Fair Medicare reimbursements as a means to maintain patient access to medical services is an issue that MITA has supported for years.

On the surface, it seems as if the process of paying doctors for routine medical services should be a straightforward transaction between the Medicare program and the clinician performing the service. In reality, Medicare reimbursements are a complicated mix of formulas governing how the Centers for Medicare & Medicaid Services (CMS) will pay for thousands of different medical products and services—with additional adjustments made to those rates based on location, patient characteristics, quality measures, and a number of other factors.

One piece of this formula, the sustainable growth rate (SGR), has vexed physicians for almost a decade, and it remains one of the most intractable health policy issues on Capitol Hill.

Paying for Coverage

According to the Congressional Budget Office (CBO), since the Medicare program was created in 1965, several methods have been used to determine how much it pays physicians for each covered service. Initially, the program compensated physicians on the basis of their charges and allowed them to bill beneficiaries for the full amount above what Medicare paid for each service. In 1975, Medicare payments were still linked to what physicians charged, but the annual increase in fees could not exceed the increase in the Medicare economic index, or MEI. Because those changes were not enough to prevent total payments from rising at an unsustainable rate, from 1984 through 1991 the yearly change in fees was determined directly by Congress through legislation.

Starting in 1992, the payment system based on physicians’ charges was replaced by a fee schedule. That schedule bases payment for individual services on measures of the relative resources used to provide them. The schedule was not intended to control spending—it was designed to redistribute spending among various physician specialties.

The fee schedule was updated annually by a combination of the MEI and an adjustment factor designed to counteract increases in the volume of services being delivered per beneficiary. That factor, known as the volume performance standard (VPS), was based on historical trends in volume. However, the VPS mechanism led to highly variable changes in payment rates, and the Congress replaced it with a new mechanism—the SGR—starting in 1998.

The SGR mechanism aims to control spending for physicians’ services. It does so by setting an overall target amount of spending (measured on both an annual and a cumulative basis) for certain types of goods and services. Included are payments for physicians’ services as well as payments that Medicare makes for items such as laboratory tests, imaging services, and physician-administered drugs that are furnished “incident to” (in connection with) physicians’ services. Payment rates are

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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.

Policymakers had two main goals when they adopted the SGR mechanism: ensuring adequate access to physicians’ services and controlling federal spending for those services in a more predictable way than the VPS mechanism did. The SGR mechanism has a mixed record with regard to those goals.

**Shifting Nature of Reimbursements**

Not long after the adoption of SGR, a curious economic condition began to affect the application of the formula. Beginning in 2002, spending as measured by the SGR method began to significantly outpace the targets established by the formula. The impact of this would have resulted in a substantial reduction in the payment rates for physicians’ services over the next several years. Annual CBO estimates since 2006 describe conditions that would have caused payment rates to decline by 25 to 35 percent.

A decrease of this magnitude would likely have a devastating effect on access to the program as physicians would likely decline accepting any new Medicare patients. Rather than risking potential program access for senior citizens, Congress stepped in to override the SGR formula on 14 separate occasions since the payment rate deficiency was uncovered in 2002. This is commonly known as the Medicare “doc fix.”

Over the years a number of people have called for repeal of the SGR formula, the so-called permanent doc fix. While simply repealing the SGR formula would cure the frequent override legislation that must be passed in Congress, it wouldn’t solve the problem of how Medicare reimbursement rates would be set. A recent CBO report estimated that a permanent repeal of the doc fix formula would cost the federal government $138 billion between 2014 and 2023.²

In 2013, the three congressional Medicare committees approved similar, bipartisan legislation to repeal the SGR formula and establish several physician office and hospital outpatient Medicare payment reforms. The intent of many of these reforms is to shift Medicare payments away from fee-for-service payments based on volume, toward limited payments that account for the quality of the care provided.

Although Congress made unprecedented progress in advancing these reforms last year, 2014 holds another set of hurdles that will need to be overcome to eliminate the SGR and establish a new mechanism to guarantee access to care while ensuring that the promise of Medicare remains for future generations. ☞

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**Medicare Timeline**

- **1935.** Social Security Act of 1935 (Public Law 74–271, now codified as 42 U.S.C. ch. 7) created the Social Security System in the U.S.

- **1965.** Social Security Amendments of 1965 (Public Law 89–97) created Medicare and Medicaid as “coordinated healthcare insurance programs” under the Social Security Administration in the Department of Health, Education, and Welfare (HEW).

- **1965-1974.** Medicare paid physicians based on physicians’ actual charges. Although payments were subject to Medicare carriers’ determinations of a “reasonable” charge, there was no set fee schedule or benchmark that limited payment rates.

- **1975.** The Medicare Economic Index (MEI) was instituted to set a fixed fee schedule, based on 1973 prices. MEI was planned to limit annual fee increases to increases in the costs of producing physician services and increases in general earnings levels.

- **1977.** The Health Care Financing Administration (HCFA) was established under HEW and became responsible for the coordination of Medicare and Medicaid.

- **1984-1991.** Annual Congressional action was required to set Medicare physician fee increases, because policymakers were concerned that prices were rising too quickly.

- **1992.** The Resource Based Relative Value Scale system was instituted. Physician payments were to be updated annually based on the MEI, plus the application of an adjustment factor (the Medicare Volume Performance Standard [MVPS], predecessor of the SGR formula) designed to counteract increases in the volume of services being delivered per beneficiary.

- **1998.** *Balanced Budget Act of 1997* (Public Law 105–33) creates the SGR system to replace MVPS as the mechanism to ensure Medicare physician spending did not exceed expenditure targets.

- **2001.** HCFA changes its name to the Centers for Medicare and Medicaid Services (CMS).

- **2002.** Healthcare costs began to outpace gross domestic product growth resulting in decreases in physician fees for Medicare services. Productivity offset changed from being based on labor productivity to multi-factor productivity resulting in the so-called “doc fix” adjustments to SGR.