# Physician payments hinge on sustainable growth rate factor

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## System can be confusing, but bears a crucial role in physician compensation

*The strongest principle of growth lies in the human choice.*

George Eliot, 1819-1880, English novelist.

Physicians are often perplexed by the vagaries of the system used to calculate reimbursement levels for medical services. This is not surprising. The system is difficult to understand, and relies heavily on the "sustainable growth rate." As will be described, the use of this term in the context of Medicare is not identical to that as applied in general finance. The handling of this term is compared and contrasted in the Figure.

In my last article ("Sustainable growth rate directs plans for expansion,"

September 15, 2004 at www.ophthalmologytimes.com), I defined the sustainable growth rate as the annual percentage increase in sales that a firm can support without changing its present mix of liabilities and equities. In the context of Medicare, the sustainable growth rate is the rate of growth in spending for physician services endorsed by the government.

There is some similarity in the treatment of the term in the two settings. Both describe the increase in payments by some entity (either customers or the government) that can be supported under a particular financial structure (either company assets or the federal budget.)

The sustainable growth rate system was established by the Social Security Act of 1997. The expressed goal of the system was to control national spending on healthcare. However, since its inception, the system has been a source of tremendous controversy.

The sustainable growth rate is determined prospectively by a formula that takes several factors into account. These factors are all estimated values. They include estimates of the changes in physicians' fees, changes in the average number of Medicare beneficiaries, changes in expenditures due to regulatory changes, and growth in per capita gross domestic product. Sustainable growth rates were 8.3%, 6.7%, and 7.4% in 2002, 2003, and 2004 respectively.

Target expenditures can be calculated once the sustainable growth rate is known. The target expenditures for a given quarter equal the previous year's target expenditures for the same quarter with a percentage increase equal to the sustainable growth rate. Since the sustainable growth rate is determined through estimates, target expenditures are inherently based on estimates as well.

For example, given the 2004 sustainable growth rate of 7.4%, target expenditures for the fourth quarter of 2004 will be 7.4% more than

winter 2003's target expenditure of $18.2 billion, or $19.5 billion.

The federal government calculates an index annually that is modified by variances between actual and target expenditures. Eventually, a fee schedule update is determined that is then used to change the conversion factor from one year to the next. The conversion factor is the number multiplied by the geographically-adjusted relative value units of a CPT code to determine the fee schedule amount for the service. (For more details on the resource-based relative value system, see my previous article, "Resource-based relative value scale dictates revenue stream," December 15, 2003 at www.ophthalmologytimes.com.)

Organized medicine has mounted several complaints against the present SGR system. One is that the system is based on estimates, which often prove erroneous. The fee schedule is thus sensitive to estimation error, and physicians have suffered as a result of such errors.

Another problem is that the costs of physician-administered outpatient drugs are included in actual physician expenditures. Therefore, actual physician expenditures are increased every time a Medicare beneficiary receives a drug infusion in a physician's office. It is argued that drugs are a product rather than a medical service and that doctors are not reimbursed through the procedural fee schedule for the drugs. It follows that the costs of these drugs should not be lumped into the category of actual expenditures. Indeed, there has been a recent explosion in the number of available drugs and the amount of spending on these drugs. The current system has the effect of penalizing physicians through lower fee schedule amounts every time such a drug is administered in the office.

Another complaint is that changes in gross domestic product should not be part of the sustainable growth rate calculation. The point is that payment for doctors should not depend upon factors such as GDP which are not logically correlated with health care. In reality, health care needs of the population invariably increase despite the fact that GDP declines in certain years.

Another point of contention is that the overall improvement in available medical care is being funded somewhat at the expense of physicians through fee schedule reductions. These improvements are manifest in part as new coverage determinations. Additional care through new coverage determinations will be reflected by increased actual physician expenditures.

The physicians rendering services through these new coverage determinations will indeed be paid according to the fee schedule amount. However, the additional physician expenditures that result will negatively impact the conversion factor, thus having a negative impact on physicians overall.

The current environmental focus on cost containment means that physicians must watch operations closely. One of the most important areas of operations is inventory management. This will be the topic of my next article.

**Figure 1** Comparison of sustainable growth rate

| | Finance | Medicare |
|---|---|---|
| **Purchaser of services** | Customer | U.S. Government |
| **Financial structure** | Assets, liabilities, owners' equity | Federal budget |
| **Source** | Formula established through theory | Formula derived through political process |

OT Graphic

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