

## Issue Brief:

# Understanding the SGR Analyzing the “Doc Fix”

### Foreword

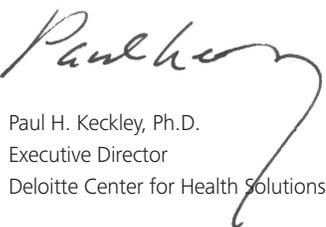
The federal government had no way of anticipating the phenomenal growth of costs that would be associated with Medicare when it was created in 1965. The United States currently spends just under 18 percent of its Gross Domestic Product (GDP) on health care. If current systems remain unchanged, national health care spending is projected to account for 31 percent of U.S. GDP by 2035 and 46 percent of GDP by 2080.<sup>1</sup> These ballooning costs place a heavy burden on the U.S. economy, from the impact of U.S. health care costs on companies that foot the bill for private insurance, to national policy issues, such as the impact of federal health care costs on defense and education budgets. Several factors have increased federal expenditures on health care including greater demand and utilization, growing costs from medical inflation, and expanding Medicare enrollment related to retiring Baby Boomers. Medicare currently represents over 15 percent of all federal outlays. By 2020, Medicare enrollment is expected to increase to 63.5 million beneficiaries and to a projected 17.4 percent of all federal outlays.<sup>2</sup> As a result, the current federal payment system is not financially sustainable, especially in the broader context of government spending and economic recovery challenges facing the U.S.

Medicare Part B provides federal insurance coverage for outpatient costs under the Medicare plan. The payment mechanism for Medicare Part B has evolved significantly since its implementation, due to changes in the U.S. economy and increased patient enrollment in the Medicare system. The Sustainable Growth Rate (SGR) was created with the intent to provide access for patients, control federal health spending on Medicare Part B, and distribute costs across different medical specialties. However, federal health care expenditures have continuously grown over their targets in the past decade, mainly due to input prices, thus rendering the SGR obsolete. Since 2002, the Medicare Part B payment mechanism has called for reductions to physician reimbursements; however, Congress has consistently implemented methods to override these reductions and continues to increase physician reimbursement rates annually. At the end of 2011, a 27.4 percent reduction to physician reimbursements was called for if the SGR was to be applied. If Congress continues to override SGR-mandated physician fee reductions through 2018, the SGR formula suggests that physicians will face a 49 percent reduction in reimbursement rates at that time. Such a drastic cut to physician reimbursements, without implementing mechanisms to decrease health care costs, will result in physicians discontinuing medical services to Medicare beneficiaries.



This Issue Brief reviews the historical events leading to the creation of the SGR; examines the SGR formula and problems with its use; discusses changes recommended by various groups (i.e., MedPAC, the Bowles-Simpson Commission, and the American Medical Association); provides cross-sector implications for stakeholders; and offers Deloitte's suggestions on a way forward.

The SGR is complicated: It is necessary that industry stakeholders understand it fully, and thoughtfully consider its modification in the broader context of the industry's sustainability rather than a narrow context focused exclusively on physician payments. That said, hospitals, health insurance plans, and medical device and drug manufacturers are appropriately concerned that physician payments be structured to provide consumers access to a stable clinical talent pool while also leveraging technologies and core competencies of allied health professionals to lower the growth rate of per-capita spending for health services. The SGR debate – its replacement or alteration – is relevant to both short-term policy-making around physician payments and longer-term issues of fiscal sustainability of the overall health system.



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## Overview

U.S. health care costs have consistently outranked those of all other developed nations (OECD nations). Per capita health care spending in the U.S. averages \$8,402 and accounts for 17.9 percent of total GDP;<sup>3</sup> compared to the OECD average of \$3,233 per capita and 9.6 percent of total GDP.<sup>4</sup>

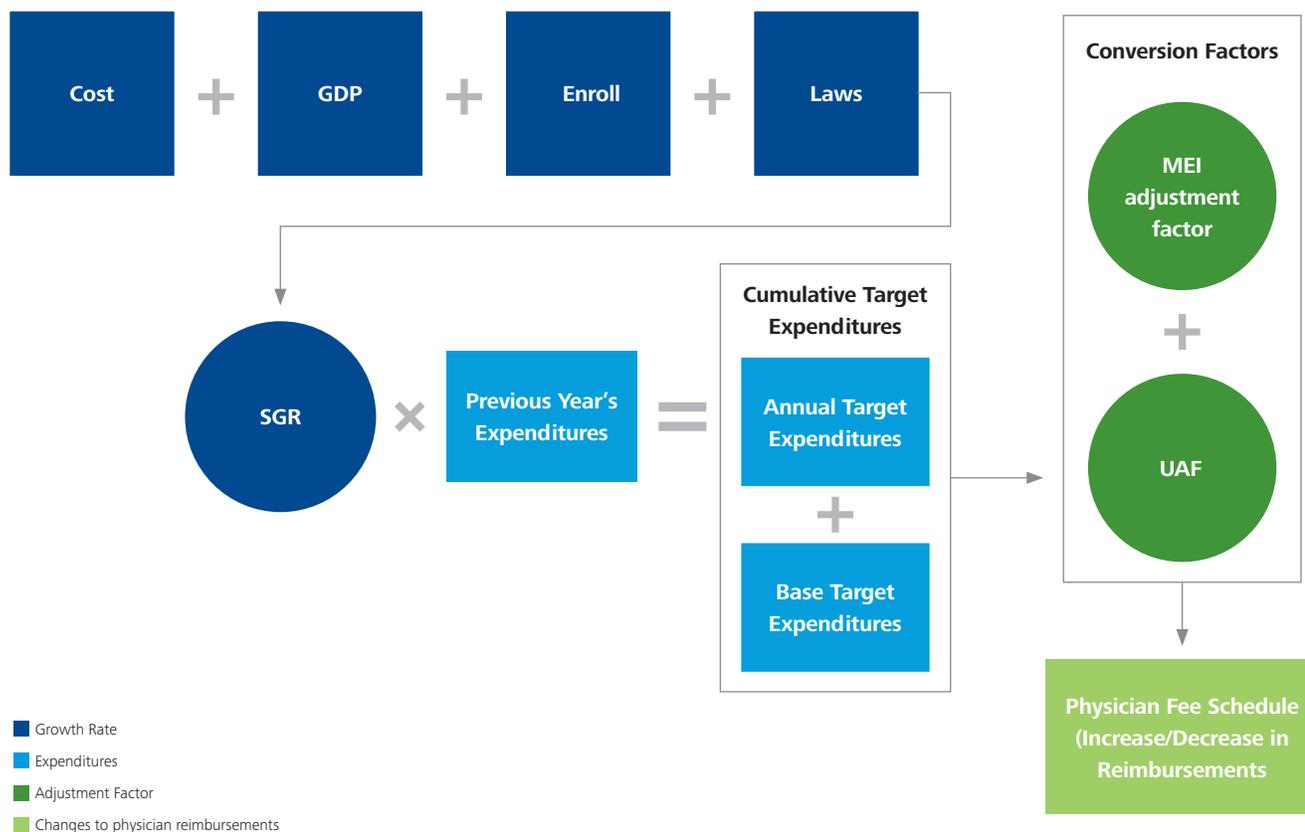
The primary factors driving U.S. health care costs are *medical prices and costs associated with increased utilization*, followed by costs associated with population growth and age-sex mix. Additionally, compared with other nations, U.S. health care costs are higher because of *higher physician fees*.<sup>5</sup> Between 2012 and 2017, medical prices are expected to account for an average of 3.8 percentage points of the total 6.7 percentage points projected in personal health care expenditures in the U.S.<sup>6</sup>

Explanation of terms and abbreviations used in this report can be found in Appendix A.

## What brought about the need for the SGR?

Since the introduction of Medicare in 1965, U.S. government spending on health care has grown continuously. Much of the increase in health care costs between 1965 and 1975 is attributed to advances in technology and standards of care, but it also is due to the rapid increase in the number of services provided by physicians and a worsening of the obesity epidemic.<sup>7</sup> Prior to 1975, Medicare reimbursements were based on charge rates determined by the physician. In 1975, Congress established the Medicare Economic Index (MEI), a set fee schedule to reimburse physician services with the intent that annual increases in physician fees could not exceed the fee schedule set by the MEI. The MEI, however, did little to curb federal health care expenditures. Between 1984 and 1991, Congress voted annually to increase physician reimbursements set by the fee schedule, as a result of increased physician costs to provide medical services to patients. The MEI alone proved unable to constrain federal spending and did not account for costs associated with changes to disease patterns, population growth, and overutilization of the health care system including defensive medicine practices.

Figure 1: The SGR mechanism



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### The SGR mechanism

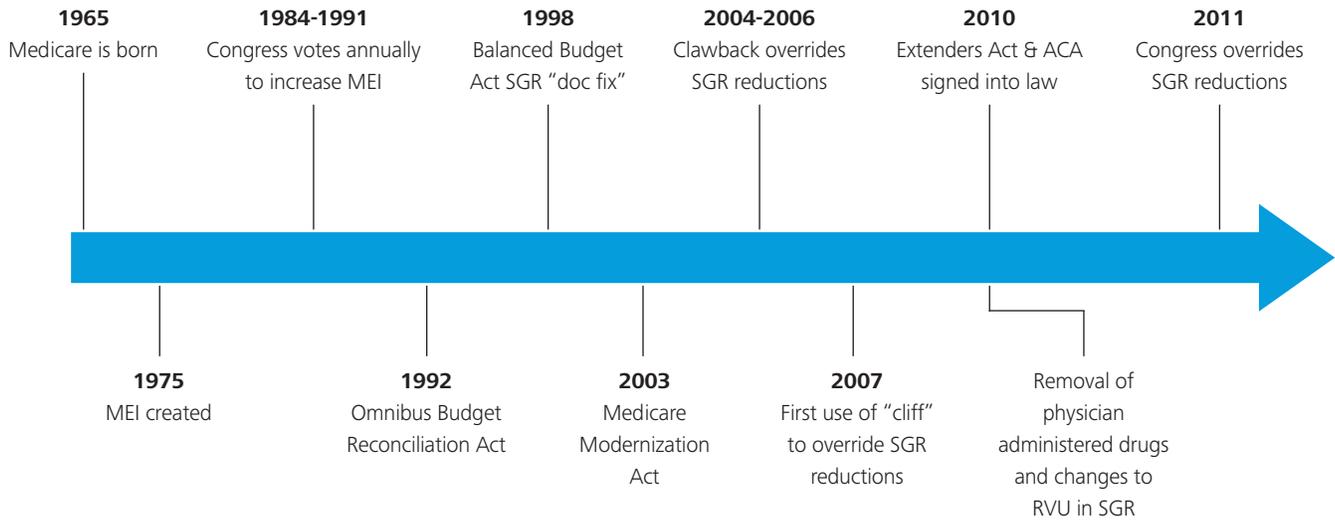
The SGR was established in 1998 to contain increases in physician fees set by the MEI by applying a “growth factor” to the Medicare Part B fee schedule. This growth factor accounts for:

- Changes to physician costs associated with providing medical services
- Changes to the number of enrollees in the Medicare system
- Changes to costs associated with laws and regulations that impact health care costs
- Changes to inflation and the GDP over time.

Two primary goals of the SGR are to ensure patient access to physicians and to control federal spending in a more predictable way.<sup>8</sup> The SGR mechanism is composed of three major components (See Figure 1 and Appendix B for a detailed look at the SGR equation):

1. Expenditure targets
2. Growth rate (SGR)
3. Annual adjustments

### Timeline of SGR<sup>9</sup>



**1965 – Medicare is born.** Medicare reimburses based on physicians’ actual charges. No benchmarks or fee schedules exist to cap costs.

**1975 – Medicare Economic Index (MEI)** is created and sets a fixed-fee schedule for physicians’ services. Currently, over 7,000 services fall under this fee schedule.

**1984-1991 –** Congress votes annually to increase allowable physician fees set by the MEI.

**1992 – Omnibus Budget Reconciliation Act** creates “RB-RVS Medicare Fee Schedule,” in which CMS assigns relative value units (RVUs) to physician reimbursements. Physician service reimbursements are based on MEI and the Medicare Volume Performance Standard (MVPS) conversion factor. No penalties were enacted for exceeding expenditure targets.

**1998 – Balanced Budget Act (BBA)** replaces the MVPS conversion factor with the SGR conversion factor. CMS is responsible for making adjustments to the SGR annually.

**2003 – Medicare Modernization Act (MMA)** adds a 10-year moving GDP per-capita growth rate to the SGR formula.

**2004-2006 – Clawback approach.** Congress overrides SGR mechanism reductions to physician reimbursements, using the “clawback” approach. *(See section on clawback and cliff congressional changes to SGR for more details.)*

**2007 – Cliff approach.** Congress starts using the “cliff” approach to override recommended reimbursement reductions to physicians. Congress has voted to override reductions annually since 2007 using this method. *(See section on clawback and cliff congressional changes to SGR for more details.)*

**2010 – Physician-administered drugs are removed from SGR expenditure calculations** after physicians successfully argue that they have no control over costs of drugs and should not be penalized for these costs.

**2010 – Extenders Act.** Congress votes to override SGR expenditure reductions through 2011 using the “cliff” approach and votes to increase reimbursement rates by one percent.

**2011 – Congress votes to increase physician fee schedule** reimbursement by one percent each year for 2012 and 2013 and overrides SGR expenditure reductions using the “cliff” approach.

## Problems with the SGR

Like the MEI, the SGR mechanism has proved to be too rigid for the evolving nature of health care.

### Key issues with the SGR include:

- It does not distinguish between medical specialties or physician behavior (for example, no rewards for cost-conscious physicians), and does not account for changes in disease patterns (such as increased chronic diseases like obesity).<sup>10</sup>
- It is unable to adjust for the rapid increase in the number of Medicare Part B beneficiaries as more Baby Boomers access Medicare.<sup>11</sup>
- It puts no caps on the costs of physician-administered drugs (such as chemotherapy), which are reimbursed at market price.<sup>12</sup>
- It is unable to account for slowed economic growth since 2000 and simultaneous increases in Part B expenditures, resulting in a negative UAF to rein-in costs.<sup>13</sup>
- The SGR used a single data point for the base year (the aggregate Part B expenditure between April 1996 and May 1997), which did not account for new technologies, standards of care, and increased costs for medical care. Consequently, a deficit developed between the budgeted expenditure and actual expenditure and the SGR mechanism attempted to recoup the cost by implementing substantial fee reductions.<sup>14</sup>
- MEI was adjusted by a flawed productivity measure.<sup>15</sup> Over the last two decades (1990-2010), the U.S. economy has experienced a compound annual growth rate in labor productivity of 1.7 percent, while health care became less productive by -0.6 percent annually, resulting in a significant underestimation, by 2.3 percentage points annually, in the rise of medical practice costs.<sup>16</sup>

The inability of the SGR mechanism to adapt to changes in the practice of health care and the rising costs associated with these measures has resulted in shrinking gross profit margins for physician practices. Over the last 10 years, the true cost of providing care has increased roughly 25 percent, while reimbursement has risen only five percent. This disconnect between costs and

payments is partly related to having set reimbursement prices. Rather than letting market forces determine prices as it does with practice inputs, changes to reimbursement rates from CMS must be approved by Congress. The resulting gap between rising costs and stable payments has left many feeling that Medicare is “too stingy.”<sup>17</sup> Even more worrisome, if the SGR were allowed to begin its “claw back” of the deficit by implementing the calculated January 2012 cut of 27.4 percent to reimbursement rates, the disparity between cost and revenue growth would more than double.<sup>18</sup> (*See section on Clawback and cliff congressional changes to SGR.*)

## Clawback and cliff congressional changes to SGR

Each year since 2003, Congress has chosen to override SGR-mandated reductions; instead, it has instituted increases in physician reimbursements out of fear of putting an aging patient population’s access to health care at risk. Congress has enacted two types of changes to the SGR equation since it started overriding the scheduled reductions; they are known as the clawback and cliff approaches.<sup>19</sup>

- **The clawback approach** creates a short-term increase in payment without adjusting annual expenditure targets through the UAF; it assumes the financial costs resulting from overriding these reductions will be recouped over the course of several years. CBO projections using this approach through 2015, with reinstatement of the SGR mechanism in 2016, project costs to be at \$218.5 billion in 2021, with a 10-year window to recoup costs.<sup>20</sup>
- **The cliff approach** assumes Congress will enact a short-term increase in payment, with a large payment rate reduction the following year. Congress has been using this method every year since 2007, which has resulted in a projected 29.4 percent “cliff” if the cumulative reductions are enacted at the end of 2012. CBO projections using this approach through 2017, with reinstatement of the SGR mechanism in 2018, project costs to be at \$107.7 billion in 2021, with a 49 percent reduction to physician reimbursements in 2018 to recoup costs.<sup>21</sup>

## Prominent proposals to change the SGR

With the upcoming presidential election likely to have a significant impact on the fate of the Affordable Care Act, and Congress set to address the SGR issue in the post-election, lame-duck session, 2012 is shaping up to be the most significant year for health care since Medicare was established in 1965. Perhaps now, given the push for budget deficit reduction, the SGR requires a permanent solution. Congress cannot afford to continue to intervene as it did at the end of 2011, when it blocked the January 1, 2012, 27.4 percent reduction in Medicare Part B fees. Likewise, the implications of allowing such a cut to take place – namely, reduced physician participation in Medicare and reduced enrollee access – would be equally disastrous. A 2010 survey by the American Academy of Family Physicians (AAFP) revealed that 61.8 percent of primary care physicians would stop accepting new Medicare patients and 72.5 percent would limit Medicare appointments if a 25 percent scheduled pay cut were allowed to take effect on January 1, 2011.<sup>22</sup> When Congress convenes to address the issue, it will undoubtedly look to the recommendations offered by groups like the American Medical Association (AMA),<sup>23</sup> the Medicare Payment Advisory Commission (MedPAC),<sup>24</sup> and the National Commission on Fiscal Responsibility and Reform (Bowles-Simpson).<sup>25</sup> While these groups and others differ in their proposed handling of the issue, all agree that reform begins with repealing the current SGR law. (See Figure 2 for a comparison of their recommendations.)

## MedPAC

MedPAC is an independent congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. The commission, consisting of 17 members including five practicing physicians, released its recommendations for handling the SGR issue on October 14, 2011, a proposal totaling \$200 billion. Recommendations include:<sup>26</sup>

- Repealing the SGR mechanism
- Instituting a 10-year freeze on reimbursement rates for primary care specialties and decreasing rates for all other specialties by 5.9 percent in each of the first three years, followed by a freeze in reimbursement for the following seven years
- Regular data collection by the Secretary of the Department of Health and Human Services (HHS) from efficient provider practices to be used to determine new RVUs for each service
- Increasing shared savings opportunities for providers who join Accountable Care Organizations.

Given that primary care represents only eight percent of the total Medicare expenditure, the exemption represents a relatively small cost.

## AMA

Similar to MedPAC, the AMA recommends repealing the SGR mechanism. In place of the SGR, the AMA recommends that reimbursement rates be frozen for five years, while Medicare “transitions to an array of new payment models designed to enhance care coordination, quality, appropriateness, and costs.”<sup>27</sup>

The AMA provides suggestions for the trial of four new payment models based on partial capitation, virtual partial capitation, accountable medical home payment, and condition-specific capitation. Under the partial capitation model, physicians would receive a predetermined, risk-adjusted, monthly payment for a certain group of patients. The virtual partial capitation model would establish a per-patient monthly budget to which actual expenditures would be compared. Reimbursement for each service would then be adjusted to keep the total cost within budget. The accountable medical home payment model encourages physicians to improve care to achieve savings, without penalizing them for the use of specialty services that are not under their control. Lastly, the condition-specific capitation model, which is tailored towards specialty practice, offers physicians a predetermined payment to treat a certain condition.<sup>28</sup>

## Bowles-Simpson

The National Commission recommendation on Fiscal Responsibility and Reform (commonly referred to as the Bowles-Simpson Commission, named for the commission’s co-chairs, Alan Simpson and Erskine Bowles) is a Presidential Commission established in 2010 to identify “policies to improve the fiscal situation in the medium term and to achieve fiscal sustainability over the long run.” The commission’s recommendations on physician reimbursements under the SGR mechanism include:<sup>30</sup>

- Freeze physician payment rates through 2013; then reduce payment rates by one percent in 2014
- Reinstate the SGR system in 2015, using 2014 spending as the new base rate
- Forgive past overspending
- Create an improved physician repayment formula
- Set limits on long-term growth of federal health care spending to cap at changes in GDP+1%
- Increase the financial responsibility of Medicare beneficiaries.

## Obama Administration

Although the Obama Administration has not proposed a specific solution to the SGR issue, its September 2011 budget proposal assumes legislation will be enacted to fix the SGR policy. The anticipated cost of Medicare over a 10-year period is \$293 billion, suggesting this budget is based on a 10-year payment freeze.<sup>31</sup>

Figure 2: Comparison of SGR recommendations

	Freezes physician payment rates	Reduces physician payment rates	Suggests reinstatement of SGR mechanism after a freeze?	Create revised payment system?	Total projected costs (ten year)
<b>Bowles-Simpson</b>	Through 2013	Reduces payment by 1% for 2014	Reinstates SGR in 2015 using 2014 expenditures as new baseline (replaces 1998 \$49 billion baseline)		\$261.7 billion
<b>Obama Administration Budget Proposal</b>	10 year freeze				\$293 billion
<b>Affordable Care Act</b>				PCORI Bundling ACO	No projection
<b>MedPAC</b>	10 year freeze, 3 year price reduction, 7 year freeze	Cuts rates by 5.9% annually for each of 3 years			\$200 billion
<b>AMA</b>	5 years + MEI				No projection
<b>CBO Cliff</b>		Assumes a 49% reduction to reimbursements in 2018	Assumes SGR will be reinstated in 2018		\$107.7 billion
<b>CBO Claw</b>		Assumes gradual reduction over 10 years to recoup costs	Assumes SGR will be reinstated in 2016		\$218.5 billion

### The Affordable Care Act 2010

The ACA utilizes coordination of care and integrated care as means to reduce total health care expenditures. It provides physician incentives to reduce unnecessary procedures and makes knowledge more readily available regarding best practices. These may help address the rising cost of health care, as well as make the overall system more effective. The cost-saving provisions in the ACA estimate that CMS will be able to reduce expenditures by \$575 billion over the next 10 years and lower Medicare Part B beneficiary premiums by \$200 annually by 2018.<sup>32</sup> Actual 10-year costs to Medicare will depend on what other mechanisms are put in place along with the ACA reductions. These provisions include:

- Patient Centered Outcomes Research Institute (PCORI)** is an independent advisory board with “a \$3 billion budget to support comparative effectiveness research” to help health care providers make more informed decisions about the benefits and harms of preventative, diagnostic, therapeutic, and health delivery systems.
- National Pilot Program on Payment Bundling**, set to launch in 2013, gives a single provider (e.g., hospital or physician group) one bundled payment for an inpatient “episode of acute care in a hospital,” followed by outpatient “post-acute care in a skilled nursing home or rehabilitation facility, the patient’s home, or other appropriate setting.”
- Bundled Payments for Care Improvement Initiative** encourages physicians, hospitals, and other health care providers to increase patient care coordination while in the hospital and after the patient is discharged. This initiative was designed to “provide opportunities for care improvement that are consistent with the goals and approach of the National Pilot Program on Payment Bundling.”<sup>36</sup>
- Medicare Shared Savings Program** (which includes accountable care organization models) is “a program that helps a Medicare fee-for-service program provider become an ACO.”<sup>37</sup> The Accountable Care Organization (ACO) is a payment model that provides coordinated care to its patients. Its goal is to reduce “unnecessary duplication of services” and to “prevent medical errors.”<sup>38</sup>

## Implications: Why does SGR matter?

SGR implementation has wide-ranging implications for stakeholders, particularly providers. If implemented, the SGR could reduce physician reimbursement rates through Medicare as much as 30 percent on Jan. 1, 2013. Reductions in physician fees, in conjunction with other economic factors and market pressures, may have contributed to the recent reduction in physician hours worked, implicating adequacy of future physician workforce supply.<sup>39</sup> According to respondents to the Deloitte Center for Health Solutions 2011 Physician Survey, 93 percent fear new payment reforms and bundled payment approaches proposed in the ACA will result in inadequate payments to physicians. This survey also found that there currently exists a general dissatisfaction among the physician workforce: In a post-reform world, only 18 percent reported being excited about the future of medicine and 69 percent felt that prospective physicians would reconsider medicine as a career.<sup>40</sup>

## Physicians

The SGR has the most significant implications for physicians serving large Medicare patient populations. In many communities, physicians have leverage to negotiate with employers and health insurance plans adequate payments to make up for losses in serving Medicare patients. For most medical practices, the move from fee-for-service payments to value-based compensation delivered in clinically integrated “systems” of care means merger/employment/affiliation with a single health system or health plan. In each community, the circumstances will vary. Under any scenario, the SGR fix will only accelerate or slightly delay the inevitable. Therefore, physicians should consider:

- What health system or health plan provides the highest level of clinical autonomy and financial security to the practice?
- Which of these partners has the operational skill best suited to manage population health, measure outcomes and efficiency, and optimize synergies among physicians and allied health professionals to achieve competitive advantage in the market?
- How might practice operating costs be minimized while required investments in information technologies and regulatory compliance be satisfied?

## Acute hospitals

For hospitals, the SGR is part of a larger group of issues articulated by affiliated physicians including declining payments from insurance companies and Medicare, increased transparency and reporting obligations, and the looming presence of Medicare and its SGR leverage. At the same time, physician alignment with hospitals and plans is accelerating, as participation in accountable care, medical homes, bundled payments and value-based purchasing drive closer alignment. Key considerations for hospitals:

- How should the hospital best align its clinical and financial interests with a subset of the hospital’s medical staff wherein performance risk is shared?
- How does a hospital or commercial health plan “carve out” higher-performing physicians in its network for purposes of contracting and performance improvement? And how are employer and consumer expectations of “open networks” best managed/altered?
- What is the hospital’s financial capacity to offset short- and long-term compensation expectations of its affiliated physicians? Which capital and operating resources should be modified to achieve the stability in the physician workforce necessary to achieve its goals?

## Commercial health insurance plans and employers

A complement of physicians is necessary to manage a population of enrollees. The tools most adaptable to these management responsibilities – information systems, medical management, health coaching, diagnostics, and therapeutics interventions – are often more readily available in a commercial health plan infrastructure. For plans and employers, the SGR debate has profound implications:

- How might SGR drive consolidation between physicians and hospitals that might precipitate higher costs?
- How should health plans support, create, and interact with high-performing networks of local physicians to reinforce medical autonomy and professionalism while achieving population-based performance improvement and lower per capita costs?
- How should plans relate to physicians long term? Are trust issues manageable, and suitable financial arrangements achievable, given the history of distrust between physicians and commercial health plans?

## State and federal policy-makers

The physician's ordering pen is the basis for the majority of expenditures in the health care system. Consumers trust physicians more than hospitals, health insurance plans, and government.<sup>41</sup> So how should policies that threaten or frustrate physicians and, specifically, payment schemes that are targets of physician criticism be addressed so as to:

- Assure the public that physicians will be well-trained, paid reasonably for clinical competence, and accessible?
- How should policy-makers link physician performance to team-based models? What is the relative value of physician experience, training and expertise in bundled payment schemes?
- How might remedies to practice operating costs and inefficiencies be addressed to improve operating margins for medical practitioners? Might liability reforms, allowances for joint ventures/risk sharing and other strategies be reconsidered in context of assuring a viable physician workforce?
- How should scope of practice, meaningful use, and medical education be integrated into an overarching physician workforce strategy? Is the issue the SGR? Or the medical profession's future?
- Which proposal to replace the SGR has merit?

## Our view

The recommendations for solving the SGR problem are a means to bridge the health care system to new payment models. None of the options proposed by the various groups outlined in this Brief offers a viable long-term solution. Reinstatement of the SGR at a later date would only give rise to the same issues we currently face, as the mechanism itself is flawed.

On July 11, 2012, physician leaders of the AMA, AAFP, the American College of Cardiology, the American College of Surgeons, and the American Society of Clinical Oncology testified before the Senate Finance Committee, providing physician perspectives on the SGR. All panelists supported repeal of the SGR; however, a solution or replacement was far from achieved. Some recommendations included: freezing payments while continuing and expanding CMS payment reform demonstrations and allowing physicians to enroll in these programs on a rolling basis; using a combination of payment methods, not just one; creating a patient-centric, value-based payment update to replace the SGR that would capture the contribution various providers make to a patient's experience, the appropriate use of care, and the improvement of quality; and improved data collection (better quality and more timely) and utilization of clinical data for outcomes studies rather than only Medicare claims data. The panelists' recommendations were predicated upon stabilizing payments in the short term until a more viable approach could be achieved.<sup>42</sup>

The current proposals are temporary, at best. Congress must address the issue from a long-term perspective, embedding the discussion in broader context of the sustainability of a physician workforce that's well-trained, accessible, and affordable. The issue is not just the SGR. The broader issue is the future of the medical profession. The discussion should start with that as its central premise and include all stakeholders, not just the profession itself.

Mechanisms as outlined in the ACA are in place to lead industry and policymakers toward a market-based solution. These include:

**1. Accelerate risk-sharing with providers:** Mechanisms financed by the ACA are projected to create savings to Medicare of \$418 billion over 10 years.<sup>43</sup> Processes should focus on mechanisms to:

- Improve the quality of patient care by creating incentive mechanisms to alter provider behavior to only deliver medical services necessary to improve patient outcomes by:<sup>44</sup>
  - Reducing the number of hospital readmissions
  - Reducing hospital-acquired conditions by imposing penalties on hospitals with high rates of complications such as bed sores, catheter-related infections, and injuries related to falls
  - Bundling payments for services
  - Improving physician quality reporting
  - Promoting formation of ACOs
- Appropriately price services by:<sup>45</sup>
  - Improving productivity and market basket adjustments in provider settings
  - Reducing payments to Medicare Advantage plans
  - Modifying payments for imaging services
  - Establishing competitive bidding mechanisms for durable medical equipment
- Reduce waste and fraud by:<sup>46</sup>
  - Increasing the number of Medicare auditors
  - Requiring in-person physician visits for medical services associated with abuse
- Promotion of mechanisms to reform the delivery system by:<sup>47</sup>
  - Creating Accountable Care Organizations
  - Rewarding providers for better care through value-based purchasing mechanisms

Policy-makers working with industry should consider accelerating these efforts to improve the overall performance of the health care system and clarify the role of physicians in the broader context of the system.

**2. Provide tools for physicians and their partners to accelerate changes that encourage professional development, collaboration with peers, and management of populations:** Physicians seek a career in medicine that recognizes its status, rewards its performance, and designates its role clearly and distinctly from other clinical professions. Physicians think of themselves as captains of care management ships. They understand the new normal presents uncharted waters and navigational challenges; they nonetheless want to be at the helm.

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Policy-makers, industry leaders, medical society and academic medicine leadership should consider creation of a vision for American medicine that is realistic, positive, and visionary. A high priority should be placed on forecasting the future of its necessary talent – a dynamic modeling process that accommodates changes in disease prevalence, changes in incentives, changes in the role of consumers, and access to technologies that improve efficiency and effectiveness.

## Appendix A – Glossary of terms

### **ACA – the Patient Protection and Affordable Care Act of 2010**

The Patient Protection and Affordable Care Act was signed into law by President Obama on March 23, 2010. The ACA changes the health care system with the hopes to increase projected national medical spending and decrease Medicare spending. <http://www.ppaca.com/>

### **BBA – Balanced Budget Act**

The Balanced Budget Act of 1997 was established to balance the federal budget by 2002 by reducing federal expenditures by \$160 billion between 1998 and 2002. The BBA established the Sustainable Growth Rate formula and the Medicare Payment Advisory Commission (MedPAC) as measures to reduce federal health care expenditures, which accounted for \$127 billion dollars of the cuts made in this Act to balance the federal budget. <http://www.govtrack.us/congress/bills/105/hr2015>

### **CF – Conversion Factor**

The Medicare conversion factor converts the relative value units (RVU) for each service in the Medicare physician fee schedule into a dollar payment amount. This conversion factor is based on the Medicare Economic Index (MEI), the annual expenditure target, and other adjustments. The SGR is used to annually update the conversion factor. (See Relative Value Unit (RVU) and Sustainable Growth Rate (SGR)) <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2012f.pdf>

### **MEI – Medicare Economic Index**

The Medicare Economic Index (MEI) is the measure of changes to physician costs associated with medical services. It was developed as a way to estimate physicians' operating costs and earning levels. It created a fixed-fee schedule for Medicare physicians, and limited the annual fee increases in the cost of physician charges and salaries. For a full history of the MEI, please see <http://healthcare-economist.com/2011/01/27/history-of-the-medicare-economic-index-mei/>

### **MedPAC – the Medicare Payment Advisory Commission**

MedPac was established under the Balanced Budget Act of 1997. It is an independent congressional agency that advises the United States Congress on issues that affect the Medicare program, such as the payment mechanism, quality, and access. There are 17 members of MedPac Board, each serving three-year term limits. Currently, five of the 17 members on MedPAC are physicians. <http://www.medpac.gov/>

### **MMA – Medicare Modernization Act**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made significant changes to the Medicare program. The MMA allowed for eligible Medicare beneficiaries to enroll in one discount drug card starting in 2004. Additionally, this Act allowed for Part D of Medicare to cover anyone who was eligible for Part A or B. These cards allow for discount rates for prescriptions within the Medicare formulary. Under the MMA, services under the Medicare Advantage plans were adjusted. Additionally, the MMA created Health Savings Accounts that replaced the Medicare Savings Accounts. The MMA also added a 10-year moving GDP per-capita growth rate to the SGR formula. (See Sustainable Growth Rate (SGR)). <http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf>

### **MVPS – Medicare Volume Performance Standard**

The MVPS was established under the Omnibus Budget Reconciliation Act of 1989 to control federal spending on Medicare. The Omnibus Budget Reconciliation Act created the RB-RVS Medicare Fee Schedule in which CMS assigned relative value units (RVUs) to physician reimbursements. These RVUs were multiplied by a conversion factor (CF), which translated the value of physician work into a dollar amount. The MVPS was a formula used to annually update the conversion factor. The SGR replaced the MVPS in the Balance Budget Act of 1997. (See Conversion Factor (CF), Relative Value Units (RVU), Resource Based Relative Value Scale (RB-RVS), Sustainable Growth Rate (SGR)). <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2013p.pdf>

**RB-RVS – Resource Based Relative Value Scale**

The Omnibus Budget Reconciliation Act of 1989 switched the Medicare reimbursement system to an RB-RVS payment schedule, which took effect on January 1, 1992. In this system, physicians were paid based on the resource costs that are required by the services they provide.

The RB-RVS was divided into three main components: physician work, practice expense, and professional liability insurance. Payment is made by multiplying the combined costs of a service by a conversion factor, which is now updated annually by the SGR. The value is also adjusted by geographic differences in resource cost. The RB-RVS accounts for 44 percent of the total relative value for each service. (For more information see Relative Value Units (RVU) and conversion factor (CF)). <http://www.cms.gov/apps/glossary/default.asp?Letter=R&Language=English>

**RVU – Relative Value Unit**

An RVU is a value assigned to physician work based on factors such as physician time, skill, and intensity needed to provide service. It also includes physician practice-related expenses and malpractice costs. RVUs are multiplied by a conversion factor (CF) to convert physician work into dollar amounts and a geographic adjustment (GA) factor to account for geographic variations in physician costs. The SGR is used to annually update the CF. Prior to the SGR, the MVPS was used to update the CF.  $\text{Physician Payment} = \text{RVU} \times \text{GA} \times \text{CF}$  (See Sustainable Growth Rate (SGR) and Conversion Factor (CF)). <http://www.cms.gov/apps/glossary/default.asp?Letter=R&Language=English>

**SGR – Sustainable Growth Rate**

The sustainable growth rate (SGR) is comprised of three main components: the expenditure target, the growth rate, and the annual adjustments to payment rates. It was established under the Balanced Budget Act of 1997, as a way to control federal spending and to provide patient access to physicians. This rate was also established to help distribute the costs between different specialties within the health care industry. The SGR takes into account the inflation rate of goods and services, the rate of change in enrollment in Medicare Part B, the average annual growth rate of GDP per capita, and impact of changes in laws or regulations that would affect spending. It is used to update the conversion factor that translates physician work (determined by RVUs) into a dollar amount. (See Relative Value Unit (RVU) and Conversion Factor (CF)). <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2013p.pdf>

**UAF – Update Adjustment Factor**

The UAF is an adjustment factor that compares the actual and target expenditures each year and sets a conversion factor to ensure that projected spending does not exceed the target expenditures for the year. There is an annual and cumulative component to the UAF to ensure that spending will be brought back in line over the course of several years if it deviates from the target expenditures set by Congress. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2013p.pdf>

## Appendix B – Breakdown of the SGR formula

### Expenditure targets

When the SGR mechanism was first implemented, CMS used the actual Medicare Part B expenditures from April 1996 through March 1997 (totaling \$48.9 billion) as the base target. This base target was multiplied by a growth rate, known as the SGR, to attain the target expenditures for 1998. After 1998, annual expenditure targets have been calculated by multiplying the SGR and expenditures from the previous year. Annual expenditure targets are added together each year to create a cumulative expenditure target. Often the cumulative target is written as sum of the annual targets and the base figure:

### Cumulative Target = Annual Expenditure Targets + Base Target

The total cumulative target at the end of 2012 is projected to be \$1.2 trillion. Targets are based on services covered in the Medicare Part B physician fee schedule and services provided “incident to” a visit with a physician.<sup>48</sup>

#### Physician services versus “incident to” services

Physician fees are based on services provided directly by a physician and are reimbursed on a fee-for-service schedule provided and updated annually by the Centers for Medicare & Medicaid Services. Examples covered in the Medicare Part B fee schedule include outpatient hospital services, physical therapy services, or durable medical equipment used within the physician’s practice. The physician fee schedule sets Medicare Part B reimbursement rates to physician.

“Incident to” services include medical services “incident to” a visit with a physician. These services each have their own fee schedule, separate from the physician fee schedule, but are included in the annual target expenditures for Medicare Part B. Examples include laboratory tests, physician-administered drugs, and fees for visits charged by a nurse practitioner or a physician’s assistant. These services are not included in the physician fee schedule because physicians have no control over the prices associated with these services. For example the price of chemotherapy, a physician administered drug, is set by the market price.

**Expenditure Targets = (physician fees) + (lab tests + drugs + other “incident to” services)**

### The growth rate

The SGR formula is composed of 4 components:<sup>49</sup>

1. **Estimate of % change in costs associated with running physician practice** – This variable adjusts for health care inflation, taking into account changes in prices of physician goods and services and “incident to” services. The goods and services provided by physicians are set by the Medicare fee schedule and changes to the allowable increases in reimbursement are measured by Medicare Economic Index (MEI). “Incident to” services, such as laboratory tests, have their own fee schedule, which are updated annually for inflation. Other “incident to” services, such as physician-administered drugs (e.g., chemotherapy) are set by market price.
2. **Estimate of % change in number of beneficiaries** – This variable measures changes in patient enrollment in Medicare Part B.
3. **Estimate of % change in GDP per capita** – This variable measures the 10-year annual average growth rate of real GDP (GDP is adjusted for inflation).
4. **Estimate of % change in costs from laws and regulations** – This variable accounts for any changes in costs that occur as a result of laws and regulations.

These four components are added together to calculate the overall rate in growth used to calculate target expenditures each year.

### SGR = $\Delta$ Physician costs + $\Delta$ enrollment + $\Delta$ Real GDP per capita + $\Delta$ in law or regulation costs

The SGR is used to update a conversion factor (CF) that converts physician RVUs into dollar amounts.<sup>50</sup>

#### How are RVUs factored into physician reimbursements?

An RVU is a value assigned to physicians work based on factors such as physician time, skill, and intensity needed to provide service. It also includes physician practice-related expenses and malpractice costs. RVUs are multiplied by a conversion factor (CF) to convert physician work into dollar amounts and a geographic adjustment (GA) factor to account for geographic variations in physician costs. The SGR is used to annually update the CF. Prior to the SGR, the MVPS was used to update the CF.

**Physician Payment = RVU x GA x CF**

## Annual adjustments

Annual expenditure targets are updated using two major adjustment factors:

1. **MEI adjustment factor** – The MEI adjustment factor is a weighted average of annual price changes for physician practice costs covered in the physician fee schedule. This adjustment factor accounts for inflationary changes that need to be incorporated into the fee schedule. These changes are then incorporated into the percent change in allowable physician fees in the SGR formula.
2. **The Update Adjustment Factor (UAF)** – The UAF compares the actual and target expenditures each year and sets a conversion factor to ensure that projected spending does not exceed the target expenditures for the year. If actual spending is greater than the expenditure target, the UAF will be negative and reduce physician reimbursement rates the following year to recoup costs. This reduction cannot exceed seven percent per year. If the actual spending is less than the expenditure target, the UAF will be positive, and will increase physician reimbursement rates by no more than three percent per year. Health care inflation is accounted for through the MEI adjustment factor before the UAF is applied. There is an annual and cumulative component to the UAF to ensure that spending will be brought back in line over the course of several years if it deviates from the target expenditures set by Congress.

### Determination of adjustments to the fee schedule

Fee schedule updates are determined by comparing target expenditures to actual expenditures and updated to the MEI accordingly.

If actual spending compared with target is:	Then	Update compared with MEI is:
Higher	→	Lower (up to minus 7%)
Equal to	→	Equal to
Lower	→	Higher (up to plus 3%)

Modified from: Steinwald, AB. The Basics of the Sustainable Growth Rate. National Health Policy Forum. Accessed on June 21, 2011 at [http://www.nhpf.org/library/the-Basics\\_SGR\\_06-21-11.pdf](http://www.nhpf.org/library/the-Basics_SGR_06-21-11.pdf)

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