

# History of Medicare Conversion Factor Under the SGR

The Medicare conversion factor (CF) is a scaling factor that converts the geographically adjusted number of relative value units (RVUs) for each service in the Medicare physician payment schedule (MFS) into a dollar payment amount. The initial Medicare CF was set at \$31.001 in 1992. Until 2015, subsequent default or current law CF updates were determined largely by an expenditure target formula. In 2015, the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015 permanently eliminated the existing expenditure target, ie, the sustainable growth rate (SGR), and replaced it with fixed updates that are specified in the legislation. The CF update may also be affected by miscellaneous adjustments, including those for budget neutrality.

## SGR Permanently Repealed

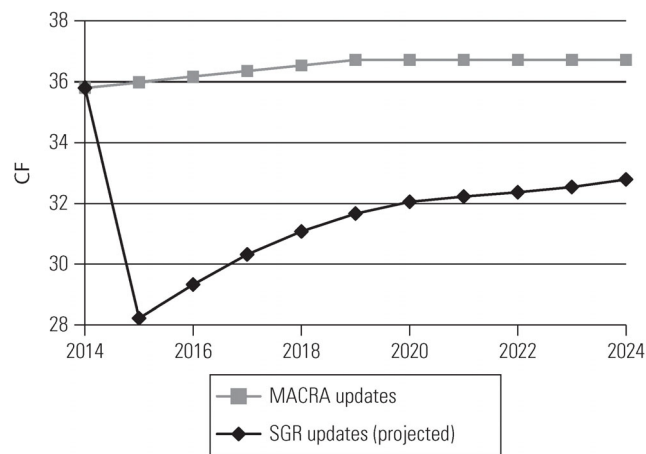
The SGR was enacted as part of the Balanced Budget Act of 1997, replacing the original MFS expenditure target, known as the Medicare volume performance standard (MVPS). Updates under the SGR formula were initially positive, but it turned negative beginning in 2002 in which payment cuts were allowed to go through, reducing the CF by about 5%. Subsequent cuts were blocked by legislation, using methods that, until recently, had resulted in ever-steeper cuts for the following years. In all, there were 17 temporary SGR fixes that blocked CF cuts that ranged from 4.4% in 2003 to 27.4% in 2012. The last temporary fix expired April 1, 2015, with a 21.2% CF cut, which was set to go into effect.

However, this cut was blocked by MACRA, which eliminated the SGR and, instead, specified updates for all future years. The update for April 1, 2015, was set at 0.0%; however, a 0.5% increase was provided on July 1, 2015. Updates for 2016 to 2019 were set at 0.5%, and for 2020 through 2025 were set at 0.0%. Beginning in 2026, MACRA specified that updates will differ depending on whether the provider is in an alternative payment model (APM). For providers in APMs, the annual CF update will be 0.75%. For others, the update will be 0.25%.

The impact of MACRA is enormous; with the SGR cut scheduled for April 1, 2015, the Medicare physician CF would have fallen from just under \$36 to roughly \$28.20. Instead, the CF was stabilized, and Medicare physician pay for the remainder of 2015 was 27% greater than it would have been under the SGR.

Projections of SGR updates provide an indication of future impacts. Although SGR updates beyond 2015 would have depended on a variety of factors, under reasonable assumptions Medicare physician pay under MACRA in 2024 is 12% greater than it would have been under the SGR. In addition, over the 10 years from 2015 to 2024, Medicare physician pay under MACRA is, on average, 17% greater than the projected pay under SGR (see Figure 10-1). Over the 10 years from 2015 to 2024, the update provisions of MACRA are projected to increase payments for Medicare physician services by roughly \$150 billion, compared to what would have occurred under the SGR.

**Figure 10-1. MACRA Stabilizes Medicare Physician Pay**



Note: MACRA and SRG updates exclude budget-neutrality and misvalued-code adjustments.

## Medicare Economic Index

The Medicare Economic Index (MEI) is no longer part of the annual CF update process. The MEI is a measure of medical practice inflation; however, because CF updates are now set by MACRA, there is no longer an explicit inflation adjustment in the update.

The MEI was used between 1976 and 2015 as a proxy for inflation in the cost of operating a medical practice. The largest single determinant of changes in the MEI was the change in professional workers' earnings, which was the proxy for physicians' own time in the index. The index also included measures of changes in:

- Nonphysician compensation, including fringe benefits
- Expenses for office space and equipment
- Medical materials and supplies expenses
- Professional liability insurance
- Medical equipment expenses
- Other professional expenses

The Centers for Medicare & Medicaid Services (CMS) used data from the federal Bureau of Labor Statistics to measure changes in the prices of all these components of practice expense (PE) except professional liability insurance (PLI). CMS used its own survey data to measure changes in PLI premiums. These price changes are weighted by each component's share of total physician practice revenue. The revenue shares were based largely on data from the American Medical Association's (AMA's) physician practice information (PPI) survey, which was fielded in 2007 and collected PE information for 2006.

CMS convened a Technical Advisory Panel (Panel) in 2012 to review all aspects of the MEI. The Panel recommended several changes to the price proxies and cost components of the index, and CMS implemented most of the recommendations effective with the 2014 MEI. Key changes included:

- changing the price proxy for physician compensation from hourly earnings in the general economy to earnings of professional workers;
- using commercial rents in place of residential rents for the office space (fixed capital) portion of the index.
- moving payroll for nonphysician personnel who can bill independently from the PE portion to the physician compensation (work) portion of the index;
- creating new categories for clinical labor costs and for other professional services (eg, billing); and
- increasing the physician benefits share of the index.

The changes to the cost categories and weights are aimed at improving the accuracy of the MEI as a description of the cost structure of medical practice. Changes to the price proxies generally move away from broad price measures to those more closely associated with physicians. The revenue shares for the major MEI categories are shown in Table 10-1, along with the associated wage and price changes for the 2015 MEI.

The MEI includes an adjustment for productivity growth, ie, the MEI is reduced to account for potential improvement in the productivity of physician practices. Beginning with the 2003 MEI, the productivity adjustment is based on the 10-year average of economy-wide multifactor productivity growth. For 2015, the weighted average increase in input prices captured under the MEI was 1.7%, and the productivity adjustment was -0.9%, yielding a net change of 0.8% in the MEI.

The current MEI weights are based primarily on results from the AMA’s PPI survey, which collected data from 2006, and are utilized to determine the proportion of work, PE, and PLI relative values within the MFS. In the calendar year (CY) 2023 MFS Final Rule, CMS finalized new MEI weights utilizing data from the US Census Bureau’s Service Annual Survey (SAS) and, in the future, will supplement the SAS data with other sources when SAS does not provide necessary details. These changes lead to substantial changes in the weights for many of the key components of physician PE. For example, the weight for non-physician compensation increases from 16.6% in the current MEI to 24.7% in the proposed MEI, and the weight for PLI decreases from 4.3% to 1.4%. Although CMS has finalized the MEI using these new data, the agency will delay its implementation to future rulemaking, recognizing the need for public comment due to the significant impact to physician payments. The current proportions of payment are physician work 50.9%, PE 44.8%, and PLI 4.3%. The proposed weights would be physician work 47.3%, PE 51.3%, and PLI 1.4%.

**Table 10-1. The 2015 MEI**

<b>Component</b>	<b>Weight</b>	<b>Wage/Price Change</b>
Physicians’ own time	50.9%	1.9%
Nonphysician payroll	16.6%	1.8%
Other practice expenses	32.6%	1.4%
Total (weighted average)		1.7%
Less productivity adjustment		-0.9%
2015 MEI		0.8%

## Expenditure Targets and Performance Adjustment

Generally, the most important element in determining default or current law CF updates is the performance adjustment. The performance adjustment is based on a comparison of actual and target expenditures. The method of determining this factor has changed over time. Initially, the performance adjustment was based on the Medicare volume performance standard (MVPS). This formula, which had been altered under the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), was projected to produce substantial long-term payment cuts.

In 1997, Congress enacted key changes to the CF update process as part of the Balanced Budget Act (BBA), replacing the MVPS with the sustainable growth rate (SGR) system. This system was also seriously flawed, however, and further revisions

that were advocated by AMA were adopted as part of the Balanced Budget Refinement Act (BBRA) of 1999. In 2015, MA-CRA legislation permanently repealed the SGR update methodology for physicians' services, which provides positive annual payment updates of 0.5%, beginning from July 1 and lasting through 2019, which requires that CMS establishes a merit-based incentive payment system (MIPS) under which MIPS eligible professionals receive annual payment adjustments based on their performance in a prior period. These and subsequent other changes to the expenditure target system are described in the remainder of this section.

### The MVPS and Conversion Factor Updates Prior to 1998

Under the MVPS system, a target rate of fee-for-service Medicare physician spending growth was calculated each year. This target rate of growth was compared to actual spending growth for the year to determine the CF update two years later. If actual spending growth exceeded the target in a given year, for example, physicians would be penalized with a below-inflation update two years later (in which MEI is the measure of inflation). If actual spending growth was below the target, then an above-inflation update would be awarded. The two-year lag was specified to allow for delays in claims processing.

This formula-driven approach to updating the CF was not automatic, however. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) gave Congress the authority to set its own CF updates and spending targets. As part of its deliberations, Congress was required to consider the recommendations submitted by CMS and the Physician Payment Review Commission (PPRC). If Congress failed to act on these recommendations, however, annual updates were set by the default (MVPS) formula, which had also been established under OBRA 89.

The default MVPS target rate of spending growth was based on the following factors:

- Changes in Medicare payment levels
- Changes in the size and age composition of the Medicare population
- The five-year historical average growth in the volume and intensity of physician services
- Changes in expenditures resulting from law and regulation

The target was then reduced by a legislatively determined number of percentage points known as the *performance standard factor*. The performance standard factor was increased from 2.0 to 4.0 percentage points by OBRA 93.

With the modifications to the MVPS formula specified in OBRA 93, Medicare payments were projected to decline steadily over time. Payments were virtually guaranteed to fall over the long term given the structure of the MVPS system, which essentially set the target rate of spending growth at the expected rate of spending growth minus 4 percentage points. The PPRC projected that the default formula would generate annual CF cuts of 2% or more indefinitely.

Separate MVPS targets for surgical and nonsurgical services were also established under OBRA 89, allowing separate CFs for each service category. A third service category, for primary care services, was established in 1994 under provisions of OBRA 93. By 1997, the separate targets and updates under the MVPS system resulted in a surgical CF that was 9% greater than that for primary care, and 14% greater than that for nonsurgical services. As the CFs diverged, interest grew among various groups to eliminate multiple MVPSs and return to a single CF.

### The Sustainable Growth Rate System and the BBA

The BBA of 1997 established a single CF for all physician services excluding anesthesia as of January 1, 1998. The legislation also replaced the MVPS with the SGR expenditure target system. Under SGR, a target rate of spending growth is calculated each year based on changes in the following:

- Fees for physician services (in practice, primarily the MEI)
- Medicare fee-for-service enrollment
- Real (inflation-adjusted) per capita gross domestic product (GDP)
- Spending due to law and regulation

The factors that go into determining the SGR target (see Table 10-2) are like those used in the MVPS, with the major change being the use of real per capita GDP in place of historical average volume growth. A second major change is that the SGR

system is cumulative. The target growth rate is applied to the allowed amount of spending for the prior year to determine the (dollar amount of) allowed spending for the following year. Running totals of actual and allowed spending, beginning April 1, 1996, are kept, and the performance adjustment is based on the difference between cumulative allowed and actual spending. The performance adjustment is limited to a maximum bonus (if spending is below target) of 3% and a maximum penalty (if spending is above target) of -7%.

**Table 10-2. SGR Targets for 2010–2014**

***Allowed Growth in Medicare Physician Spending as of November 2014***

	2010	2011	2012	2013	2014
Payment (inflation), %	0.9	0.2	0.6	0.4	0.7
Fee-for-service enrollment, %	1.1	1.0	0.9	0.5	0.2
Real per-capita GDP growth, %	0.6	0.6	0.9	0.9	0.7
Law and regulation, %	6.1	2.8	2.6	0.5	2.4
Total	8.9	4.7	5.1	1.3	0.8

With the introduction of GDP to the target, funding for Medicare physician services was tied directly to the state of the US economy. In 1997, the Congressional Budget Office and others projected that the SGR would reduce physician payments even more than the MVPS. However, the system offered the opportunity for improved payment levels if growth in the utilization of Medicare physician services was relatively low.

The SGR system, as specified in the BBA, had several technical flaws. A key flaw was the lack of any specific provision regarding the correction of projection errors. CMS originally set a target rate of growth each fall for the coming fiscal year. This target rate of growth was based on projections of the components of the target for that year, including real per capita GDP growth and changes in fee-for-service enrollment. CMS underestimated these components for the fiscal year 1998 and 1999 targets, and this reduced target SGR spending relative to what it should have been.

Despite this shortfall, CMS estimated that actual spending was at or below the target amount for the first two years of SGR. The 1999 update, the first to be determined under the SGR system, was 2.3% (before budget-neutrality and other adjustments), and the 2000 update was 5.4%.

Congress corrected some of the SGR’s technical flaws in the Balanced Budget Refinement Act of 1999 (BBRA). The BBRA did not, however, direct CMS to correct the fiscal year 1998 and 1999 projection errors (although it did allow CMS to correct projection errors going forward). Despite this, actual SGR spending appeared to be within the target amount as late as spring 2001. The 2001 update was 4.5%, which included the maximum 3% bonus performance adjustment. Then, US economic growth faltered, and the Commerce Department revised its official estimate of GDP growth in 2000 downward. These events reduced allowed or target spending. At the same time, utilization growth for SGR services increased, driven in part by rapid growth in the utilization of physician administered drugs, which were included in SGR at that time. Utilization of many diagnostic services also increased markedly. As a result, actual spending growth increased.

Combined, these changes would have resulted in a negative update in 2002. According to CMS, the update in 2002 would have been -3.8% based on these factors alone. In addition, CMS discovered it had undercounted actual SGR spending beginning in 1998. In all, actual spending was undercounted by \$4.5 billion for 1998 through 2000, or roughly 3% of SGR spending over this period. Correcting this error further reduced the 2002 CF update to -5.4% and assured that another CF cut would be forthcoming in 2003.

### Congress Acts on the 2003 Update . . .

In its December 31, 2002, Final Rule on the physician payment schedule, CMS announced that a 4.4% cut to the Medicare CF would take effect March 1, 2003. CMS also estimated that spending for SGR services for the period April 1, 1996, through December 31, 2002, exceeded the allowed or budgeted amount by \$16.5 billion, an amount equal to roughly one-fourth of allowed spending for 2002. Barring any legislative or administrative action to correct this problem, the SGR “deficit” could easily have reached \$20 billion through 2003. Another 4% to 5% pay cut in 2004 was a near certainty, and cuts would likely have extended out several years.

However, on February 13, 2003, after intense lobbying by the AMA and state and specialty societies, and with support from CMS, Congress passed an appropriations package (H. J. Res. 2) that included language authorizing CMS to correct the FY 1998 and 1999 SGR projection errors. Two weeks later, in a revised rule, CMS made the corrections to the targets. The fiscal 1998 target was increased from 1.5% to 3.2%, and the fiscal 1999 target was increased from -0.3% to 4.2%. As a result, the \$16.5 billion shortfall in SGR funding through 2002 was eliminated (wiping out the huge “deficit” in the system) and allowed spending for SGR services was increased by 6.5% for 2003 and every subsequent year. With these changes, the 4.4% pay cut scheduled to go into effect March 1, 2003, was replaced with a 1.6% increase.

### . . . but Deficits Quickly Return

Although the correction of the FY 1998 and FY 1999 projection errors had an estimated cost to the federal government of some \$54 billion over 10 years and successfully reversed a Medicare pay cut in 2003, it did not eliminate the potential for future cuts. The bill restored money to the SGR budget, but it did not change the structure of a system with the potential to produce cuts in pay if GDP growth is slow or utilization growth for SGR services is high.

Both trends continued in 2002 and 2003. Real per capita GDP growth totaled less than 3% for 2001 through 2003 combined, averaging less than 1% annual growth. Utilization growth for MFS services accelerated from 2% to 3% per year in the late 1990s to roughly 5% in 2001 and 6% in 2002. Utilization of drugs, included in SGR spending, grew even faster. Medicare allowed charges for such drugs increased from \$1.8 billion in 1996 to \$8.6 billion in 2004, an average annual increase of 22%.

The combined effect of below-average growth in GDP and accelerating utilization growth for SGR services led to a quick return of an SGR deficit, projected in the fall of 2003 to total some \$6 billion for CY 2003 alone. As a result, CMS announced in the November 7, 2003, Final Rule on the 2004 physician payment schedule that the 2004 update would be -4.5%.

### . . . Cuts for 2004–2006 Are Blocked (Temporarily)

Congress blocked the 4.5% cut slated for 2004 and another likely cut in 2005 with a provision in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) that was enacted late in 2003. The provision replaced these cuts with updates of 1.5% for 2004 and 2005. The MMA also changed the real per capita GDP component of the SGR target from a single-year estimate to a 10-year moving average starting with the CY 2003 target.

Pay updates would have reverted to the SGR formula in 2006, with a resulting 4.4% cut, but Congress acted again, freezing the CF at the 2005 level with a provision in the Deficit Reduction Act (DRA) of 2005. Although MMA and DRA prevented a steep decline in Medicare physician pay, no money was added to the SGR budget to accommodate the resulting increases in spending. The SGR provision of the MMA increased Medicare physician pay for 2004 alone by 6% (a 1.5% pay increase instead of a 4.5% pay cut), but no funds were added to the SGR budget for that provision. As a result, the SGR deficit ballooned, reaching \$41 billion through 2006, or more than half of the \$81.3 billion SGR budget for that year.

CMS announced a 5% CF cut for 2007 in its Final Rule for the 2007 physician payment schedule. This was the first of many predicted by CMS actuaries at that time. Medicare physician pay cuts of roughly 5% per year were projected out to at least 2015. The cuts were spread out due to the -7% limit on the performance adjustment.

These cuts were, in part, a consequence of not increasing the SGR budget to accommodate the 2004–2006 pay fixes. This approach kept the net federal cost of these provisions to a minimum. Given enough time, the SGR system will reclaim any unfunded increase in spending with future pay cuts. Funding the SGR pay fixes for 2004–2006 would have been expensive. In 2005, the Congressional Budget Office estimated that retroactively funding the 2004 and 2005 fixes would have cost \$46 billion over 10 years. However, while less expensive in the short term, this approach of borrowing from future SGR budgets to fund current pay fixes greatly inflated the cost of subsequent attempts to block SGR cuts.

### Temporary Fixes 2007–2015

Just prior to adjourning in December 2006, the 109th Congress passed HR 6111, which again included a stop gap measure to prevent the scheduled 5% CF cut for 2007. The bill again set the Medicare CF update at 0.0% for 2007, which froze the CF at the 2005 value of \$37.8975. Cost was a major factor in the design of this provision, which differed in two important ways from the MMA and DRA update provisions.

First, unlike MMA and DRA, the Tax Relief and Health Care Act (TRHCA) of 2006 allowed funds to be added to the SGR budget for 2007 to accommodate the extra spending that occurred with a CF freeze instead of a 5% cut. According to the Congressional Budget Office, this would have increased net federal spending on Medicare by \$11 billion over five years and \$27 billion over 10, if not for the second unique feature of the TRHCA. Under the bill, the 2008 Medicare CF update was to start from the 2007 CF that would have been in place if not for the bill. That is, the 2008 CF update was to include both the 5% cut that would have occurred in 2007 and the 5.3% SGR cut for 2008, resulting in an actual CF cut for 2008 of 10.1%. This reduced the federal cost of this provision to roughly \$3 billion over 10 years and did not increase the SGR deficit but, of course, greatly raised the stakes on fixing the 2008 CF update.

The 10.1% cut scheduled for January 1, 2008, was again postponed by a provision in the Medicare, Medicaid, and SCHIP Extension Act of 2007. This bill, passed in -December 2007, replaced the cut with a 0.5% increase in the CF for the first six months of 2008. However, the temporary nature of the fix would have resulted in a 10.6% cut on July 1, 2008, without further action. Congress did act, though, in July of 2008 to retroactively block the 10.6% cut and to further set the 2009 update at 1.1% with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. The cuts were only postponed to 2010, though. Like the previous two fixes, the MIPPA rolled the cuts that would have occurred together in the subsequent update. Combining now four years of cuts (2007–2010), the January 1, 2010, SGR cut would have been 21.2%. Moreover, the Medicare actuaries projected additional cuts for 2011 through 2014 that would have put 2014 Medicare physician pay a further 20% below the 2010 level. Table 10-3 provides a summary of the SGR cuts that have been scheduled since 2002.

**Table 10-3. Dealing with SGR Cuts Since 2002**

Date of Cut	Scheduled Cut	Replaced with	Legislation
Jan 1, 2002	5.4%		Not blocked
Mar 1, 2003	4.4%	1.6%	Consolidated Appropriations Resolution
Jan 1, 2004	4.5%	1.5%	Medicare Prescription Drug, Improvement, and Modernization Act (also set 2005 update of 1.5%)
Jan 1, 2006	4.4%	0.0%	Deficit Reduction Act
Jan 1, 2007	5.0%	0.0%	Tax Relief and Health Care Act
Jan 1, 2008	10.1%	0.5%	Medicare, Medicaid, and SCHIP Extension Act
Jul 1, 2008	10.6%	0.0%	Medicare Improvements for Patients and Providers Act (also set 2009 update of 1.1%)
Jan 1, 2010	21.2%	0.0%	Department of Defense Appropriations Act
Mar 1, 2010	21.2%	0.0%	Temporary Extension Act
Apr 1, 2010	21.2%	0.0%	Continuing Extension Act
Jun 1, 2010	21.2%	2.2%	Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act
Dec 1, 2010	23.0%	0.0%	Physician Payment and Therapy Relief Act

Jan 1, 2011	24.9%	0.0%	Medicare and Medicaid Extenders Act
Jan 1, 2012	27.4%	0.0%	Temporary Payroll Tax Cut Continuation Act of 2011
Mar 1, 2012	27.4%	0.0%	Middle Class Tax Relief and Job Creation Act of 2012
Jan 1, 2013	26.5%	0.0%	American Taxpayer Relief Act of 2012
Jan 1, 2014	23.7%	0.5%	Pathway for SGR Reform Act of 2013
Apr 1, 2014	24.1%	0.0%	Protecting Access to Medicare Act of 2014
Jul 1, 2015	21.2%	0.5%	Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

With cuts of this magnitude, the cost of SGR reform grew to substantial proportions. In April 2010, the Congressional Budget Office (CBO) estimated that to keep Medicare physician pay in line with medical-practice inflation would cost more than \$330 billion over 10 years. CMS provided some relief in 2010 by proposing to remove drugs from their definition of allowed and actual SGR spending. CMS further decided to make this change effective for all years since the inception of SGR. Drugs accounted for about 4% of SGR allowed spending for any given year but accounted for as much as 10% of actual spending. As a result, this change greatly reduced the gap between target and actual spending in the SGR system. Before this change, the cumulative SGR deficit through 2009 was \$72 billion, or more than 75% of allowed spending for 2009. With drugs removed, the cumulative SGR deficit through 2009 was \$19 billion. This change fell short of affecting the huge cut for 2010 but reduced both the magnitude of SGR cuts under current law after 2010, and the cost of SGR reform.

The 21.2% cut for 2010 was blocked by months at a time. First, the Department of Defense Appropriations Act, the Temporary Extension Act, and the Continuing Extension Act froze pay at the 2009 level through May 31. Then, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act increased pay by 2.2% for June through November. Physicians were then facing a 23% cut December 1, 2010. This was blocked for one month by the Physician Payment and Therapy Relief Act of 2010, and physicians were facing a 25% cut on January 1, 2011 (the combination of the 23% that was postponed from December 1, and a further 2.5% cut scheduled for January 1, 2011). This in turn was blocked by the Medicare and Medicaid Extenders Act of 2010, with the provision extending for the whole of 2011. Like the others, this bill only postponed the cut until January 1, 2012.

On December 23, 2011, President Obama signed the Temporary Payroll Tax Cut Continuation Act of 2011 into law, which in part provided for an additional two-month reprieve from the CF cut, expiring after February 29, 2012. The cut was further postponed by the Middle Class Tax Relief and Job Creation Act of 2012, which provided a 0% update through December 31, 2012. A 26.5% cut would have taken effect on January 1, 2013. This cut was postponed for another year under the American Taxpayer Relief Act, which was signed into law just after this cut was scheduled to take effect. This once again set the update for 2013 at 0%.

In 2013, some positive news in the effort to do away with the SGR presented themselves. In response to the exceptionally low rates of growth in Medicare physician spending in recent years, the CBO cut its cost estimate for replacing SGR. The 10-year cost of replacing SGR updates with annual pay freezes, which stood at nearly \$300 billion in 2011, fell from \$244 billion in November 2012 to \$117 billion as of December 2013 (it has since edged up somewhat). In 2013, both the Senate Finance and House Ways and Means committees overwhelmingly approved SGR repeal legislation. This repeal effort fell short, however, and a 3-month patch was implemented with the Pathway for SGR Reform Act of 2013, which included a 0.5% update.

Providers faced a 24.1% cut on April 1, 2014, but this was blocked for a year with another temporary fix in the Protecting Access to Medicare Act of 2014. In 2015, MACRA permanently eliminated the SGR and replaced it with fixed updates of 0.5%, which started on July 1, 2015, lasting through 2019.