

***Position Statement on Medicare Part B Payments: The Sustainable Growth Rate Formula***

The North American Spine Society (NASS) is a multidisciplinary medical organization dedicated to fostering the highest quality, evidence-based, and ethical spine care by promoting education, research, and advocacy. NASS is comprised of more than 5,000 members from several disciplines including orthopedic surgery, neurosurgery, physiatry, neurology, radiology, anesthesiology, research, physical therapy and other spine care professionals.

**Background/Introduction:**

The Sustainable Growth Rate (SGR) formula has been in effect since 1997, and aims to control spending for physician services provided under Medicare Part B. It does so by setting an overall target amount of spending (measured on both an annual and a cumulative basis) for goods and services provided under Part B. Included are payments for physicians' services as well as payments for laboratory tests and imaging services furnished "incident to" physicians' services, as well as physician-administered drugs. Payment rates are adjusted annually to reflect differences between actual spending and the spending target—upward if spending is below the target, downward if spending is above the target.

More than 90 percent of physician and non-physician providers agree to participate in Medicare Part B. Surveys generally show that beneficiaries do not experience significant difficulties in getting access to care, but the timeliness of this access is unclear. Regardless, access to care is likely to be significantly reduced if future scheduled cuts are allowed to take effect and the implementation of a long-term solution to the SGR system fails. A survey conducted by the American Medical Association found that 60 percent of respondents would stop or limit services to Medicare beneficiaries in the event of future cuts.<sup>1</sup>

From 1997 through 2007, total Medicare spending has increased by approximately 7.5 percent per year.<sup>2</sup> Part B expenditures have exceeded their spending target every year since 2002, and are projected to increase annually by 8 percent over the next decade.<sup>3</sup> Part B reimbursements were decreased by 4.8 percent in 2002<sup>3</sup> and Congress has intervened every year from 2003 to 2008 to avert further cuts mandated by spending that exceeded the formula driven target. Growth in spending can be attributed both to an increase in the fees that Medicare pays for each service, which have historically risen by an average of about 2 percent annually and the addition of covered services and increase in volume and intensity of services that have risen by about 4.5 percent annually over this same period of time. Despite exceeding annual targets, Part B expenditures have not increased as a proportion of total Medicare spending, remaining steady at around 20 percent of overall Medicare expenditures since 2000.<sup>2</sup> Growth in Part B expenditures is projected to increase by 8 percent annually between 2008 and 2018, while

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<sup>1</sup> [www.ama-assn.org/ama1/pub/upload/mm/399/mc\\_survey.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/399/mc_survey.pdf)

<sup>2</sup> [www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf](http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf)

<sup>3</sup> [Medicare's Physician Payment Rates and the Sustainable Growth Rate](#). CBO TESTIMONY Statement of [Donald B. Marron](#), Acting Director. July 25, 2006.

national economic growth is expected to be only 4.8 percent.<sup>4</sup> Under the current reimbursement formula, this discrepancy will continue to produce annual reimbursement cuts in physician reimbursements over this period.

The SGR formula is calculated based on the following four parameters.

- (1) The estimated percentage change in fees for physicians' services.
- (2) The estimated change in the average number of Medicare fee-for-service beneficiaries.
- (3) The estimated 10-year average annual percentage change in real gross domestic product (GDP) per capita.
- (4) The estimated change in expenditures due to changes in law or regulations.

**Theoretical advantages of the SGR formula:**

Presuming expenses could be maintained within the target, the formula does account for physician expenditures, and would allow for a reasonable increase in payment annually.

**Problems with the SGR:**

The Medicare payment system for physicians is widely recognized as being flawed, as it is based on a formula that calls for payment cuts to offset volume and expenditure growth in physician services. Since 2002, spending as measured by the SGR method has consistently been above targets established by the formula, requiring Congress to take action annually to prevent cuts in physician reimbursements. Most recently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) averted a 10.6 percent cut scheduled to begin in July 2008 and implemented 18-months of positive physician payment updates. This period of reprieve has allowed the physician community to develop alternative Medicare physician payment reform proposals to address the long-term viability of the SGR payment system. In the event that Congress fails to adopt a solution by the end of 2009, physicians will begin to receive a 21 percent cut in reimbursements starting on January 1, 2010, and up to 40 percent in cuts over the next decade—all while medical practice costs are expected to increase by 20 percent over the same period. A long term solution is needed.

Reimbursement under Medicare Part B should be determined by factors that directly contribute to the cost of providing care to the program's beneficiaries. Using a general economic factor (GDP) to determine the annual update under the SGR formula is inappropriate as there is no defined relationship between economic output and the cost of providing care to Medicare patients. In no other market is GDP used to determine the rate of reimbursement for goods and services and using it to determine the rate at which physicians are reimbursed for services provided is improper. Additionally, health care costs traditionally inflate at a higher rate than other segments of the market for a variety of reasons. Physicians who participate in Medicare have no control over drug and device costs, development of newer technologies (which can have significantly higher costs than older treatments in the beginning), the influence of demographic shifts in increasing cost of patient care or patient need for drug and imaging services—two services that contribute significantly to Part B expenditures. The SGR fails to

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<sup>4</sup> Government Accountability Office. GAO-08-1102R Medicare Imaging Payments

take higher inflation rates into account and the formula must therefore be replaced with one that accurately accounts for increases in the cost of providing health care.

### **Alternatives to the SGR:**

There is bi-partisan consensus in Congress that SGR is a flawed formula. There are currently three basic alternatives for replacing SGR:

#### *1) MEI Formula: Replace the SGR update formula with the Medicare Economic Index (MEI)*

The MEI measures changes in the cost of physicians' time and operating expenses and is a weighted sum of the prices of inputs in those two categories. The primary barrier to replacing the SGR with payment updates based on MEI is the price tag. According to the Congressional Budget Office (CBO) estimates, net federal outlays would increase by \$58 billion over the 2007–2011 period and \$218 billion over the 2007–2016 period if SGR was replaced by an MEI based formula. Spending per beneficiary under this option would be about 30 percent higher in 2016 than under current law. In addition to the financial constraints, governmental bodies are concerned that replacing SGR with MEI may fail to contain volume of services.

#### *2) Subdividing targets within SGR: Create separate targets for various subdivisions within Medicare Part B – E&M codes (primary care, office care); Minor procedures; Major procedures; Imaging and diagnostic tests; Physician administered drugs; Anesthesia services.*

Drugs have consumed an ever-increasing share of SGR dollars, increasing from 3.7% of the total in 1996 to 9.7% in 2007. This means that drug costs are lowering the allowable growth target for actual physician services each year as drug costs consume an increasing share of total allowed spending under the SGR. Legal analysis suggests that the Centers for Medicare and Medicaid Services (CMS) has the authority to adjust the SGR formula by removing Part B drugs from physician services, which would greatly impact the annual update the SGR provides.

Setting volume growth targets for each physician specialty is another option. NASS concern with this approach is that it lessens collaboration between physicians of different specialties. An additional option includes geographic/regional targets.

#### *3) Cost control:*

a) *Medical home model:* In this model, Medicare beneficiaries must enroll in a Medical Home (MH) with primary care or alternative centralized system of care. The system offers care management, coordination, patient education, and authorization for specialty referrals. MHs receive a per-member, per-month (PM-PM) fee in addition to covered fee-for-service (FFS) payments, plus efficiency and quality incentives.

b) *Episode of care model:* The episode of care model bundles payments per episode. If hospitalization is involved, the bundled Diagnosis Related Group (DRG) payment would include physician payment. This option provides incentives for cost control and quality care. Some believe that this option provides an incentive for either hospitals or providers to “cherry pick” cases, which could be difficult to avoid. There is no consensus on the entity that receives and subsequently distributes the bundled payments (hospital vs. physician).

c) *Accountable care organizations*: In this model, physicians and beneficiaries are assigned to an accountable care organization (ACO). The ACO is held accountable for growth in volume and quality of care. While this option would provide accountability in comparison to national targets, beneficiaries are limited in their choice of physician assignment.

d) *Value-based purchasing*: A value-based purchasing program replaces payment incentives on volume with those aimed at improving quality, adopting HIT and using information from Comparative Effectiveness Research (CER) to determine reimbursement levels.

**NASS Position:**

1) *Removal of Drug Costs from Medicare Part B*: NASS requests Congress and CMS use their authority to remove the costs of Medicare Part B covered drugs from the reimbursement formula. NASS believes that removing these costs from the physician payment baseline would improve clarity on exact costs for physician services under Medicare Part B, and facilitate a permanent fix to the flawed SGR formula.

2) *Removal of Non-Physician Imaging Costs from Medicare Part B*: NASS requests Congress and CMS use their authority to include only physician fees costs associated with diagnostic imaging in the reimbursement formula, and to exclude from the reimbursement formula all non-physician costs, such as the technical component of or facility fee services, associated with diagnostic imaging . NASS believes that removing these costs from the physician payment baseline would improve clarity on exact costs for physician services under Medicare Part B, and facilitate a permanent fix to the flawed SGR formula.

3) *Budget neutral provision*: NASS urges Congress to disregard budget neutral proposals that attempt to adjust Medicare physician payment. The attempt of some proposals to adjust physician payments in a budget neutral fashion, offsetting increases in primary care payments with decreases in specialty care reimbursements, diminishes the value of specialty care and can result in access issues for Medicare patients. Further, these proposals discredit the Resource-Based Relative-Value Scale (RBRVS) and the Relative-Value Update Committee (RUC) process, which has been charged with valuing all codes. Based on the current system used to determine the value of treatments provided, CMS shifted nearly \$4.5 billion per year from specialty to primary codes beginning January 1, 2007.<sup>5</sup>

4) *Episode of care system*: NASS believes that the development of any episode of care or coordinated care system should focus on improving patient care and providing more effective outcomes, and not on cost containment. The development of any acute care episode fee sharing system or coordinated care system must be under the control of the physician who knows the patient's needs best, and not a non-physician entity such as the hospital or any third party. While NASS believes that it can be appropriate for physicians and their contracted hospitals to share in the financial rewards associated with participation in an episode of care system, the physician charged with coordinating care must have the ability to direct all patient care decisions.

5) *Keeping up with health care costs*: NASS urges Congress to examine the costs of running a practice and address the SGR issues in a way that takes into account the pace at which medical costs rise. The cost of running a practice has and will continue to far outpace the payments made to physicians through

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<sup>5</sup> [www.annals.org/cgi/reprint/146/12/896.pdf](http://www.annals.org/cgi/reprint/146/12/896.pdf)

Medicare unless the SGR system is changed to more accurately account for the cost of providing care to the nation's seniors. In many cases, physicians have been forced to abandon Medicare altogether secondary to these costs. NASS supports physician payment initiatives that keep pace with the ever increasing costs of running a medical practice while allowing patient access to the high quality health care services they require.

6) *Working with physicians:* NASS further urges Congress to direct CMS to work directly with specialty care physician groups in order to better meet the needs of all physicians and their patients.