



Physician Reimbursement Gets a Reprieve from Congress

Eddie L. Hoover, MD
Buffalo, New York

Key words: physician reimbursement ■ Medicare ■ sustainable growth rate ■ Medicare fee updates

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Physicians entered the final month of 2006 fully expecting a 5% reduction in reimbursement from Medicare beginning in 2007. However, on Saturday, December 9, 2006, the Senate passed a Medicare relief action that “blocks” the 5% cut and freezes the fee schedule conversion factor at the 2006 level of \$37.90 for the coming calendar year. The president is expected to sign the bill. This annual ritual of threats to physician reimbursement began in 2002 when the system Medicare used to determine the annual increases in physician fees—the sustainable growth rate (SGR)—reduced fees by almost 5%. Following aggressive lobbying by the medical establishment, last-minute legislative actions voided the annual projected decreases in reimbursement from 2003 until the present, and last week’s action by the Senate grants physicians another year of injunctive relief. However, these reductions are scheduled through 2015.

The SGR works by setting spending targets and adjusting physicians’ fees based upon the alignment of actual spending with target projections. If there is growth in the number of services provided to Medicare beneficiaries (i.e., volume) and in the complexity and costliness of services (i.e., intensity), then spending will surpass the SGR target figures, as this model allows for very limited growth in these areas. If the growth in a given year surpasses the average growth in the gross domestic product per capita, Medicare fee updates are then set lower than the estimated increase in the average cost of providing physicians’ services. Thus, a large gap between spending and the target may result in fee reductions. It is generally conceded that the SGR model is flawed, but there are two

reasons why physicians’ fees are projected to decline under this model. The growth in spending due to “volume and intensity” has greatly exceeded the amount allowed under the SGR model, resulting in excess spending that *must* be recouped through reduced fee updates. The administrative and legislative actions from 2003 until the present that voided these fee reductions failed to revise the spending targets. Consequently, the SGR model *must* offset the additional spending resulting from the excess “volume and intensity” and the minimum fee updates by reducing fees.

From 2000 to 2005, Medicare experienced an increasing number of beneficiaries receiving physicians’ services, and there was an increasing number of physicians’ services provided to these beneficiaries who were treated. This was true in practically every state’s rural areas as well as their urban regions. The number of physicians billing Medicare and the proportion of services for which Medicare’s fees were accepted as full payment also increased during this period of time. While these data demonstrate that beneficiaries were able to access medical care, it only serves to point out the inadequacies of the SGR model and the need to overhaul the system in what is essentially a zero sum game at this time.

The legislation passed last weekend included another wrinkle that has been on the horizon for some time, namely the “pay for reporting” quality incentive program (P4P). This program will be featured in this column next month.

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