The MEI measures the changes in the costs of the various expenses involved in providing physician services.³ The largest expense category is physician compensation, comprising over half of the expenses of providing physician services. Compensation for nonphysician personnel accounts for almost 20 percent of the index. Other expense components, like professional liability insurance and medical equipment, contribute smaller shares to the total.

The SGR

The SGR itself is the actual amount that the spending target is raised (or lowered) from one year to the next. Its components represent the factors that affect physician spending (Table 2). It is the product of the estimated change in:

- **Inflation** in the costs of providing the Medicare services included under the target
- The number of **beneficiaries** in Medicare’s fee-for-service (FFS) program⁴
- The overall economy, as measured by the real gross domestic product (**GDP**) per capita, which is intended to accommodate increased volume
- Medicare **laws and regulations** that affect physician service utilization or spending⁵

TABLE 2
Components of the SGR, 2004 to 2007

SGR TOTAL	6.6%	4.6%	1.7%	0.7%
COMPONENTS, Change in:	2004	2005	2006	2007
Inflation	1.3	0.8	2.7	2.6
FFS Beneficiaries	1.3	0.3	-3.1	-2.9
Real Per Capita GDP	2.1	2.2	2.2	2.2
Laws & Regulations	1.7	1.2	0.0	-1.0

Source: Federal Register, vol. 70, no. 223, November 21, 2005, p. 70309; and Herb B. Kuhn, Centers for Medicare & Medicaid Services (CMS), letter to Glenn M. Hackbarth, Medicare Payment Advisory Commission (MedPAC), April 7, 2006; available at www.cms.hhs.gov/SustainableGRatesConFact/Downloads/MedPAC_Letter_Estimated_2007.pdf.

The Annual MEI Adjustment Calculation

The adjustment to the MEI⁶ is the percentage of actual spending on physician services that is above or below the spending target on an annual and on a cumulative basis. For example, the 2006 spending target was \$81.7 billion and actual spending was \$97.4 billion (Figure 3). The difference between cumulative spending (since 1996) and the cumulative target was \$47.4 billion. This cumulative comparison is incorporated in the MEI adjustment because the update, by statute, cannot be more than 7 percentage

FIGURE 3
Calculating the Adjustment to the MEI

$$\left(\frac{\text{Target} - \text{Actual}}{\text{Actual}} \times 0.75 \right) + \left(\frac{\text{Cumulative Target} - \text{Cumulative Actual}}{\text{Actual Spending} \times \text{SGR}} \times 0.33 \right) = \text{MEI Adjustment}$$

2007 MEI Adjustment

$$\left(\frac{\$81.7 \text{ billion} - \$97.4 \text{ billion}}{\$97.4 \text{ billion}} \times 0.75 \right) + \left(\frac{\$693.6 \text{ billion} - \$741.0 \text{ billion}}{\$97.4 \text{ billion} \times 1.007} \times 0.33 \right) = -28.0\%^*$$

* Adjustment is limited to a range of -7 percentage points to +3 percentage points. The calculated adjustment falls below the bottom end of the negative range, so the 2007 MEI adjustment is -7 percentage points.

Source: Herb B. Kuhn, CMS, letter to Glenn M. Hackbarth, MedPAC, April 7, 2006.

points below the MEI or more than 3 percentage points above the MEI in a single year. Any residual difference between actual and target spending from previous years will be “picked up” through the cumulative part of the formula. As a result, the further the actual spending is from the target, the longer it could take to bring spending in line with the target.

WHY IS THE UPDATE NEGATIVE?

At least through 2012, payment updates under the SGR mechanism are projected to be negative. This is because actual spending has been higher than the annual target for several years, beginning in 2002. That year, fees were reduced by 4.8 percent. The updates in subsequent years also would have been negative except for congressional actions that allowed a positive or zero update percentage for 2003, 2004, 2005, and 2006.⁷

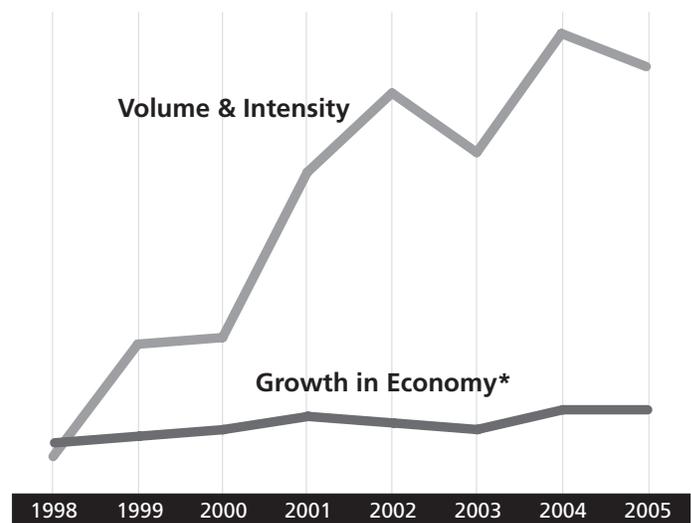
The discrepancy between actual and target spending has continued to grow for two reasons. First, when it suspended the updates, Congress did not modify the calculation of the target at the same time. This means that the difference between what the fees were between 2004 and 2006 and what they would have been had the SGR-determined update been used has been added to cumulative spending, but not to the target. For example, in 2005, spending was \$14 billion more than the target, which contributed to the cumulative difference of \$30 billion.⁸ Because the cumulative comparison is specified in statute and thus constitutes current law, the discrepancy between actual fees and what they would have been had the SGR-determined update been applied, needs to be repaid through lower physician fee updates.

Second, the volume and intensity of physician services has been rising faster than GDP, pushing spending further above the target (Figure 4).⁹ For example, for 2005, the Centers for Medicare & Medicaid Services (CMS) estimated that growth in the volume and intensity of physician services increased physician spending by 7.5 percent.¹⁰ In the same year, the GDP—which is the component of the SGR to account for increased volume of services—was 2.3 percent. Physician spending grew 5.2 percentage points faster than GDP, which is spending growth not accounted for in the target.

WHAT IS THE PROBLEM?

Four years of congressional overrides of the updates determined through the SGR methodology are evidence enough that something is broken and

FIGURE 4
Annual Increase in the Volume and Intensity of Physician Services, Compared to Growth in the Economy, 1998 to 2005



*Ten-year moving average GDP per capita.

Source: Herb B. Kuhn, CMS, letter to Glenn M. Hackbarth, MedPAC, April 7, 2006.

needs to be fixed. The congressional actions are primarily in response to concerns about physician fees increasing at less than the costs of providing services and the potential impact of this on access to care for Medicare beneficiaries. The American Medical Association (AMA) testified before the U.S. House of Representatives' Committee on Ways and Means that, "Physicians simply cannot absorb these draconian payment cuts and, unless Congress act(s), it is difficult to see how they can avoid discontinuing or limiting the provision of services to Medicare patients."¹¹ However, evidence to date does not indicate any change in beneficiary access due to lower fees. During 2002, when fees actually were cut, the volume and intensity of physician services rose, and they have continued to rise since then.¹² Even so, MedPAC and GAO agree with the Congressional Budget Office, which believes beneficiary access "may change if payment rates are significantly reduced, as will occur if the SGR mechanism operates as currently specified in law."¹³

In addition to failing to update fees to keep up with inflation, the SGR methodology has been faulted for inequity. The update applies to all physician services, affecting the payments to all physicians treating Medicare patients. Yet, increases in physician spending have not been equal. The growth in the volume and intensity of imaging services, for example, has contributed a disproportionate amount to overall physician spending.¹⁴ Widely noted geographic differences in the use of services¹⁵ suggests that either volume and intensity of services should increase more in areas with lower use patterns, or that spending should be constrained in areas with higher use, or both. Further, technological developments that would boost service use are likely to apply to some services more than others, yet all volume and intensity growth is treated the same under the SGR methodology.

A related concern is that the methodology may be ineffective. The belief that linking physician fee updates and a budgetary target could contain physician spending has been called into question. According to MedPAC, the SGR approach is flawed because "it was assumed that the system would provide physicians with a collective incentive to control the volume of services. This goal is unrealistic, however, because an individual physician reducing volume in response to incentives provided by the SGR system would not realize a proportional increase in payments.... If anything, an individual physician has an incentive to increase volume under such a system."¹⁶

FIXING THE SGR METHODOLOGY

Clearly, the choice of a "fix" to the SGR methodology depends on the component of the SGR problem that is of most concern and the emphasis on the budgetary consequences of any fix. The SGR methodology could be changed to reduce the difference between actual spending and the target (thus reducing the chances of a negative update) or to provide differential updates to reward or penalize certain actions. Reducing the

actual and target spending differentials would, by definition, result in higher physician spending, which may address beneficiary access concerns. Differential updates could also result in higher physician spending, but not necessarily. Some believe that differential updates could improve the equity of the update and the effectiveness of incentives provided through the update in changing physician behavior.

Loosening the Spending Target

There are several ways to reduce the difference between actual spending and the target that would keep the basic the SGR methodology intact. The spending target could be raised by changing its calculation. Alternatively, spending could be lowered by modifying the definition of spending that is compared to the target. Another option would be to “buy down” or eliminate the residual, cumulative difference between the target and actual spending that had not been addressed through reduced updates. These changes would raise Medicare physician spending and affect beneficiaries through higher premiums and co-payments, as well as put pressure on the federal budget.

The gap between actual spending and the target could be reduced (which would lead to higher fee updates) by substituting a different measure of “allowable” cost increases associated with technological advances. As stated, GDP is used as a benchmark to increase the target for additional spending. The rationale for this is that as the economy grows, so does the ability to apply more resources to health care spending.¹⁷ The need for health care, however, does not increase proportionately with growth in the economy. In some cases health care services may be so desirable that society would want to expend additional resources. For example, increases in primary care or preventive services may be expenditures that society would value. Given rapid technological growth and evidence that the Medicare population may be in need of additional services to treat multiple, chronic conditions, a more realistic benchmark may be higher than the GDP. Determining another metric for growth in spending beyond population and inflation that would be more appropriate than GDP, however, would be subject to controversy and disagreement.

The definitions of spending used in the target and the actual amount of spending under the SGR methodology could be modified. Currently, more services are included in the SGR definitions than those actually paid under the physician fee schedule.¹⁸ Spending associated with services and supplies “incident to” a physician office visit and related to physician fee schedule services are included in the definition because physicians are responsible for ordering and often performing these services. Physicians may financially benefit from providing these services, so they are included under the target to provide incentives for physicians to control their

Increasing physician fees would not only raise Medicare spending but also beneficiary spending through higher co-payments and premiums.

volume and intensity.¹⁹ Removing physician-administered drug costs from the calculation of actual spending and the target was proposed when spending for these drugs was climbing faster than spending for other physician services.²⁰ The reason for this proposal was that, although physicians ordered and administered the drugs, they had to purchase the drugs and did not control their price.²¹ However, physicians do have control over the volume and type of drug used, which does affect overall spending.²² Spending for physician-administered drugs has since fallen, therefore removing these services has not been specifically suggested because their removal would not narrow the gap between actual and target spending, but would instead widen it.

Physician fee updates are projected to be negative through 2015, in part, because of the spending that accumulated while the SGR-determined updates were suspended. The cumulative target could be rebased, or calculated from a more recent start point, to reduce or eliminate the effect of unrecovered spending. This, however, would have a budgetary impact because the budgeting rules assume that the spending above the target will be recovered through lower updates. The cost or savings associated with any changes are measured relative to this assumption. Therefore, reducing or eliminating the residual spending that has not been recovered would be counted as a cost for federal budgeting purposes. In this way, changes to the cumulative component of the formula could add significantly to budgetary concerns.

Any of these “fixes” also would have real budgetary implications for the Medicare program and its beneficiaries because they would raise Medicare spending. These increases would, in turn, directly affect beneficiary out-of-pocket costs through higher beneficiary co-payments and premiums, which are calculated as a share of fees and spending, respectively. Co-payments for most physician services are 20 percent of the Medicare fee, so any fee increases raise beneficiary obligations. As an illustration of the possible effect on premiums, CMS estimates that the Medicare premium will rise 1.5 percent to \$95 per month if 2007 physician fees are held to 2006 levels, rather than subject to the SGR-determined cut.²³

Targeting the Target

Some argue that the effectiveness and equity of the SGR methodology could be improved by implementing separate targets for different segments of physician spending. This could strengthen the relationship between any given physician’s actions and subsequent fee updates. Individual physicians would have more of an effect on the volume and intensity of services that would contribute to meeting the spending target. This approach is likely to receive serious attention because MedPAC is required to evaluate separate targets in its congressionally mandated report on alternatives to the SGR.²⁴ Specifically, the Commission must consider separate spending targets that would apply to physicians in group practices,

hospital medical staffs, types of service, geographic areas, and physician outliers (meaning physicians with spending or practice patterns that are very different from those of otherwise similar physicians).

Segmenting physician spending to apply separate targets could achieve multiple policy objectives. Regional targets, for example, could be a tool for reducing geographic disparities in health care utilization. Tighter spending targets could be applied to regions that have higher-than-average physician spending to give physicians stronger incentives to either slow growth in spending, or reduce service use to bring patterns in line with the overall average. At the same time, looser targets in underserved areas could be a means to provide greater access.

Categories of services could also be subject to different spending targets. Services that exhibit particularly high rates of growth, such as imaging services for example, could be singled out for tighter spending targets and lower updates. Alternatively, the use of additional preventive services, for example, could be encouraged through looser targets and higher updates. A variant of this option would be to aggregate spending by physician specialty, which could be used to bolster certain medical specialties. Primary care physicians, for example, could receive higher updates for the services they provide than specialists to address what many perceive as payments that are too low to encourage enough physicians to enter primary care.

To encourage physicians to manage services for a given population, separate targets could be applied to spending associated with organized groups of physicians. For example, physicians in a multi-specialty group practice could be subject to a spending target with higher updates if their combined spending was lower than what was expected from a similarly situated group. Group practices would then be rewarded for adopting efficient patterns of care across the range of services they offered. Most physicians, however, are not part of a multi-specialty group. Another option would be to aggregate the spending associated with all physicians affiliated with a particular hospital for the purpose of applying a spending target. This might support physician efforts to strengthen affiliations in an effort to manage spending within their control.

Any of these options could reinforce the link between the individual physician's actions and financial reward or penalty through the Medicare update mechanism. The strength of the relationship between individual actions and the incentives would be directly proportional to the size of the spending segment. An individual physician's control over the financial reward or penalty would be greater when the services provided by that physician comprised a larger proportion of the total spending associated with the target.

Separate spending targets could strengthen the relationship between an individual physician's actions and financial rewards or penalties through Medicare's fees.

Implementation — Implementing separate spending targets with different associated updates would require overcoming several technical issues. Allocating spending to the appropriate target is subject to error, and these estimates become less precise as the number of spending targets grows. Yet, the smaller the spending target, the more any inaccuracy in assigning spending would affect the relationship between actual and targeted spending. The smaller the target, the greater the need to account for variations in health care needs through a risk adjustment mechanism. Because health care costs in a small spending segment would be concentrated in a relatively small number of beneficiaries, the presence of relatively few beneficiaries with high costs could skew the spending subject to the target. In this scenario, spending could be above the target if the comparisons did not adequately account for differences in risk across different populations.

Another set of difficult implementation issues associated with defining the segments of spending and then assigning separate targets is political. As more and more lines are drawn that affect fees and fee increases, the more disagreement there will likely be with respect to which spending belongs where. This kind of segmentation would require more explicit decisions about which spending is more desirable than other spending. The Medicare program is not supposed to affect clinical decision making, yet decisions about differential updates could be perceived as decisions that would directly affect the practice of medicine.

Relative Fees — Aside from these implementation issues, segmented targets would change the structure of the physician fee schedule over time. The physician fees were developed to reflect the resource use of each service relative to the overall average. With the application of different updates—regardless of the way the spending was segmented—the relative comparisons across the fees would be changed. This would affect an underlying tenet of the payment system that the fee for a service be the same across providers. Over time, fees might no longer be the same for the same service, nor would they necessarily differ according to the resources needed to provide each service. This might be an acceptable change to the structure of the fee schedule if the resultant fees more accurately represented the value of services to society. How this would be assessed, however, would be difficult.

SCRAP THE WHOLE THING?

Because of the payment cut in 2002 and projected cuts through 2015, the AMA urges Congress to “repeal the SGR and replace it with a system that keeps pace with increases in medical practice costs.”²⁵ MedPAC also has advocated eliminating the SGR and bases its annual update recommendation on assessments of payment adequacy and how efficient providers’ costs are likely to change in the coming year. In recognition of the effect of Medicare physician spending on the federal budget, the Commission acknowledges that Congress may need to keep some form of volume control in determining the final update to physician fees.²⁶

Rather than relying on the SGR methodology, which treats all physicians and services alike, MedPAC proposed focused policy approaches to limit inappropriate volume increases.²⁷ For example, after it identified imaging services as one of the fastest growing among physician services, the Commission analyzed spending for imaging and the physicians who provided the services. Based on this analysis, MedPAC developed a set of recommendations to Congress to reduce inappropriate use and improve the quality of imaging services. These recommendations included expanded ability to identify improper claims, reduced payments for services requiring fewer resources, payment to certified providers only, and expanded restrictions on physician self-referral.

Targeted approaches to controlling inappropriate volume increases would be more transparent than the automatic SGR methodology.

This type of approach to controlling spending on particular types of services could also be applied in various geographic areas or used to identify specialties if analysis indicated that special circumstances contributed to utilization that was believed to be unwarranted. This would subject spending control decisions to greater transparency than the automatic SGR-based updates, which are applied across all services. The data and resources to conduct such analyses, however, would need to be available.

BUT CAN WE LIVE WITHOUT IT?

Before the SGR methodology and its predecessor, Medicare experienced multiple years of double-digit physician spending increases due primarily to growth in the volume and intensity of physician services, not changes in fees. The targets and subsequent feedback through the update were intended to provide incentives to control the volume and intensity of physician services. It is not possible to determine the extent to which this incentive had an impact on physicians in the aggregate. There were few, if any, reports of instances in which physician prescribing and ordering behavior changed because of fee updates, although spending growth did moderate after implementation of the initial version of the targets.

The physician spending update approach is the only one in which Medicare links annual updates to a spending target, but other Medicare payment systems include checks on or incentives for providers to control volume and intensity growth. Payments for most facility services [such as acute care hospitals, skilled nursing facilities (SNFs), and home health agencies] bundle the payment to cover all services provided during a specified period of time (for example, the hospital stay, a day, a 60-day episode). In this way, the provider has financial incentives to control the volume of services delivered during the period covered by the payment. In addition, most other Medicare payments are predicated on a physician determining that the service was needed, which provides a check on rising volume.

Moreover, beneficiaries may be hesitant to enter a hospital or a SNF unless they feel there is no other choice; this reluctance constrains

service use. Beneficiaries may be less resistant to returning for additional office visits or having more tests or imaging services provided in a physician's office to definitively confirm or rule out a diagnosis. Regardless of the monetary cost of any particular service, the time and emotional costs of admission to treatment in a facility are likely higher than the costs associated with some of the physician services that have witnessed the greatest growth.

CONCLUSION

Few would wholeheartedly endorse the current SGR method for updating physician payments. This methodology has resulted in updates that do not keep up with inflation in the cost of providing services, and it may not provide the collective incentives to moderate the rising volume and intensity of physician services as intended. Some have even argued that it has the opposite effect—that its fee reductions have actually caused the volume of services to go up as physicians seek to maintain their income.

Yet the fiscal pressures on the Medicare program are real. The challenge of accommodating increased Medicare spending on physician services will only intensify as the population ages and has greater health care needs and as new technology expands effective treatments. Spending control mechanisms may be more effective for other Medicare services than for physician services, which could contribute to an escalating share of health care spending on physician services. Maintaining the appropriate balance of resources across the components of health care may ultimately result in the most efficient Medicare spending, but determining and achieving this balance will be difficult.

Congressional and policy discussions about how to control physician spending have focused on ways to ensure that Medicare spending is for appropriate services that help its beneficiaries. It is widely accepted that Medicare should pay reasonably for services that are valued. Doing this would require more detailed and timely data on the resources required to provide each service and information on the value of particular services to different populations. More systematic and targeted approaches to reducing unnecessary service growth require more specific information about what services are actually provided and the value of those services. Developing this information and ensuring its accuracy and timeliness could require significant resources. If those investments are made, future discussions about the level of and growth in physician spending will be better informed. In the meantime, the blunt tool of the SGR has matched the specificity of the information available and may allow policymakers to control spending without interfering in clinical decision making.

More acceptable approaches to controlling physician spending that balance beneficiary access and federal budget realities have yet to be realized.

ENDNOTES

1. For more information about physician spending growth and the contribution of escalating service use and intensity of services to higher Medicare spending, see Laura A. Dummit, "Medicare Physician Payments and Spending," National Health Policy Forum, Issue Brief 815, October 9, 2006; available at www.nhpf.org/pdfs_ib/IB815_PhysicianSpending_10-09-06.pdf.
2. Prior to the SGR methodology, Medicare used the volume performance standard (VPS) methodology to update the conversion factor for physician fees. The VPS also included a spending target.
3. The MEI is the weighted average annual price change for the inputs used to produce physician services.
4. This is to ensure that both the target and actual spending reflect the costs of services provided to the same group of beneficiaries. The costs of services provided to beneficiaries in Medicare Advantage (MA), the managed care part of Medicare, are not included in either measure. So, even though the total number of Medicare beneficiaries rises each year, changes in enrollment in MA could reduce the count of beneficiaries used in calculating the SGR.
5. Changes in Medicare law or regulations, such as adding a new benefit or altering provider participation requirements, can affect physician spending. This factor accounts for those spending changes so that physicians are not held accountable through their fees.
6. This is referred to as the update adjustment factor, or UAF. *Federal Register*, vol. 70, no. 233, November 21, 2005, p. 70304.
7. In 2003, the update was 1.6 percent (instead of -4.4) because Congress allowed the administration to raise the cumulative expenditure target. The update was 1.5, 1.5, and 0.0 percent in 2004, 2005, and 2006, respectively. Donald B. Marron, Congressional Budget Office (CBO), "Medicare's Physician Payment Rates and the Sustainable Growth Rate" statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, July 25, 2006; available at www.cbo.gov/ftpdocs/74xx/doc7425/07-25-SGR.pdf.
8. Marron, CBO statement.
9. The Government Accountability Office (GAO) determined that between April 2000 and April 2005, the average annual percentage change in the number of services per beneficiary was 4.4 percent and the average annual percentage change in service intensity per beneficiary was 5.2 percent. GAO, "Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems," GAO-06-704, July 2006; available at www.gao.gov/new.items/d06704.pdf.
10. The Centers for Medicare & Medicaid Services (CMS) recently estimated that the 2007 projected growth in the volume and intensity of physician fee schedule services was about 5 percent. CMS, "Medicare Premiums and Deductibles for 2007," fact sheet, September 12, 2006; available at www.cms.hhs.gov/apps/media/press/release.asp?Counter=1958.
11. Nancy Nielsen, American Medical Association, statement before the Subcommittee on Health of the House Committee on Ways and Means, February 10, 2005; available at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=2484>.
12. GAO, "Medicare Physician Services," GAO-06-704; and MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2006, available at www.medpac.gov/publications/congressional_reports/Mar06_EntireReport.pdf.
13. Marron, CBO statement, p. 3.
14. Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Growth in the Volume of Physician Services*, December 2004, available at www.medpac.gov/publications/congressional_reports/Dec04_PhysVolume.pdf; and Herb B. Kuhn, CMS, letter to Glenn M. Hackbarth, MedPAC, April 7, 2006, available at www.cms.hhs.gov/SustainableGRatesConFact/Downloads/MedPAC_Letter_Estimated_2007.pdf.

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15. See, for example, John E. Wennberg *et al.*, “Use of Medicare Claims Data to Monitor Provider-Specific Performance Among Patients With Severe Chronic Illness,” *Health Affairs* (October 7, 2004), pp. var-5–var-18.
16. MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2002, p. 74.
17. GAO, “Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms,” GAO-05-85, October 2004; available at www.gao.gov/new.items/d0585.pdf.
18. Services paid under the physician fee schedule include evaluation and management services, procedures, and surgeries provided by physicians or under certain conditions by health practitioners under the direction of a physician.
19. Services and supplies related to physician fee schedule services include those that are “incident to” an office visit, such as injections and associated supplies and outpatient physical or occupational therapy; screening tests; diagnostic x-rays, laboratory or other tests; and surgical dressings, splints, or casts. The Medicare payment for these services is based on other methodologies. In 2005, Medicare spending was about \$82 billion under the physician fee schedule, while \$94.5 billion was spent on all of the services accounted for in the SGR methodology. Marron, CBO statement.
20. Medicare has traditionally covered physician-administered drugs and certain drugs administered through durable medical equipment as part of its outpatient benefit. These should be distinguished from drugs provided through private plans under the outpatient prescription drug benefit (Part D), which was implemented beginning in 2006.
21. GAO, “Medicare Physician Payments,” GAO-05-85.
22. See Mireille Jacobson *et al.*, “Does Reimbursement Influence Chemotherapy Treatment for Cancer Patients?” *Health Affairs*, 25, no. 2 (2006), pp. 437–443.
23. See CMS, “Medicare Premiums and Deductibles for 2007.”
24. MedPAC is required to report to the Congress in March 2007 on alternatives to the SGR mechanism for updating physician fees.
25. Cecil B. Wilson, American Medical Association, “Medicare Physician Payments: 2007 and Beyond,” statement before the Committee on Energy and Commerce, Subcommittee on Health, U.S. House of Representatives, September 28, 2006, p. 2; available at <http://energycommerce.house.gov/108/Hearings/09282006hearing2045/Wilson.pdf>.
26. MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2005, pp. 170–171; available at www.medpac.gov/publications/congressional_reports/Mar05_EntireReport.pdf.
27. Mark E. Miller, MedPAC, “Medicare payment to physicians,” statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, July 25, 2006; available at www.medpac.gov/publications/congressional_testimony/072506_Testimony_physician.pdf.



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