

Medicare Physician Payment Updates: Time to Adopt MedPAC Recommendation to Replace the SGR

Medicare reduces payments to physicians and other practitioners whenever program expenditures for their services exceeds a target called the Sustainable Growth Rate or SGR. Despite several Congressional fixes, this formula has led to arbitrary and automatic payment cuts that threaten Medicare patients' continued access to high quality medical care. ***The time has come to abandon the SGR and adopt the recommendation of the Congressionally-created Medicare Payment Advisory Commission (MedPAC) to update payments for physicians and other practitioners using the same approach as for all other providers so that payment increases better reflect increases in the cost of practice.***

Because of the SGR formula, Medicare cut payments to physicians and other practitioners by 5.4% in 2002. Another 4.4% cut was scheduled to take effect in 2003 and the Centers for Medicare and Medicaid Services was predicting cuts of similar magnitude for 2004 and 2005. The 2003 cut was transformed to a 1.6% increase when Congress took action in mid-February to restore funds that would have been in the system if the 1998 and 1999 targets had adequately reflected all the components of the SGR formula. At the time, Congress thought it had averted multi-year cuts.

A few weeks later, however, CMS sent a letter to MedPAC stating, "While we had previously estimated positive updates for 2004 and later years, we now estimate updates will be negative for 2004-2007." For 2004, the letter said, the update is likely to be minus 4.2% but it could be anywhere from minus 5.8% to plus 0.6%. Its explanation for the sudden reversal was that estimates of GDP growth had declined and Medicare beneficiaries' use of services had increased.

The SGR is an unsound and unworkable system

This forecast cut is not the result of a deliberate decision by Congress. Instead, the continuing cuts are an unintended consequence of an unsound and unworkable formula. The SGR locks lawmakers into irrational payment policies and threatens Medicare patients' access to medical care.

There are significant design flaws in the SGR. The formula cuts payments if growth in Medicare patients' use of services is higher than GDP growth, even though health care needs do not go away when economic performance slows. It fails to account for many factors that of necessity contribute to increased use of physician services by seniors and the disabled, such as the growing proportion of beneficiaries who are very old and/or suffer from diabetes, renal failure and other chronic diseases.

In addition, the SGR requires Medicare officials to predict the unpredictable as demonstrated in the -5.8% to +0.6% range of possible updates CMS has provided for 2004. Because it is impossible to accurately forecast future GDP growth, health care needs and Medicare enrollment, payment updates cannot be accurately predicted. Most medical practices are small businesses. Payment rates under the SGR are subject to volatile and unexpected swings that create chaos for these practices.

While CMS Administrator Tom Scully's predicted access "meltdown" was averted in 2003, the 4.2% cut projected for 2004 could once again throw health care access for senior and disabled Americans into crisis. Nearly half the physicians responding to an American Medical Association (AMA) survey (48%) had said they would begin limiting or further limit the number of Medicare patients they treat if pay were cut by 4.4% in 2003. Although physicians and health professionals want to continue to care for their disabled and elderly patients, they cannot continue indefinitely in a situation where their Medicare costs increasingly outpace their Medicare revenues.

Spending for other providers outpaced spending for physician and other practitioners

According to CMS, the major factor driving its prediction of a 2004 cut is a surge in 2002 utilization of physician services. Data available to date, however, show that utilization per beneficiary rose by about 6% in 2002, which is only slightly greater than in 2001. Moreover, acceleration in spending was not limited to physicians and health professionals. According to CMS data cited in the March 26 *New York Times*, 2002 increases in Medicare spending for durable medical equipment, hospital, home health, skilled nursing, and hospice services all exceeded the increase in physician spending. Also, CMS actuaries wrote in a January/February 2003 *Health Affairs* article that a similar trend has been observed across all payers, not just Medicare, as “national health care spending in 2001 grew at the fastest pace since 1991.”

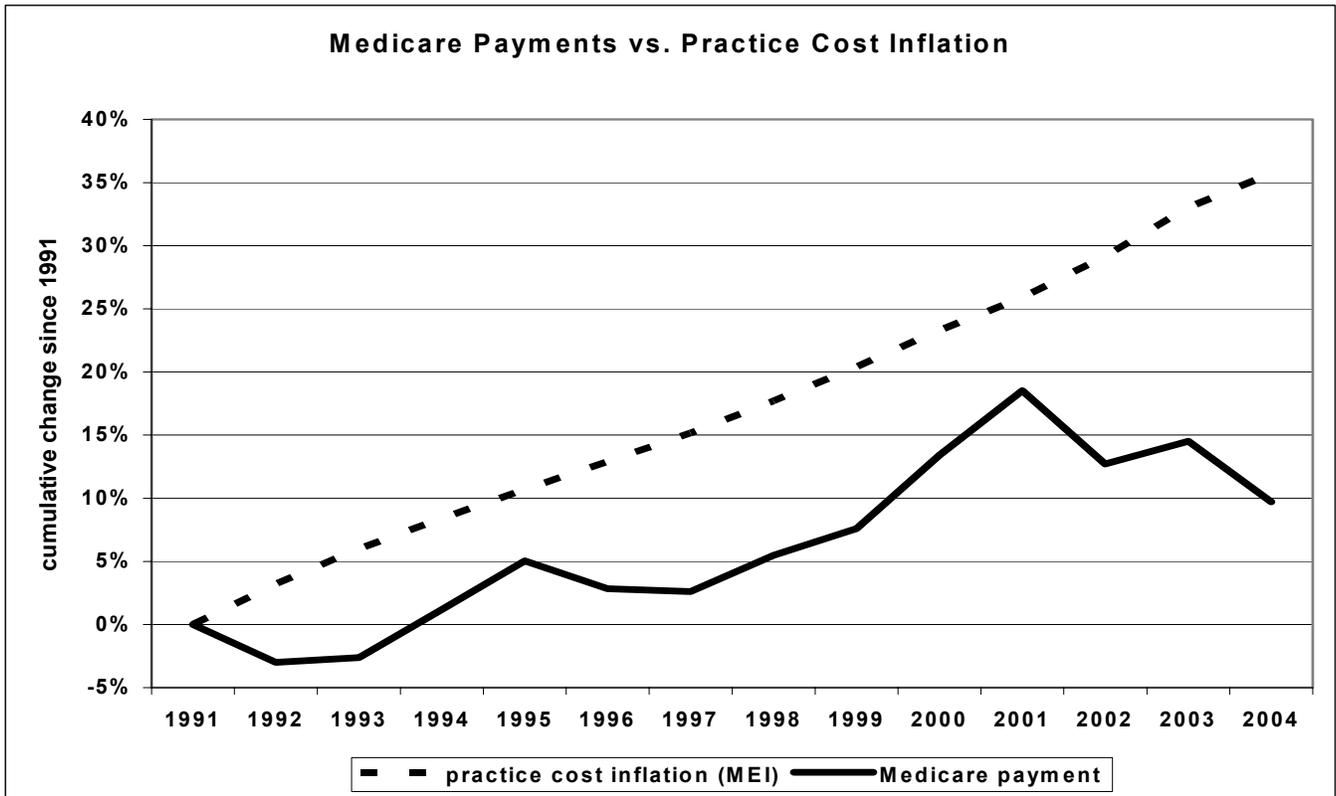
Despite these common trends, no other Medicare provider group is subject to the SGR. Instead, updates for other providers are set by Congress based on inflation in their costs. Only the update for physicians and other health professionals is based on a formula that is driven by GDP growth and imposes steep cuts while running on “automatic pilot.” For this reason, physician and health professional payment updates lag well behind other providers. **A 2004 pay cut would be the fifth reduction in physician and other practitioners’ payment rates since 1991. From 1991–2003, the average annual increase in payment was only 1.1% and, since 1991, payments have fallen 14% behind practice cost increases even using CMS’s own conservative estimates.** Even the 1.6% update for 2003 was only about half the 3% rise in practice cost inflation. With another 4.2% cut in 2004, the gap would grow to 19%.

The SGR asks physicians to restrict care even though demand is rising.

Multiple studies have concluded that the percentage of physicians accepting all new Medicare patients has been declining at least since 2001, while Medicare patients’ need for health care services continues to increase. CBO Director Douglas Holtz-Eakin recently attributed Medicare’s rising costs to “increased enrollment, development and diffusion of new medical technology ... and program expansions.” CMS actuaries and the Centers for Disease Control have concluded that a wave of new drugs has spawned steady growth in prescription drug use and physician visits. Technological advances have allowed procedures once reserved for younger patients to be safely performed on older and frailer patients. More beneficiaries are over age 75 and more have diabetes, osteoporosis, cardiovascular disease and obesity, which contribute to greater service use.

In fact the government itself has contributed immensely to the increased use of physician services. For example, Congress has expanded Medicare coverage to include several new screening tests that frequently trigger additional physician services. CMS has added coverage for a variety of new technologies, such as PET scans and cryosurgery; and in just one year (2001), Medicare’s Quality Improvement Organizations achieved a 5% increase in the use of mammograms and a 16% increase in lipid testing for targeted groups of beneficiaries.

With all these factors boosting utilization growth, it will be impossible for physicians and practitioners to live within the targets except in years of high economic growth unless they limit the number of Medicare patients in their practices or the services they provide. Spending targets and limits have led to lengthy waiting times and deteriorating quality in other countries and eventually cannot help but have the same effect in the U.S. The time has come to adopt MedPAC’s recommendation that the SGR be replaced with annual updates that reflect actual increases in practice costs, starting in 2004.



Sources: Practice cost inflation (MEI) all years and 2004 update prediction, Centers for Medicare and Medicaid Services (CMS); 1992-97 payments, Physician Payment Review Commission; 1998-2003 payments, American Medical Association.