APPENDIX A

Review of CMS's preliminary estimate of the physician update for 2008

APPENDIX A

Review of CMS's preliminary estimate of the physician update for 2008

CMS's preliminary estimate of the 2008 payment update for physician services is –5.1 percent (Gustafson 2007). However, when combined with the effect of the Tax Relief and Health Care Act of 2006 (TRHCA), CMS estimates the net change to the conversion factor from 2007 to 2008 to be –9.9 percent. Due to continued growth in expenditures on physician services and increased spending associated with legislative overrides to avert payment cuts for physician services, the sustainable growth rate (SGR) formula has called for negative updates since 2002. In communicating its estimate to MedPAC, CMS states that it is embarking on several initiatives to improve the quality and efficiency of physician services delivered to Medicare beneficiaries.

In a recent report to the Congress, the Commission stated that slowing the increase in Medicare outlays is becoming urgent (MedPAC 2007a). Medicare's rising costs, particularly when coupled with the projected growth in the number of beneficiaries, threaten to place a significant burden on taxpayers. Rapid growth in expenditures also directly affects beneficiary liability for out-of-pocket costs through higher Part B and supplemental insurance premiums.

The Commission's report also discussed several flaws associated with using the SGR formula. For example, it neither rewards physicians who restrain volume growth nor penalizes those who prescribe unnecessary services. Ideally, Medicare's physician payment system should include incentives for physicians to provide better quality of care, to coordinate care (across settings and medical conditions), and to use resources judiciously. As mandated by the Congress, the Commission examined alternative approaches to the SGR system in our report, many of which included frameworks with expenditure targets. Although some disagreement exists within the Commission about the utility of expenditure targets, the Commission is united in its belief that a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity. Examples of such reforms include pay-for-performance programs for quality, improving payment accuracy, and bundling payments to reduce overutilization.

This appendix fulfills the Commission's requirement to review CMS's estimate of the 2008 update for physician services. In reviewing the technical details involved in estimating the update under current law (in accordance with the SGR formula), we find that CMS used estimates in calculating the update that are consistent with recent trends.[1] Moreover, the Commission anticipates that no alteration in the factors of CMS's estimates would be large enough to eliminate the application of the statutory limit the SGR formula imposes. MedPAC concurs with CMS that Medicare should be initiating strategies to improve the quality and efficiency of services delivered to Medicare beneficiaries.

TABLE A–1 **Preliminary estimate of the sustainable growth rate, 2008**

Factor	Percent
2008 change in:	
Input costs for physician services*	2.0%
Real GDP per capita	1.9
Fee-for-service enrollment	–0.2
Change due to law or regulation	–1.5
Sustainable growth rate	2.2

Note: GDP (gross domestic product). Percents are converted to ratios and multiplied, not added, to produce the update. Estimates shown are preliminary.
*Input costs are adjusted for productivity and include inflation measures for services performed by a physician or in a physician's office.

Source: Gustafson 2007.

For further details on how Medicare pays for physician services, see MedPAC's Payment Basics publications, available on our website.[2]

How TRHCA affects 2007 and 2008 updates for physician services

TRHCA includes several provisions that affect physician payments in 2007 and 2008. To avert a cut in the conversion factor, it provided for a temporary one-year bonus in the fee schedule conversion factor for 2007. This increase offset the 5 percent decrease in the conversion factor required by the SGR formula. Consequently, the conversion factor for 2007 was kept at the same level as for 2006.

TRHCA also requires that the 2008 conversion factor be calculated as if the 2007 one-year bonus had never applied. Thus, estimations for the 2008 conversion factor first assume a 5 percent cut to the 2007 conversion factor and then apply the statutorily required cut (5.1 percent) in 2008, per the SGR formula. While the implementation of the one-time conversion-factor bonus will increase both actual and expected expenditures for 2007, its expiration will decrease both actual and expected expenditures for 2008.

Another provision in TRHCA allows physicians to be eligible to receive a 1.5 percent bonus on all covered services they furnished to Medicare beneficiaries between July 1 and December 31, 2007, provided they submit to CMS data on an adequate number of approved quality measures. CMS will pay this quality reporting bonus to physicians as a lump sum in 2008.

TRHCA also established a $1.35 billion fund to be used toward physician payments at the Secretary's discretion in 2008. Although the law explicitly allows the Secretary to direct the fund toward the 2008 conversion factor update, the Secretary has not yet allocated this fund. Thus, CMS's estimate of the 2008 conversion factor does not account for this fund. Even if the fund were used entirely to update the 2008 conversion factor, a legislative change would still be needed to avert a cut in 2008, because the amount needed to avert a cut exceeds $1.35 billion. CMS plans to implement this provision through the rulemaking process during the summer.

Also, TRHCA extended through 2007 the work geographic practice cost index (GPCI) floor. The floor was imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and was originally

TABLE A–2 **Update and conversion factor changes for physician services**

Updates and update factors	Percent
***Excluding* TRHCA conversion factor bonus for 2007**	
2007 update per SGR formula	–5.0%
2008 update factors per SGR formula:	
Change in MEI	2.0
Change in update adjustment factor	–7.0
2008 update per SGR formula	**–5.1**
***Including* TRHCA conversion factor bonus for 2007**	
2007 update	0.0
2008 update	**–9.9**

Note: TRHCA (Tax Relief and Health Care Act of 2006), SGR (sustainable growth rate), MEI (Medicare Economic Index). Percents are converted to ratios and multiplied, not added, to produce the update. The MEI—an estimate of the change in input prices (inflation) for physician services—includes a productivity adjustment. Estimates shown are preliminary.

Source: Gustafson 2007.

slated to expire on December 31, 2006, but TRHCA extended it to December 31, 2007.

Together, these four provisions in the TRHCA—the conversion factor bonus, the quality reporting bonus, the physician fund, and the GPCI floor extension—account for $5 billion, which will be directed toward physician payments over the coming years. These spending increases will be financed through Medicare's Supplementary Medical Insurance program, which is funded through general revenues (75 percent) and beneficiary premiums (25 percent).

Calculating the update

Calculating the physician update is a two-step process. CMS first estimates the target growth rate—the sustainable growth rate (SGR)—then computes the update. For the first step, the SGR is the target growth rate in spending for physician fees and is a function of projected changes in:

- productivity-adjusted input prices for physician fees—an allowance for inflation,[3]
- real gross domestic product (GDP) per capita—an allowance for growth in the volume of services,[4]
- enrollment in fee-for-service (FFS) Medicare—an allowance for fluctuations in the number of FFS beneficiaries, and
- spending attributable to changes in law and regulation—an allowance for policy changes that affect spending on physician services.

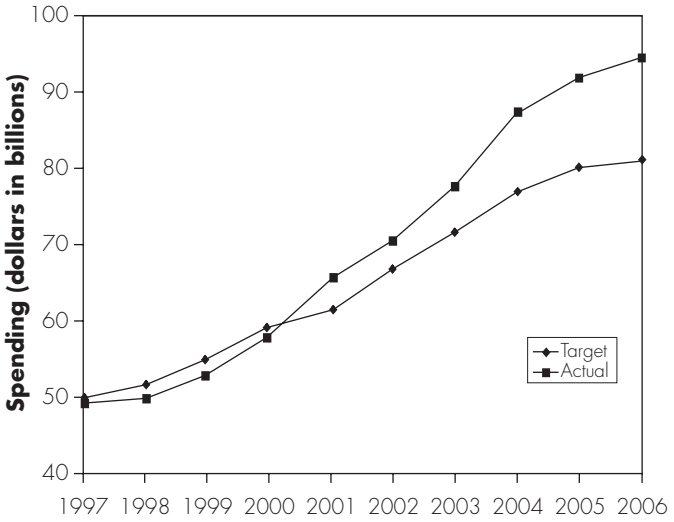
Allowing for these four factors, CMS's preliminary estimate of the SGR is 2.2 percent for 2008 (Table A-1).

For the second step, CMS calculates the update, which is a function of:[5]

- the change in productivity-adjusted input prices for physician services, as measured by the Medicare Economic Index (MEI); and
- an update adjustment factor (UAF) that increases or decreases the update as needed to align actual spending, cumulated over time, with target spending determined by the SGR.

FIGURE A–1

Beginning in 2001, actual spending for physician services has exceeded target



Note: Estimates for 2006 are preliminary.

Source: Office of the Actuary 2007 and Gustafson 2007.

The estimate of the change in input prices for use in the 2008 update is 2.0 percent (Table A-2).[6] The part of the update calculation that has the bigger effect, however, is the UAF, which CMS estimates at –7.0 percent—the maximum negative adjustment permitted under current law. When we combine this adjustment with the estimated change in input prices, the result is an update of −5.1 percent. (Note that this calculation of the estimate converts percentages to ratios, which are multiplied rather than being the sum of the two components of the adjustment.)

The UAF is negative because actual spending for physician services started to exceed the target in 2001 (Figure A-1). Since then, spending has remained above the target. In addition, overrides of the formula (in which the Congress has changed the law to prevent negative updates) have kept payment rates above the level necessary to align actual spending and the target. Indeed, the overrides in the MMA and the Deficit Reduction Act of 2005 (DRA) added to the cumulative growth in physician spending without increases in allowed (or target) spending calculated under the SGR. In total, the estimated cumulative difference in allowed spending versus actual spending results in a UAF that would be −27.7 percent, if not for the –7.0 percent limit.

Reviewing CMS's estimate

CMS's update estimate (–5.1 percent) is unlikely to change by a substantial amount because an update adjustment factor of −27.7 percent is well beyond the statutory limit (–7.0 percent). Thus, the Commission anticipates that no alteration in the factors of CMS's estimates would be large enough to bring the UAF within the limit. Even so, we review the factors that CMS considers in its update estimate for the 2008 SGR.

Changes that affect the target growth rate

As mentioned earlier, CMS's estimate is a function of projected changes in four factors: change in physician input costs, change in beneficiary enrollment, change in real GDP per capita, and change due to law or regulation (Table A-1, p. 252). If, for example, the MEI increases, then the SGR formula would allow for a proportional increase in payments to account for growth in input costs. If, on the other hand, the MEI decreases, then the SGR formula would require a proportional decrease in payments to account for declining input costs.

For the SGR, CMS's estimate of the change in input prices, as measured by the MEI, is within the range of changes in the MEI for the last 15 years—though it is at the low end of the range.[7] The MEI includes an adjustment for productivity. In fact, the recent decline in the MEI is due to recent growth in multifactor productivity (MFP) as estimated by the Bureau of Labor Statistics. Indeed, the two most recent years' MFP rates were among the highest in recent history; as a result, the 10-year moving average of the MFP increased.[8] Consequently, the MEI for 2008 is lower than in previous years because it is reduced by the MFP.[9]

The change in real GDP per capita of 1.9 percent is the 10-year moving average of real GDP estimates from the Bureau of Economic Analysis. These estimates are adjusted for population growth (BEA 2007).

The change in FFS enrollment is a little less certain. CMS assumes a decrease of 0.2 percent. This figure differs by 1 percentage point from the Congressional Budget Office's (CBO's) enrollment projection, which is a decrease in FFS enrollment of 1.2 percent for fiscal year 2008 (CBO 2007). Because CMS and CBO project similar total Medicare enrollment, differences are likely due to difficulties projecting shifts in enrollment from Medicare FFS to Medicare Advantage (MA). (CBO forecasts an increase in MA enrollment of 14 percent in 2008.) CMS may be better able to project any such shift when MA plans submit bids and identify market areas in June 2007. CMS can then revise the enrollment projection, if necessary, before the update becomes final in November 2007. Even then, CMS will have limited information on changes in enrollment in 2008, but the agency will have another two years to revise the enrollment estimate if better data become available, just as the agency does with changes in spending due to law and regulation.

CMS's estimate also allows for anticipated changes in payments due to law and regulation. For example, a change in current law that might increase total payments, such as benefit expansion under Part B, would allow CMS to estimate a proportional increase (positive impact) to the SGR. In contrast, a law change that requires a payment decrease, such as the expiration of a payment bonus, would call for a proportional decrease (negative impact) in CMS's estimate of the SGR.

Although some of the statutory and regulatory changes will, in fact, increase physician spending, CMS expects changes in law and regulation to net a –1.5 percent impact on spending in 2008.[10] Among the three provisions with negative spending effects, two are linked to TRHCA provisions discussed earlier. The provision with the largest negative impact on the SGR stems from the TRHCA conversion factor bonus. Because this bonus applies only to 2007, fee schedule rates will experience a relative decrease in 2008 to account for the absence of the bonus in 2008.[11] A second TRHCA provision that will have a negative impact on the 2008 SGR is the extension of the floor on the work GPCI through 2007. Accordingly, 2008 payment rates will fall in some geographic areas when the floor on the work GPCI expires at the end of 2007.

An MMA provision—the physician scarcity bonus—is also set to expire at the end of 2007. Under this provision, services provided by physicians in scarcity areas—determined separately for primary care physicians and specialists—received a 5 percent bonus in Medicare payments from 2005 through 2007. Thus, CMS's estimate of the 2008 update accounts for a reduction in some physician payments with the elimination of this bonus.

Despite an overall negative impact on the 2008 SGR due to law and regulation, CMS projects that three provisions will have a positive impact on spending. First, in compliance with TRHCA, $1.35 billion will be allocated

toward physician payment in 2008 from an established fund. Although the exact nature of the distribution is not yet known, the statute requires that the fund be directed toward physician payment in 2008. Second, the quality reporting bonus instituted by TRHCA will be paid to eligible providers in 2008 and therefore will increase 2008 total spending.

Finally, CMS expects a positive spending impact on the SGR due to the interaction of the DRA and the reduction in fee-schedule rates. In accordance with the DRA, for certain imaging services, Medicare pays the lesser of hospital outpatient department rates and physician fee schedule rates. Because hospital outpatient prospective payment system (OPPS) services will receive a positive update in 2008, while fee-schedule services will receive a negative update, CMS estimates total spending increases for fee-schedule services as the OPPS and fee-schedule rates come closer together. That is, for certain imaging services, the ceiling for fee-schedule payments will increase consistent with the OPPS update. (Note that, for the 2007 SGR estimate, CMS projected initial savings from the DRA legislation from those items that moved to the OPPS payment level.)

Comparison of target spending with actual spending

The remaining issue concerns CMS's estimates of actual spending for 2006 and 2007. In previous years, CMS provided MedPAC with helpful, preliminary type-of-service volume analyses for the current year with its update estimates. This year, however, CMS did not include such analyses and indicated that it was waiting for more complete spending figures. Therefore, CMS's estimate of actual spending (particularly for 2007) may increase or decrease somewhat before CMS issues a final rule on the update in November 2007.

Summary

Regardless of what happens with the various estimates that determine the physician update, it is quite unlikely that any change will overcome an update adjustment factor of −27.7 percent. For this reason, we anticipate that CMS will revise the update calculations this fall, in preparation for implementing the 2008 update on January 1, and that, barring any overriding statutory provisions, the calculations will show the maximum reduction that the statute permits: the change in productivity-adjusted input prices (as measured by the MEI) minus 7.0 percentage points. ■

Endnotes

1 Note that our purpose in reviewing CMS's estimate is not to assess the adequacy of the update, but rather to evaluate the technical details involved in estimating the update under current law. For further information on the Commission's analysis of payment adequacy for physician services, see our March 2007 report (MedPAC 2007b).

2 http://www.medpac.gov.

3 For calculating the SGR, physician fees include services commonly performed by a physician or in a physician's office. In addition to physician fee schedule services, these fees include diagnostic laboratory tests and most of the drugs covered under Medicare Part B.

4 As required by the MMA, the real GDP per capita factor in the SGR is a 10-year moving average.

5 For the update, physician services include only those services in the physician fee schedule.

6 In MedPAC's earlier update recommendation for physician services, the Commission used an MEI of 1.7 percent, which differed from this 2.0 percent estimate primarily because it was based on a forecast for the fourth quarter of 2008 (MedPAC 2007c). For the physician service update, CMS is statutorily required to use the MEI for the most recent historical quarter for which it has data.

7 Since 1992, the MEI has ranged from 2.0 percent to 3.2 percent.

8 The Bureau of Labor Statistics recently reclassified some industries in its calculations.

9 For MedPAC's physician service payment adequacy analysis, CMS provides us with forecasted input price changes that are not adjusted for productivity. We then adjust (reduce) these figures for productivity separately (MedPAC 2007c).

10 In earlier years, this component of the SGR has been positive to account for spending increases that occur when legislation expands benefits under Medicare Part B.

11 Conversion factor overrides in previous legislation (i.e., MMA and DRA) explicitly did not require a change in law and regulation for purposes of the SGR calculation. In contrast, the conversion factor bonus in TRHCA allows a change in law and regulation to be a factor in CMS's update calculation.

References

Bureau of Economic Analysis, Department of Commerce. 2007. *Current-dollar and "real" GDP.* Washington, DC: BEA. February 28. http://www.bea.gov/national/gdplev.xls.

Congressional Budget Office. 2007. *CBO estimate of Medicare proposals in the President's budget for fiscal year 2008.* Washington, DC: CBO.

Gustafson, T. A., Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2007. Letter to Glenn M. Hackbarth, Medicare Payment Advisory Commission. February 28. http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/medpacfinal.pdf

Medicare Payment Advisory Commission. 2007a. *Assessing alternatives to the sustainable growth rate system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2007b. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2007c. *Report to the Congress: Assessing payment adequacy and updating payments in fee-for-service Medicare.* Washington, DC: MedPAC.

Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2007. *Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2008.* Baltimore, MD: CMS. http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2008p.pdf.