

SGR: The Good, the Bad, & the Ugly

**Bruce Steinwald
Jessica Farb**

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The Issue

- Under current law, Medicare fees will be reduced significantly in 2012 and further reductions are likely for several years thereafter.
- This largely results from increased spending caused by Medicare beneficiaries receiving an increasing number of ever more complex and expensive physician services.
- Addressing this issue will cost billions of dollars (as scored by CBO).

Roadmap

- Basics of Medicare physician payment
- Mechanics of the Sustainable Growth Rate (SGR)
- Trends in Medicare physician spending
- How has SGR worked?
- Alternative approaches to SGR and reducing spending increases

Physician Payment Basics

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

- The physician fee schedule (PFS) replaced the previous reasonable charge method in 1992.
- The fee schedule is based on a resource-based relative value scale (RBRVS).
- Over 7,000 services including office visits, surgical procedures and diagnostic tests, are covered by the fee schedule.
- For most services, Medicare pays 80 percent and the beneficiary (or the beneficiary's supplementary insurance) pays 20 percent.

Physician Payment Formula

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

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

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

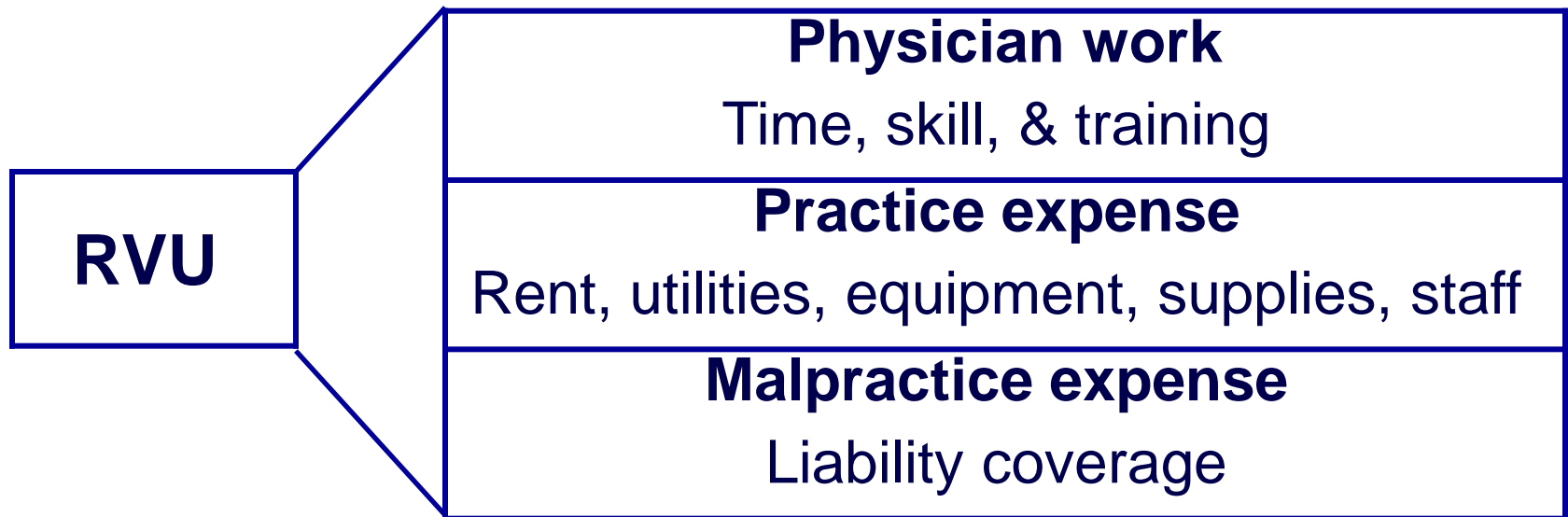
Conversion factor Converts adjusted RVUs into dollar amounts

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

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

Nationally Uniform Relative Value Units

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



Geographic Adjustment

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

Conversion Factor

- A single conversion factor is applied to all services covered by the fee schedule.
- The conversion factor for 2011 is \$33.9764.
- The conversion factor is updated each year under the sustainable growth rate (SGR) system.

Physician Payment: Example 1

Office visit, detailed (established patient)

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

RVU x Geographic adjustment x Conversion factor

2.09 x 1.124 x \$33.9764

= \$79.81

Notes: This example is based on current rates effective January 1, 2011. To simplify the calculation, the GPCIs were collapsed into one geographic adjustment factor.

Physician Payment: Example 2

Knee arthroscopy/surgery

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

RVU x Geographic adjustment x Conversion factor

18.53 x 1.124 x \$ 33.9764

= \$707.65

Notes: This example is based on current rates effective January 1, 2011. To simplify the calculation, the GPCIs were collapsed into one geographic adjustment factor.

Physician Payment: Example 3

Knee arthroscopy/surgery

- Procedure code 29850
- Performed by San Mateo CA physician in a facility setting

RVU x Geographic adjustment x Conversion factor

18.53 x 1.199 x \$ 33.9764

= \$754.87

Notes: This example is based on current rates effective January 1, 2011. To simplify the calculation, the GPCIs were collapsed into one geographic adjustment factor.

Other Fee Adjustments

- **Participation**

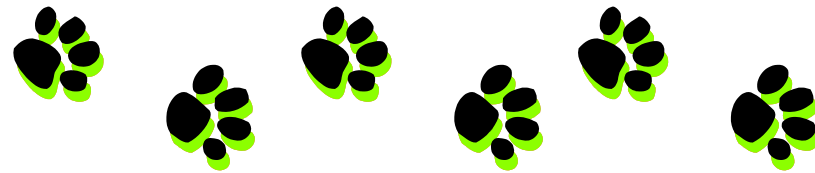
- **Participating physicians** agree to accept Medicare's fee schedule payment as payment in full.
- **Non-participating physicians** are paid 95 percent of the fee schedule, but may charge beneficiaries a limited additional amount—this practice is called balance billing.

- **Shortage Areas**

- Physicians in a designated **Health Professional Shortage Area (HPSA)** receive an additional 10 percent.
- For major surgical procedures performed in HPSAs from January 1, 2011 through December 31, 2015 ACA established an additional 10 percent bonus known as a **HPSA Surgical Incentive Payment (HSIP)**.

- **Non-physician providers**

- Generally paid 85 percent of the physician fee schedule.
- Not permitted to balance bill.



Mechanics of SGR

SGR-Determined Update

Step 1: Calculate the sustainable growth rate

Office of the Actuary (OACT)

Estimates of the SGR

- Twice a year, actuaries at CMS estimate the SGR and resulting updates to the physician fee schedule conversion factor.
- These calculations are performed in March and November for the current year.
- CMS also makes adjustments to the SGRs for the two prior years to incorporate more complete Medicare claims data.
- CMS' most recent SGR estimates reflect the legislative overrides of the system in 2009 and 2010.

Congress Created SGR to Constrain Physician Spending Growth

The SGR is the product of changes in four factors:

- Input prices for physician services as measured by the Medicare Economic Index (MEI)
- Traditional FFS Medicare enrollment
- 10-year moving average real Gross Domestic Product (GDP) per capita
- Expenditures for physician services resulting from changes in laws and regulations

SGR's Four Factors

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

The Change in the SGR Target is the Product of the Percentage Change in Four Factors

	2009	2010	2011
Factor 1: Change in input prices	1.8%	0.9%	0.2%
Factor 2: Change in FFS enrollment	-0.6%	1.6%	2.4%
Factor 3: Change in 10-year moving average of real GDP per capita	1.0%	0.7%	0.7%
Factor 4: Changes due to laws and regulation	4.1%	4.9%	-16.2%
Total SGR	6.4%	8.3%	-13.4%

Source: CMS, Office of the Actuary (OACT), November 2010

Notes: OACT estimates an increase in spending due to changes in law and regulation (factor 4) for both 2009 and 2010 as a result of the legislative overrides of the SGR-required fee update in those years. In 2011, OACT estimates a large decline in spending due to both the expected expiration of the SGR overrides in 2009 and 2010 and the requirement that the conversion factors thereafter shall be determined as if the legislation had not been in effect. Other legislative changes that contribute to estimates of this factor include: bonuses for the physician quality reporting initiative (PQRI), e-prescribing, and HIT; the imaging utilization assumption change from the ACA; the new benefit of an annual wellness visit; and the bundling of certain lab services into the dialysis composite rate.

SGR-Determined Update

Step 1: Calculate the sustainable growth rate

Step 2: Apply the sustainable growth rate to spending to determine target dollar amount

SGR Target Spending

- Yearly allowed expenditures are equal to allowed expenditures for the previous year (2009) increased by the SGR for the next year (8.3 percent in 2010). For example,

$$\begin{aligned} \text{2010 allowed spending} &= \text{2009 allowed spending} \times \text{SGR} \\ &= \$89.5 \text{ B} \times 1.083 \\ &= \$96.9 \text{ B} \end{aligned}$$

- Cumulative allowed expenditures are equal to the sum of cumulative allowed expenditures from the previous years (1996 through 2009) and allowed expenditures for the current year (2010). For example,

$$\begin{aligned} \text{Cumulative allowed spending} &= \$917.8 \text{ B} + \$96.9 \text{ B} \\ \text{(April 1996 through Dec. 2010)} &= \$1,014.7 \text{ B} \end{aligned}$$

SGR-Determined Update

Step 1: Calculate the sustainable growth rate

Step 2: Apply the sustainable growth rate to spending to determine target dollar amount

Step 3: Determine how actual spending compares to target spending

Comparing Actual Spending to Target Spending

- To arrive at a fee update, the MEI is adjusted based on the relationship between cumulative actual spending and a cumulative target.
 - If cumulative actual spending is equal to the cumulative target, the fee update will be equal to the MEI.
 - If cumulative actual spending is not equal to the cumulative target, then an update adjustment factor (UAF) is used to increase or decrease the fee update relative to MEI.
- The UAF is constrained so that the update cannot be set more than 3 percent above or 7 percent below MEI.

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

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

SGR Compares Cumulative Spending Since 1996 to Cumulative Allowed Spending Target

Time Period	Spending ^a (\$ billions)	Allowed Spending ^a (\$ billions)	Spending in Excess ^a of Allowed Spending (\$ billions)
1996-2008 ^b	\$846.4	\$828.2	\$18.2
2009	\$90.6	\$89.5	\$1.1

^aCMS Office of the Actuary estimate as of November 2010

^bApril 1, 1996 through December 31, 2008

Source: CMS

Update Adjustment Factor

- The UAF formula is set in law

$$UAF_{2010} = \frac{Target_{2009} - Actual_{2009}}{Actual_{2009}} \times 0.75 + \frac{Target_{4/96-12/09} - Actual_{4/96-12/09}}{Actual_{2009} \times (1 + SGR_{2010})} \times 0.33$$

Target spending 2009 = \$89.5 B

Actual spending 2009 = \$90.6 B

Target cumulative (4/96-12/09) = \$918 B

Actual cumulative (4/96-12/09) = \$937 B

2010 SGR = 8.3%

$$\begin{aligned} \text{2010 UAF} &= (((89.5 - 90.6)/90.6)) \times 0.75 + (((918 - 937)/(90.6 \times (1+.083)))) \times 0.33 \\ &= -0.00911 + -0.0639 \\ &= -7.3\%^{**} \end{aligned}$$

Source: Illustrative example based on data from CMS Office of the Actuary

****By statute, the UAF cannot be more than 3 percent or less than -7 percent.. Therefore, in the example above, the UAF would be -7 percent.**

SGR-Determined Update

Step 1: Calculate the sustainable growth rate

Step 2: Apply the sustainable growth rate to spending to determine target dollar amount

Step 3: Determine how actual spending compares to target spending

Step 4: Calculate the conversion factor update based on result of step 3

Conversion Factor Calculation

Baseline 2009 CF = \$30.1510

MEI 2010 = 1.2%

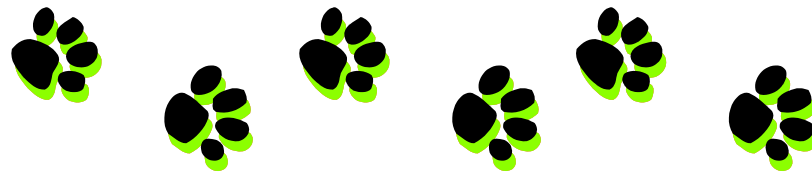
UAF 2010 = -7.0%**

Total = $((1 - \text{UAF}) \times (1 + \text{MEI}) - 1)$
= $((1 - .070) \times (1 + .012) - 1)$
= $((0.93) \times (1.012) - 1)$
= $((.9412) - 1)$
= -5.9%

2010 CF = $\$30.1510 \times (1 - .059)$
= \$28.37

Source: Illustrative example based on data from CMS Office of the Actuary

**By statute, the UAF cannot be more than 3 percent or less than -7 percent. Therefore, in the example above, the UAF would be -7 percent.

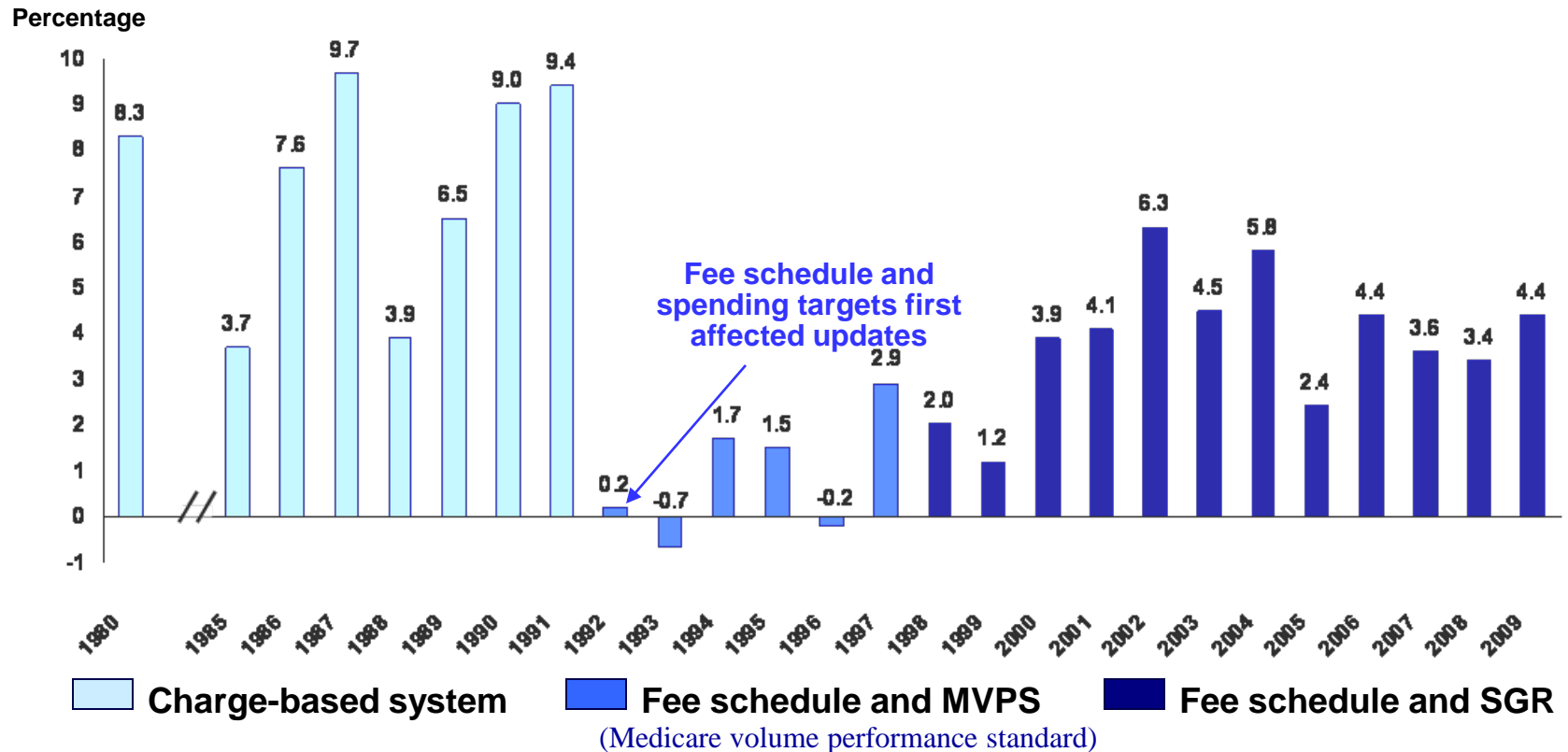


Physician Spending Trends

Trend in Medicare Spending on Physician Services

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

Growth in Volume and Intensity of Medicare Physician Services per FFS Beneficiary, 1980-2009

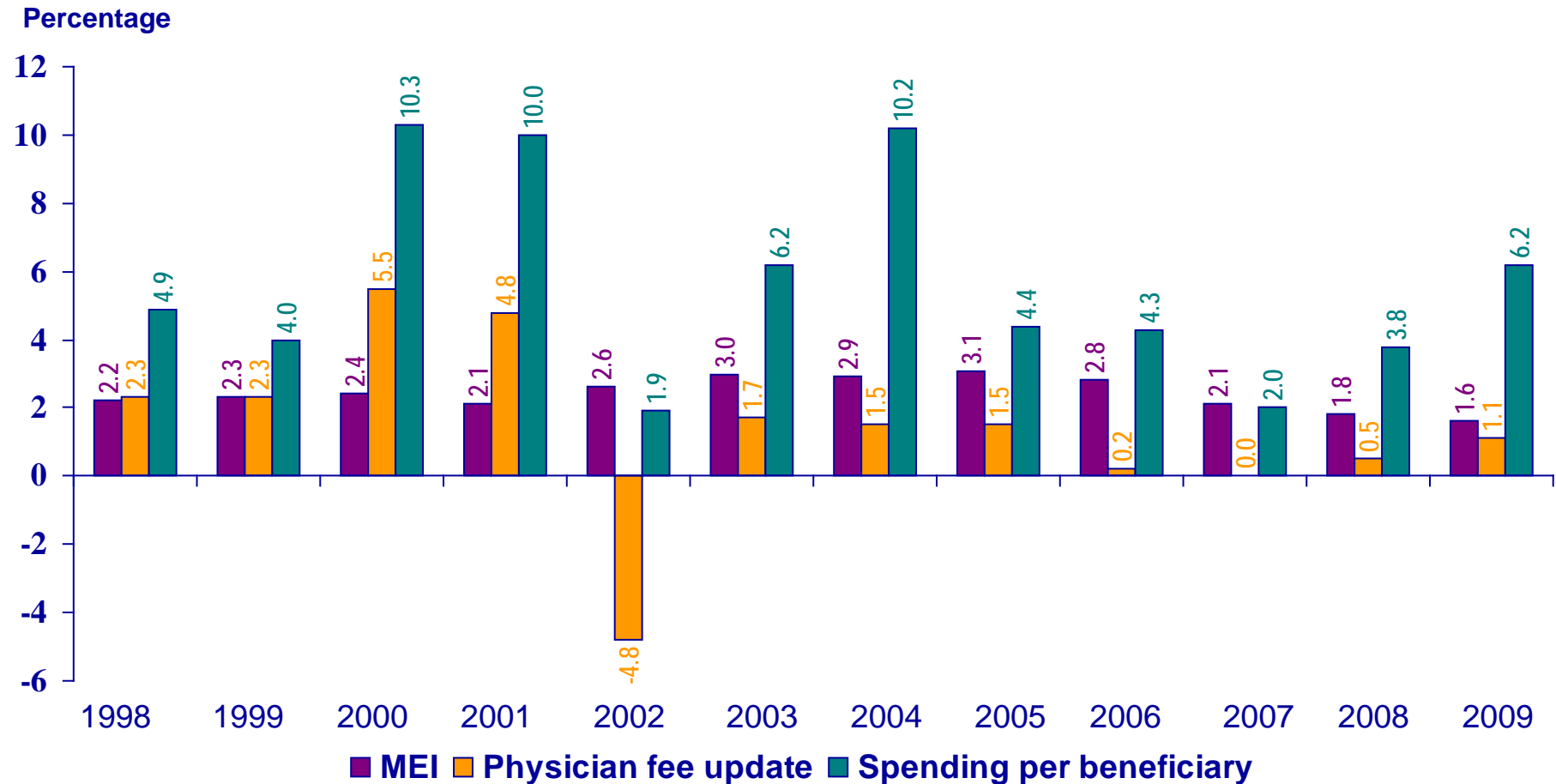


Source: Data from CMS and the *Boards of Trustees of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds*. Data for 1999 through 2008 are based on the 2010 *Annual Report of the Boards of Trustees of the Federal HI and Federal SMI Trust Funds*.

Volume and Intensity Trends

- There are three distinct periods of volume and intensity growth:
 - Medicare FFS spending per beneficiary increased rapidly before the RBRVS was implemented.
 - Medicare FFS spending per beneficiary was moderated during the 1990s after RBRVS was implemented.
 - Medicare FFS spending per beneficiary trended upward during the following decade.
- Although the most recent spending trend was not as great as the pre-RBRVS trend, on average the trend has exceeded growth in real GDP per capita.

Percentage Change in MEI, Physician Fee Update, and Medicare Spending per FFS Beneficiary, 1998-2009

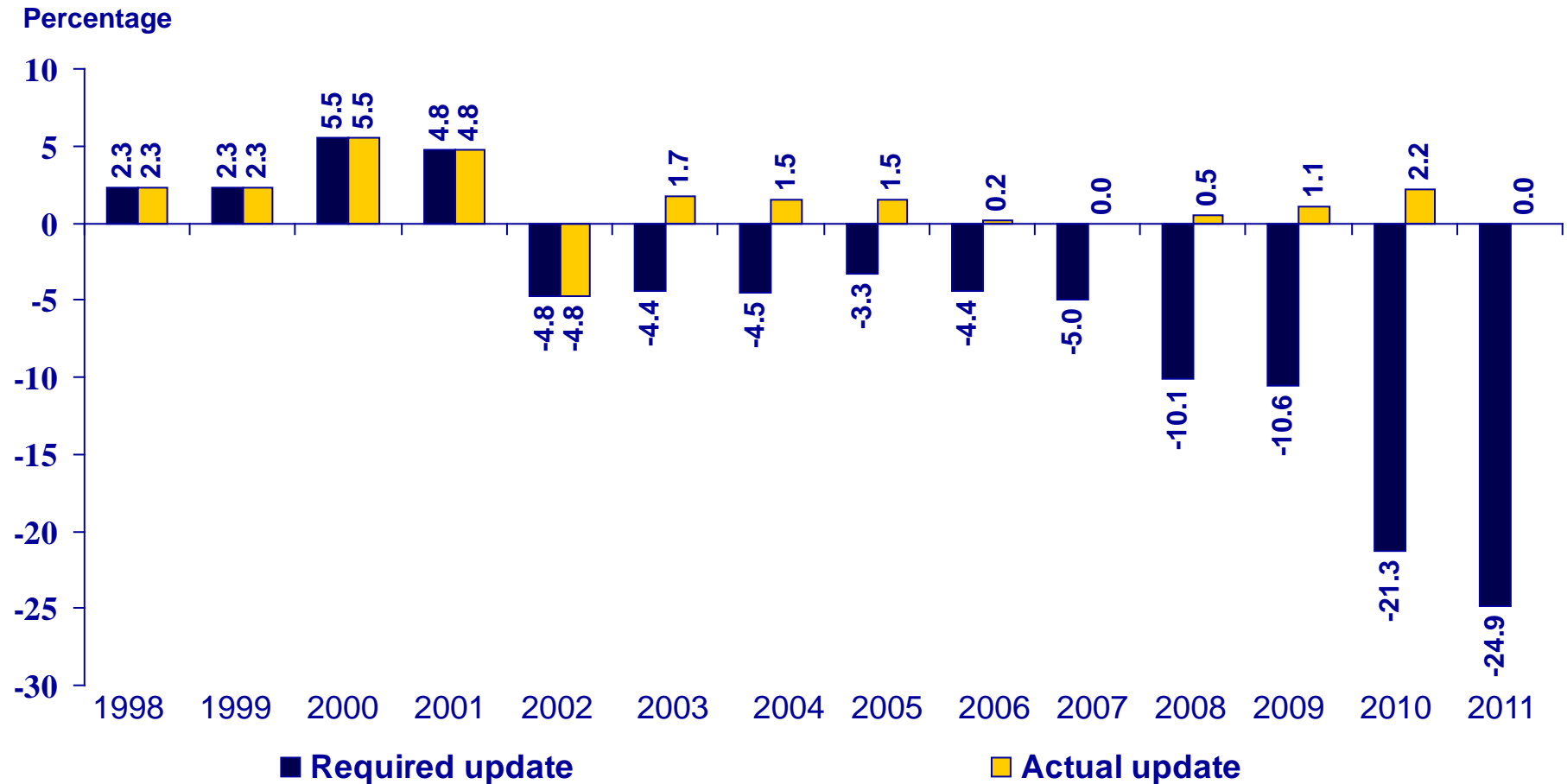


Source: Data from the Boards of Trustees of the Federal HI and SMI Trust Funds

Trends in the Updates

- The SGR was permitted to work per statute from 1998-2002.
- Congress has overridden reductions in fees beginning in 2003.
- Scheduled fee reductions have grown larger in order to achieve budget neutrality within a 10-year budget window.

Actual Update Compared to Required Update, 1998-2010



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

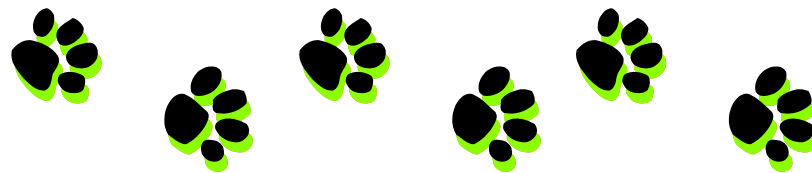
Notes: Beginning with 2008, required updates are a result of both the SGR formula and legislative changes. The actual fee update for 2010 was 0.0 percent from January through May and 2.2 percent from June through December.

Increasing Difficulty of Year-to-Year Fixes

- In 2009, expenditures under the SGR system were \$90.6 billion, whereas target expenditures were \$89.5 billion.
- As a result, the SGR called for a –21.3 percent fee update in 2010^a to offset:
 - \$1.1 billion in excess spending in 2009,^b plus
 - \$18.2 billion in excess spending accumulated from 1996 through 2008^b
- However, Congress delayed the scheduled cuts through a series of legislation:
 - 0.0 percent update from January to February 2010 (P.L. 111-118)
 - 0.0 percent update for March 2010 (P.L. 111-133)
 - 0.0 percent update for April to May 2010 (P.L. 111-157)
 - 2.2 percent update from June to November 2010 (P.L. 111-192) and continued for December 2010 (P.L. 111-286)
- To avert another year of looming cuts and last minute fixes, Congress replaced the 25 percent fee cut scheduled to take effect on January 1, 2011 and replaced it with a fee freeze (0.0 percent update to 2010 levels through December 2011 in P.L. 111-309)

^a CMS Office of the Actuary estimate as of November 2009

^b CMS Office of the Actuary estimate as of November 2010



Implications of SGR

How has SGR worked?

Positives:

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

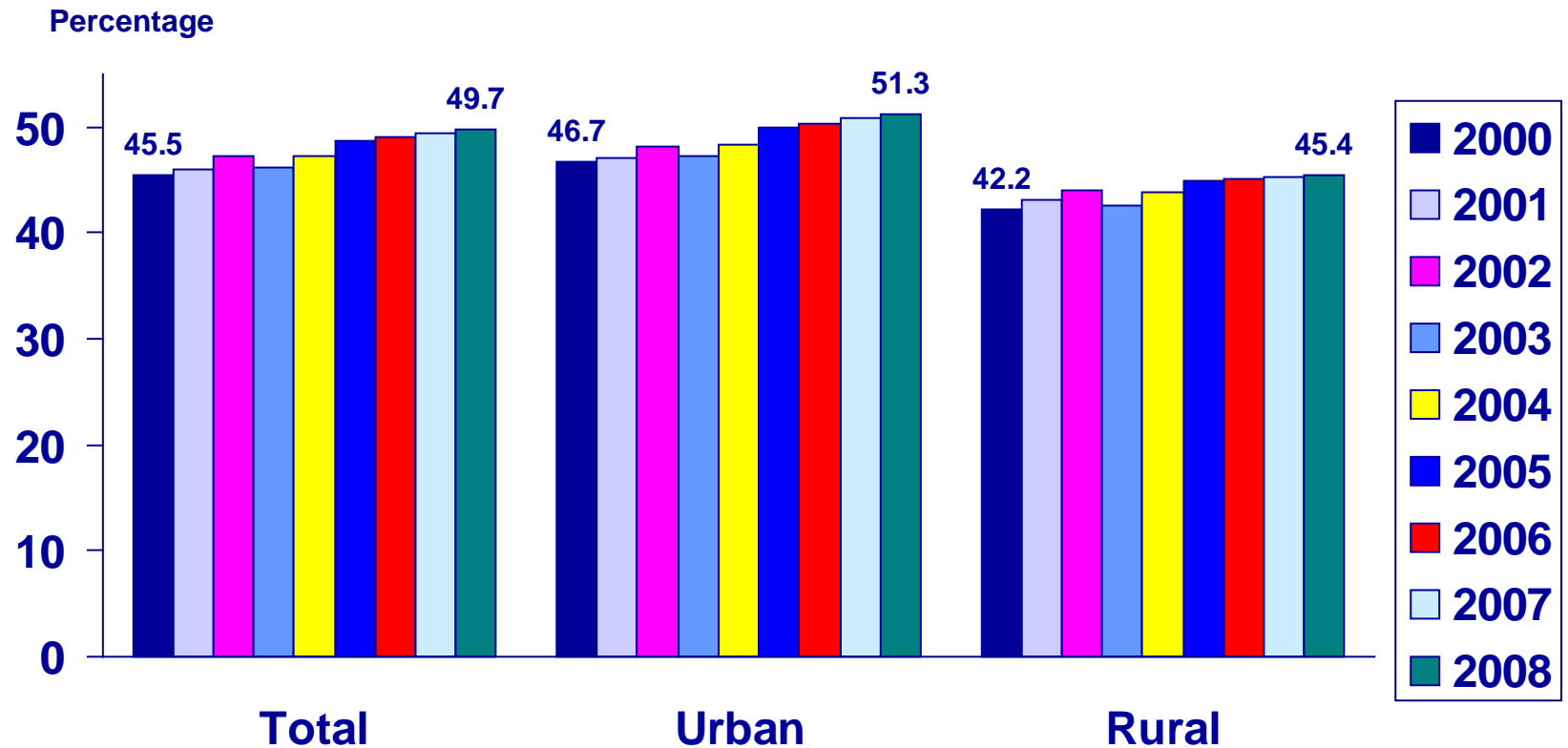
Negatives:

- Limited effect on volume and intensity
- Blunt instrument—all physicians treated the same
- System has been difficult for Congress to live with

How has beneficiary access been affected?

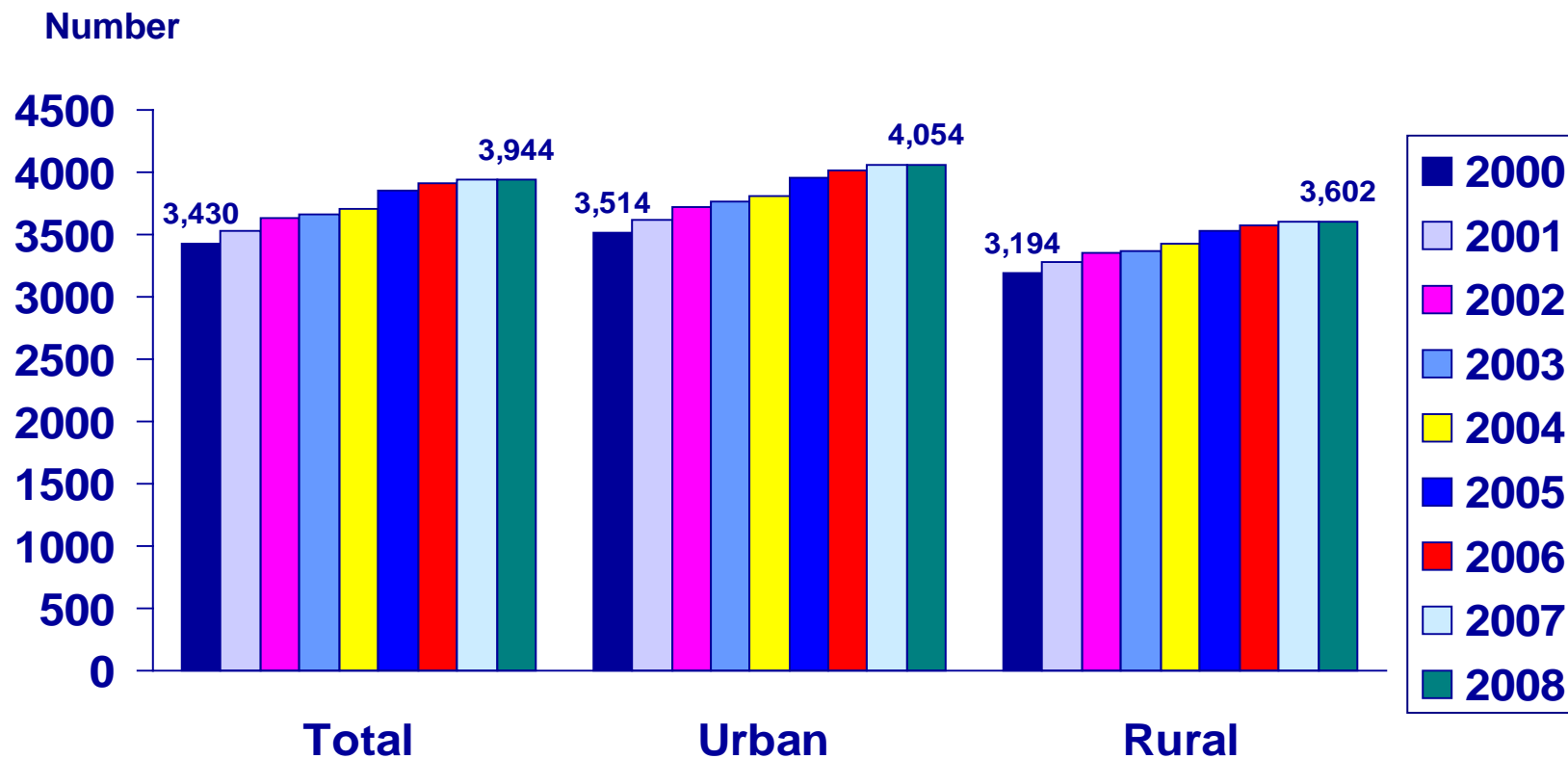
- Measures of access to services are positive:
 - Proportion of beneficiaries receiving services generally increased in the aggregate and in both urban and rural areas from 2000 through 2008.
 - Number of services provided per beneficiary generally increased in the aggregate and in both urban and rural areas from 2000 through 2008.
- Physicians appear willing to accept Medicare patients:
 - Number of physicians billing Medicare increased from 2000 through 2007.
 - Proportion of services for which physicians accept Medicare's payment in full increased from 2000 to 2008.

Percentage of Medicare FFS Beneficiaries Receiving Physician Services in April 2000 through 2008



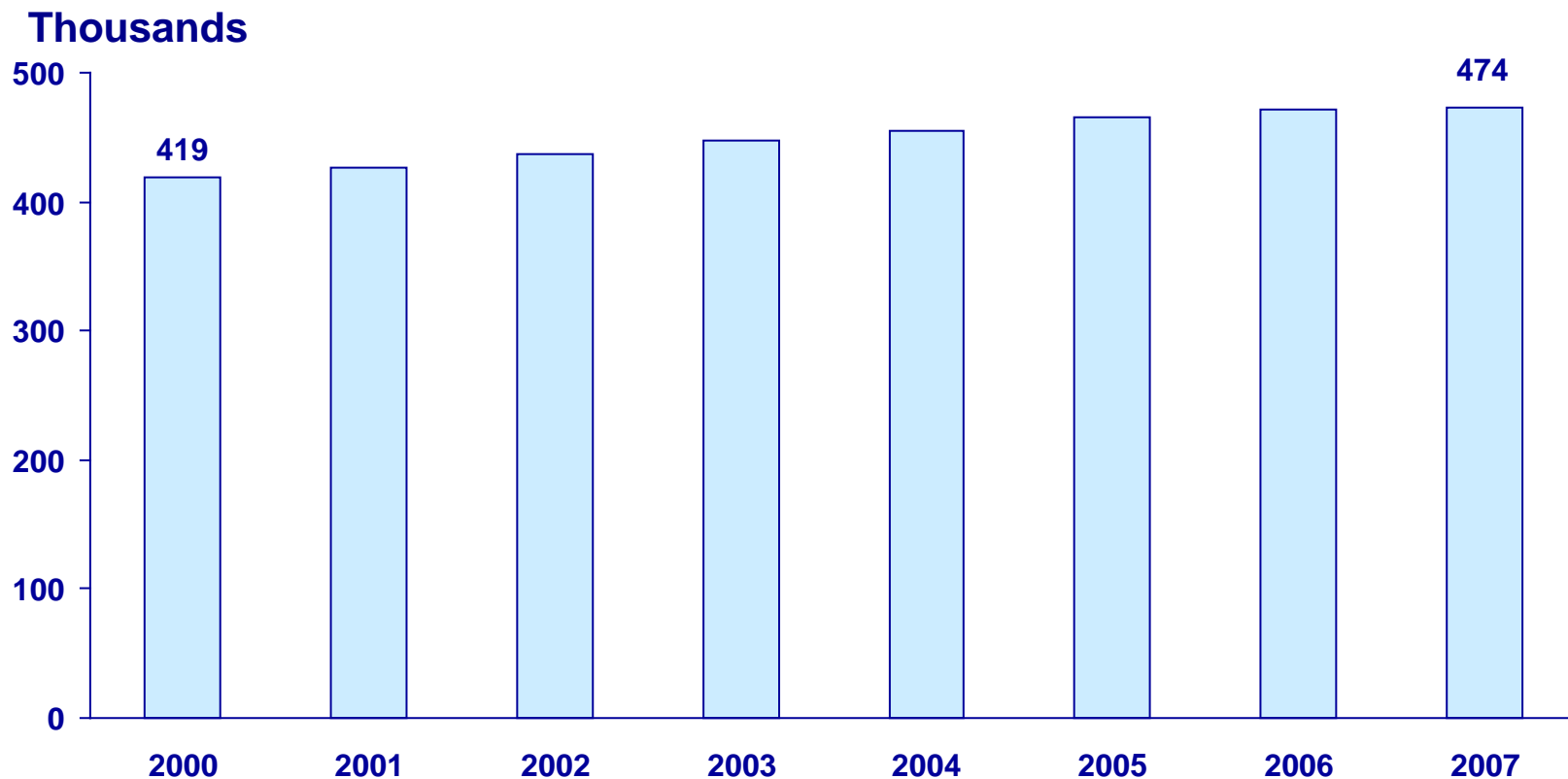
Source: GAO 09-559 *MEDICARE PHYSICIAN SERVICES: Utilization Trends Indicate Sustained Beneficiary Access with High and Growing Levels of Service in Some Areas of the Nation*

Number of Physician Services per 1,000 Medicare FFS Beneficiaries Served for April 2000 through 2008



Source: GAO 09-559 MEDICARE PHYSICIAN SERVICES: Utilization Trends Indicate Sustained Beneficiary Access with High and Growing Levels of Service in Some Areas of the Nation

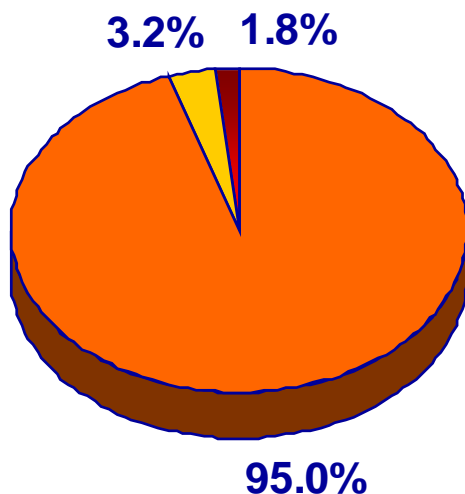
Number of Physicians Billing Medicare for Services Provided to FFS Beneficiaries in April of 2000 through 2007



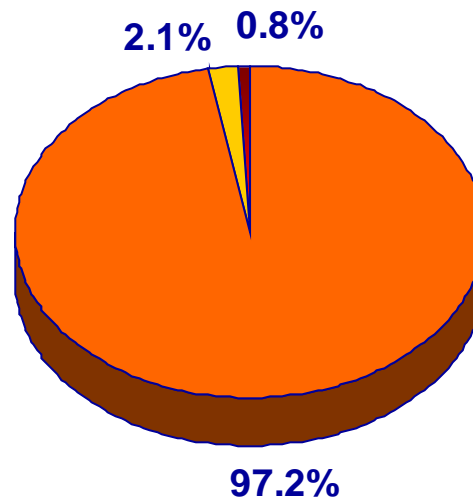
Source: GAO 09-559 *MEDICARE PHYSICIAN SERVICES: Utilization Trends Indicate Sustained Beneficiary Access with High and Growing Levels of Service in Some Areas of the Nation*

Proportion of Physician Services by Medicare Participation and Assignment Status

April 2000



April 2008



Participating/ Assigned



Nonparticipating/ Assigned



Nonparticipating/ Unassigned

Source: GAO 09-559 *MEDICARE PHYSICIAN SERVICES: Utilization Trends Indicate Sustained Beneficiary Access with High and Growing Levels of Service in Some Areas of the Nation*

How has FFS physician spending increased during a period of low average increases in fees?

- Volume and intensity growth causes spending growth.
- Illustrative evidence:
 - Increased use of profitable services such as advanced imaging.
 - Irregular growth and variation in the use of services across areas.

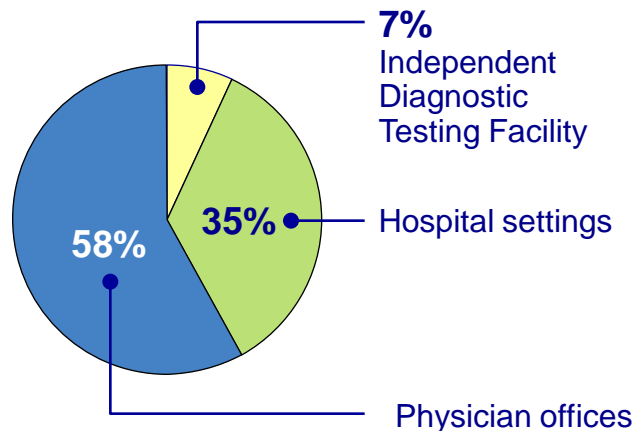
Selected Physician Service Categories per 1,000 Medicare Beneficiaries in Potentially Overserved and Other Areas

	Potentially overserved areas	Other areas
All services	2,247	1,812
Evaluation and management services	1,188	969
Procedures		
Major	25	22
Minor	191	133
Imaging services	457	385
Laboratory tests	44	34

Source: GAO 09-559 *MEDICARE PHYSICIAN SERVICES: Utilization Trends Indicate Sustained Beneficiary Access with High and Growing Levels of Service in Some Areas of the Nation*

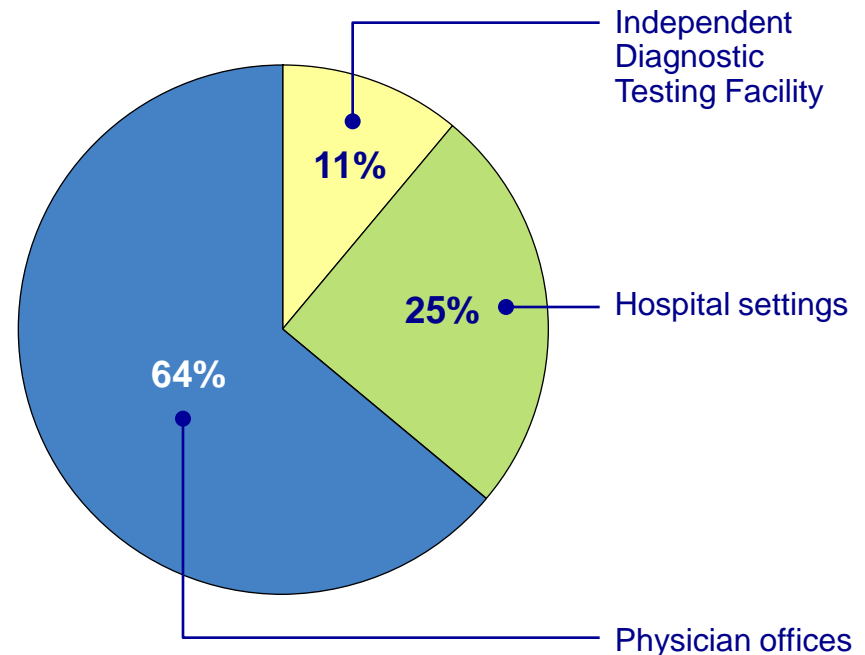
Physicians Deriving Increasing Share of Revenue from In-Office Imaging

2000 Medicare Part B imaging spending



Total: \$6.89 billion

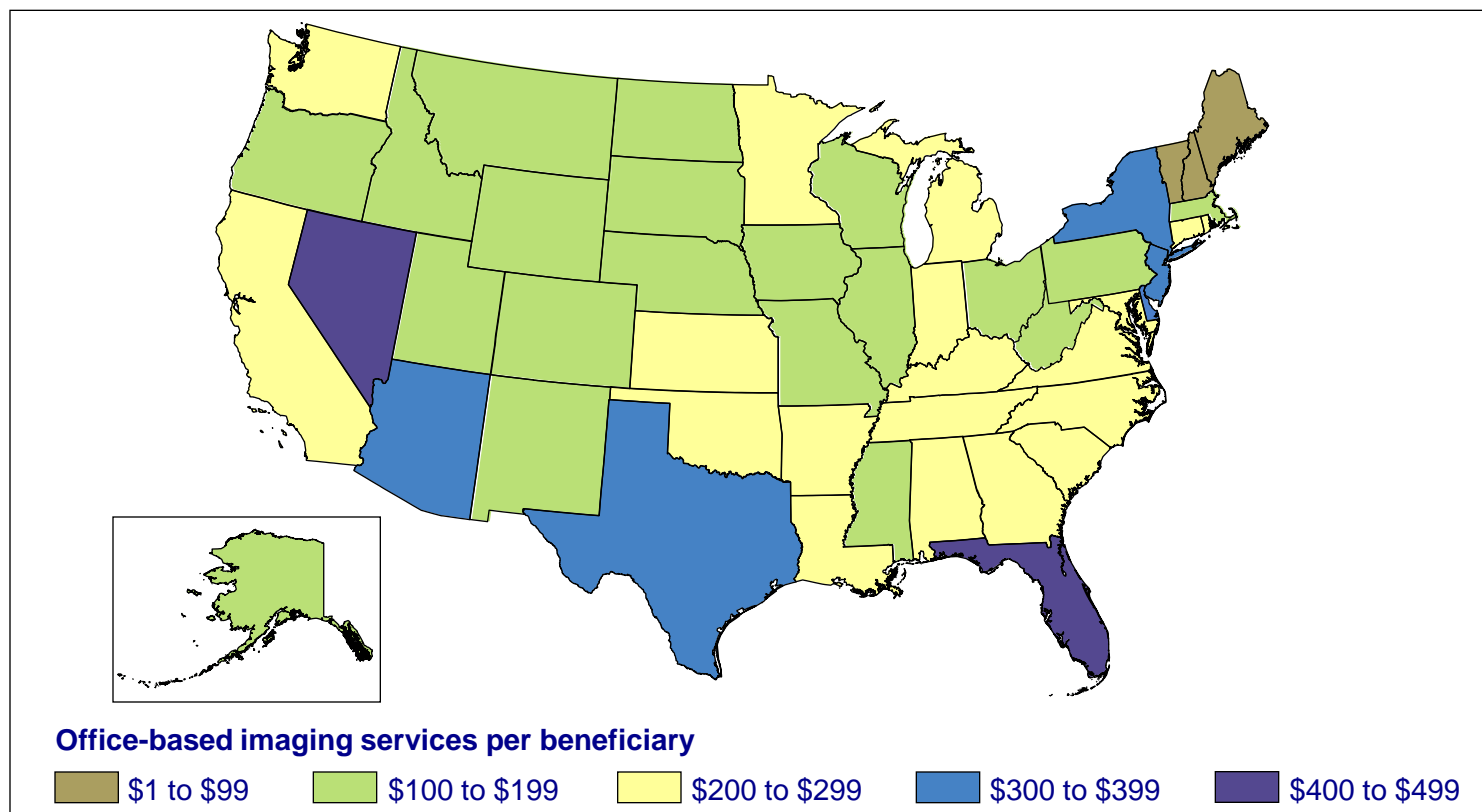
2006 Medicare Part B imaging spending



Total: \$14.11 billion

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

Substantial Variation of In-Office Imaging Use Across Geographic Regions, 2006



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



SGR Alternatives/Solutions?

Reports to Congress: GAO

- GAO was mandated by MMA to examine appropriateness of SGR and alternatives.
- 2005 GAO report characterized alternatives under two broad approaches:
 - eliminate SGR and replace it with steady fee increases based on MEI
 - retain SGR but make modifications that have the potential to result in positive fee updates.
- GAO concluded that the choice between the two broad approaches may hinge on whether primary importance should be given to stable fee increases or the need for fiscal discipline within the Medicare program

Reports to Congress: MedPAC

- MedPAC was mandated by DRA to submit a report to Congress on alternative mechanisms to the SGR, including recommendations from the Commission on such mechanisms.
- The 2007 report emphasized the need to consider sub-national alternatives, noting that the smaller the unit of accountability, the greater the incentive to create efficiencies. Although the report noted the administrative complexity of such arrangements. Such units could be at the level of a group practice or geographic area for example.
- The report also identified 2 pathways to reconfigure the national target system:
 - **Option 1** – Repeal SGR and focus on approaches for improving incentives for physicians to furnish lower cost and higher quality services. Such methods include: pay-for-performance, bundling of services, and implementing ACO's or other such organizations.
 - **Option 2** – Keep all the above reforms but also include a new system of expenditure targets to keep the pressure on providers to adopt reforms. New target system should embody the following core principles:
 - Encompass all of fee-for-service Medicare
 - Apply the most pressure in the parts of the country where service use is the highest
 - Establish opportunities for providers to share savings from improved efficiency
 - Reward efficient care in all forms of physician practice organization
 - Provide feedback with the best tools available and in collaboration with private payers
- The Commission was unable to recommend a single approach to reform SGR to the Congress, but instead emphasized the need for Medicare to develop payment systems that reward quality and efficient use of resources.

Past Attempts

- CHAMP (Children's Health and Medicare Protection Act of 2007) Act would have replaced the single SGR computation with separate spending targets for six areas of physician services:
 - evaluation and management services for primary care and preventive services
 - other evaluation and management services
 - imaging services and diagnostic tests
 - major procedures
 - anesthesia services
 - minor procedures and other services.
- Rationale – attempted to address the criticism that the current SGR penalized (or rewarded) all physicians the same regardless of the individual physician's or collective specialty's contribution towards meeting or exceeding targets

Alternative Approaches

Medicare Physician Payment Reform Act of 2009 (introduced on October 20, 2009)

Somewhat builds on CHAMP approaches but also differs in a few important ways:

- Instead of six categories of services, bill creates 2 targets—one for evaluation, management and preventive services and another for all other physician services
- Target expenditures for E&M and preventive services allowed to grow at per capita GDP plus 2 percent
- Target expenditures for all other services allowed to grow at per capita GDP plus 1 percent
- Also 2009 would become the base year rather than 1996 under current law
- Only physician services included (no lab services or other “incident to” services)

Growing Cost of Simple SGR Fixes

Date of CBO Score	Fee Freeze 10-Year Score (billions of dollars)	MEI Update 10-Year Score (billions of dollars)
May 5, 2004	*****	\$95
March 24 2005	\$48.6	\$154.5
March 24, 2006	\$127.2	\$218.2
January 2007	\$170.8	\$252.2
March 2007	\$177.7	\$262.1
March 14, 2008	\$220.1	\$288.1
May 7, 2009	\$285	\$344
April 30, 2010	\$275.8	\$329.9

Sources: American Medical Association (AMA) and the Congressional Budget Office (CBO)

Obstacles

- How to pay for any repeal or replace
- How to overcome inherent FFS incentives
- How to choose an option that's fair and acceptable to all parties

Takeaways

- No reason to believe that volume and intensity growth will fall below real GDP growth under FFS.
- The SGR system will continue to attempt to address this imbalance by reducing fee updates relative to MEI.
- So far beneficiary access not affected.
- Need to distinguish between fee stability, spending, and budgetary issues.
- Need to look outside of Part B spending to achieve savings to help offset budgetary costs.

Additional SGR Resources

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

Also CMS Website:
<https://www.cms.gov/SustainableGRatesConFact/>