APPENDIX A

Review of CMS's preliminary estimate of the 2013 update for physician and other professional services

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In CMS's annual letter to the Commission on the update for physician and other professional services, the agency's preliminary estimate of the 2013 update is –27.0 percent (Blum 2012). The prescribed reduction is due to a series of temporary increases enacted over several years that—under current law—expire at the end of 2012. Those increases prevented a series of negative updates under the sustainable growth rate (SGR) formula—the statutory formula for annually updating Medicare's payment rates for physician and other health professional services. If the temporary increases expire, the physician fee schedule's conversion factor must decrease by 27.5 percent. The result of this reduction and the 2013 update would be the SGR formula's update—specific to 2013—of 0.7 percent. This increase would be applied to the conversion factor after it had been reduced by 27.5 percent.[1]

This appendix provides the Commission's mandated technical review of CMS's estimate. We find that CMS's calculations are correct and that—absent a change in law—the expiration of the temporary increases and the formula's update for 2013 are very unlikely to produce an update that differs substantially from –27.0 percent. The temporary increases—by far, the largest factor influencing the payment reduction—were specified in law. The estimate of the SGR formula update of 0.7 percent for 2013 could change between now and when CMS would implement the update in January, but any such changes are likely to be small compared with the total reduction prescribed by law.

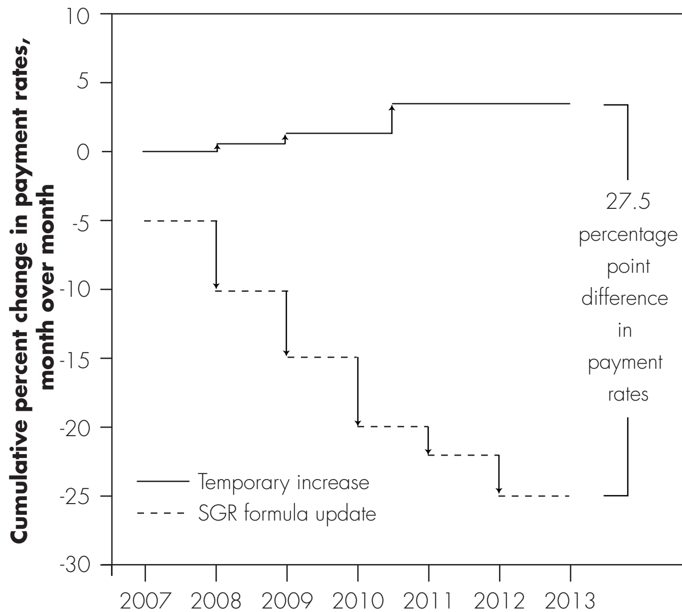
While this appendix is limited to technical issues, the Commission has concerns about the SGR formula as a payment policy. The SGR formula may have resulted in lower updates, but it has failed to restrain volume growth; in fact, for some specialties it may have exacerbated volume growth. In addition, the temporary increases, or "fixes," to override the SGR formula are undermining the credibility of Medicare by engendering uncertainty and frustration among providers, which may be causing anxiety among beneficiaries. In an October 2011 letter to the Congress, the Commission recommended repealing the SGR formula and replacing it with specified updates that would no longer be based on an expenditure-control formula (Medicare Payment Advisory Commission 2011). These updates would include a 10-year freeze in current payment levels for primary care where potential access problems are most readily apparent and, for all other services, annual payment reductions of 5.9 percent for three years, followed by a freeze for the remainder of the 10-year window.

How temporary increases and other legislative provisions have affected payments for physician and other professional services

The SGR formula is intended to limit growth in Medicare spending for physician and other professional services. If actual aggregate spending—accumulated since 1996—

FIGURE A–1

Temporary increases prevented the SGR formula's negative updates



Note: Note: SGR (sustainable growth rate). The 27.5 percentage point difference is the ratio of the cumulative SGR formula updates to the cumulative temporary bonuses (0.753/1.038 = 0.725 or –27.5 percent).

Source: Blum 2012 and Office of the Actuary 2011.

exceeds the specified target spending accumulated in the same time period, the formula calls for a downward adjustment in the physician fee schedule's conversion factor.

From 2001 to 2009, spending exceeded the target, and updates calculated with the formula would have been negative. However, except for the negative update implemented in 2002, the Congress has passed specific legislation overriding the negative updates called for by the SGR formula.

Initially, the legislative overrides prescribed a positive update for a given year—resulting in higher spending—but did not allow the corresponding spending target to rise. The result was a growing gap between spending and the target. The formula could have recouped the difference, but the process would have required many years of negative updates. In response, the Congress instituted a new method of specifying the legislated updates. Starting with the update for 2007, legislation prescribed temporary increases. When the increases expire, updates are calculated—with the formula—as if the increases had never been applied.

From 2007 through 2012, the temporary increases totaled a cumulative increase in payment rates of 3.8 percent (Figure A-1).[2] Meanwhile, the accumulated updates—called for by the formula but legislatively overridden—totaled –24.7 percent. The result is a 27.5 percent reduction in payment rates required when the temporary increases expire.

In addition to the temporary increases, recent legislation has made further changes—some raising payments and some lowering payments—for services furnished by physicians and other health professionals.

- Starting in 2011 and ending in 2016, primary care practitioners who meet certain criteria receive a 10 percent increase in payments for selected fee schedule services, as will general surgeons practicing in health professional shortage areas.
- Through 2012, there is a floor on the fee schedule's geographic practice cost index (GPCI) for the work of physicians and other health professionals. This GPCI adjusts payments up or down to account for differences in the earnings of professionals among each of 89 payment localities. The floor prevents GPCI adjustments that are less than 1.0.
- Under the Physician Quality Reporting System (PQRS), qualifying physicians and other health professionals received a 1 percent bonus on all Medicare payments received in 2011 and will receive a 0.5 percent bonus in 2012 through 2014. Starting in 2015, those who do not satisfactorily report PQRS measures will be subject to a financial penalty starting at 1.5 percent of their Medicare payments.
- The electronic health record (EHR) incentive program provides payments to physicians when they adopt EHRs and demonstrate their use in specified ways to improve quality, safety, and effectiveness of care. Physicians may receive up to $44,000 over five years, starting with $18,000 in 2011. EHR bonuses for physicians in health professional shortage areas are 10 percent higher. Starting in 2015, eligible physicians who do not satisfy the EHR criteria will be subject to a financial penalty starting at 1 percent of their Medicare payments.
- Prescribing physicians and health professionals who do not participate in the EHR incentive program are eligible for an electronic prescribing (eRx) bonus of 1 percent on all their Medicare services if they use a

qualified eRx system. This program began in 2009. Starting in 2012, eligible professionals who have not yet satisfied the eRx criteria and cannot demonstrate "hardship" exemptions will be subject to a financial penalty starting at 1 percent of their Medicare payments.

How CMS estimated the SGR formula's update for 2013

Calculating the update for practitioner services is a two-step process. CMS first estimates the SGR—the target growth rate for spending on these services—for the coming year. The agency then computes the update using that SGR and historic information on actual and target spending.

SGR for 2013

The SGR is a function of projected changes in:

- input prices for practitioner services—an allowance for inflation,[3]
- real gross domestic product (GDP) per capita—an allowance for growth in the volume and intensity 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 practitioner services.

Allowing for these four factors, CMS's preliminary estimate of the SGR for 2013 is –18.9 percent (Table A-1).

Measured by the Medicare Economic Index (MEI), CMS's estimate of the change in input prices of 0.5 percent is within the range during the past decade—though it is at the low end of the range.[5] In light of economic conditions, the agency projects relatively modest increases in practitioner compensation, staff earnings, rent, and the prices of other inputs.

The next factor in the 2013 SGR—growth in real GDP per capita—is a 10-year moving average. It includes a 10-year moving average of economic growth based on estimates from the Department of Commerce—for 2004 through 2011—and projections from the President's budget—for 2012 and 2013. This growth rate is just 0.3 percentage point more than the rate we calculate when we use Congressional Budget Office (CBO) projections for 2012 and 2013 instead of projections from the President's budget (Congressional Budget Office 2012a).

Changes in FFS enrollment are determined by the number of new Medicare beneficiaries who enroll in FFS, by the number of decedents, and by the number of current beneficiaries who choose to either leave FFS and enroll in Medicare Advantage (MA) or leave MA and enroll in FFS. For the 2013 SGR, CMS projects a net increase in FFS enrollment of 5.1 percent. This percentage is higher than the projected increase in the number of new Part B beneficiaries and includes a shift in enrollment from MA to FFS. CMS anticipates that MA enrollment will decline in 2013 as payments to MA plans are reduced. However, CBO is not projecting such a decline (Congressional Budget Office 2012b).

The remaining factor in the 2013 SGR is a –23.8 percent change in spending due to law and regulation. For this factor, expiration of the temporary increases would be the primary source of the spending decrease. Other decreases in spending due to law and regulation—such as expiration of the floor on the work GPCI, the start of automatic reductions (or a "sequester") under the Budget Control Act of 2011, and a reduction in laboratory fee schedule payments—would be relatively small compared with

TABLE A–1 Preliminary estimate of the sustainable growth rate, 2013

Factor	Percent
2013 change in:	
Input prices*	0.5%
Real GDP per capita	0.7
Fee-for-service enrollment	5.1
Change due to law or regulation	–23.8
Sustainable growth rate	–18.9

Note: GDP (gross domestic product). Percentages are converted to ratios and multiplied, not added, to produce the sustainable growth rate. Estimates shown are preliminary.
*The change in input prices includes inflation measures for services furnished by a physician or other health professional or furnished in the office of a physician or other health professional. As defined for the sustainable growth rate, those services include services billable under the physician fee schedule and laboratory services.

Source: Blum 2012.

TABLE A–2

Preliminary estimate of the SGR formula's update specific to 2013

Factor	Percent
Change in MEI*	0.6%
Update adjustment factor	0.1
Update	0.7

Note: SGR (sustainable growth rate), MEI (Medicare Economic Index). Percentages are converted to ratios and multiplied, not added, to produce the update. Estimates shown are preliminary.
*For the SGR formula update, physician services include only those services billable under the physician fee schedule.

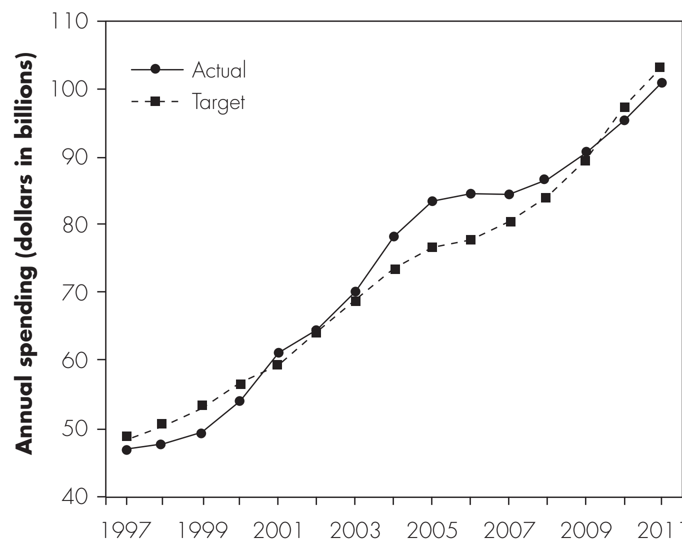
Source: Blum 2012.

expiration of the temporary increases. EHR bonuses would have a small positive effect on spending.

Why is the change in spending due to law and regulation a smaller reduction than the 27.5 percent reduction in payments that would occur when the temporary increases expire? The most important reason for the difference is that the law and regulation factor in the SGR is not an estimate of a change in payment rates; it is an estimate of a change in spending. A change in payment rates would not necessarily equal a change in spending if the change in payment rates were accompanied by a change in the volume of services. Indeed, when projecting a decrease in payment rates, CMS offsets the decrease by almost a third to account for a volume increase, consistent with the agency's research (Codespote et al. 1998).[6]

FIGURE A–2

From 2001 to 2009, actual spending exceeded the target



Note: Estimates are preliminary. Data for 1997 and 1998 are for the last three quarters of each of those years and the first quarter of the following year.

Source: Centers for Medicare & Medicaid Services 2011.

Calculating the SGR formula's update specific to 2013

After estimating the SGR, CMS calculates the SGR formula's annual update specific to the given year. It is a function of:

- the change in productivity-adjusted input prices for physician and other professional services, as measured by the MEI;[7] 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.

The estimate of the change in input prices for use in the 2013 update is 0.6 percent (Table A-2). This factor could change by November 2012 when CMS finalizes the update for 2013. By then, the MEI could be somewhat higher or lower than 0.6 percent as further data become available on changes in input prices for physician and other professional services.

For 2012, CMS estimates a UAF of 0.1 percent. This adjustment and the estimated change in input prices result in an update estimate of 0.7 percent. The UAF is positive even though actual spending—cumulated since the SGR was instituted—exceeds target spending (Figure A-2).[8] CMS's current estimate is that the excess is about $8.7 billion (Blum 2012). The reason for the seeming contradiction is that the formula for calculating the UAF does not account for all differences between actual spending and the target equally. Instead, it assigns more weight to the most recent difference—estimated for 2012—than to the historic difference since baseline (Office of the Actuary 2011). This differential weighting of recent and historic experience results in a small positive UAF for the 2013 update.

Like the MEI, the UAF could change by November. The UAF is partly a function of actual spending for physician and other professional services. When calculating the preliminary estimate of the 2013 update, CMS had data on actual spending that were nearly complete for the first

three quarters of 2011 but less so for the last quarter of that year. As more data become available, the estimate of actual spending in 2011 may change somewhat before CMS issues a final rule on the update in November. The estimate of actual spending for 2012 could also change. Nonetheless, changes in the UAF are not likely to have a large impact on the update calculations. For instance, if spending in 2012 were 1 percent higher than CMS projects, the update adjustment for 2013 would be –0.2 percent instead of 0.1 percent. In turn, the SGR formula's update specific to 2013 would go from 0.7 percent to 0.4 percent. However, such changes do not appear large when we remember that the formula's 2013 update would be applied after the conversion factor had been reduced by a prescribed 27.5 percent. ■

Endnotes

1 For the update calculations discussed in this appendix, percentages are not added. Instead, they are converted to ratios and multiplied. For instance, the decrease in payment rates of 27.0 percent is the arithmetic product of the 2013 update (0.7 percent, or 1.007) and the expiration of the temporary increases (–27.5 percent, or 0.725). The multiplication is $1.007 \times 0.725 = 0.730$, or –27.0 percent.

2 For 2007, the Tax Relief and Health Care Act of 2006 maintained payment rates at 2006 levels. For the first six months of 2008, the Medicare, Medicaid, and SCHIP Extension Act of 2007 raised payment rates by 0.5 percent. For the second six months of 2008, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) maintained payment rates at the levels for the first six months of that year. For 2009, MIPPA raised payment rates by 1.1 percent. For January and February of 2010, the Department of Defense Appropriations Act of 2010 maintained payment rates at their 2009 levels. For March 2010, the Temporary Extension Act of 2010 maintained payment rates at the levels for the first two months of the year. For April and May of 2010, the Continuing Extension Act maintained payment rates at the levels for the first three months of the year. For June through November of 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 raised payment rates by 2.2 percent. For December 2010, the Physician Payment and Therapy Relief Act of 2010 maintained payment rates at the levels for June through November of 2010. For all of 2011, the Medicare and Medicaid Extenders Act of 2010 maintained payment rates at the levels for June through December of 2010. For January and February of 2012, the Temporary Payroll Tax Cut Continuation Act of 2011 maintained payment rates at the 2011 level. The Middle Class Tax Relief and Job Creation Act of 2012 continued the payment freeze through the remainder of 2012.

3 For calculating the SGR, practitioner services are services commonly performed by a physician or in a physician's office. In addition to services in the physician fee schedule, these services include diagnostic laboratory tests.

4 As required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the real GDP per capita factor in the SGR is a 10-year moving average.

5 Since 2003, the MEI has ranged from 0.4 percent to 3.1 percent.

6 The maximum volume offset is 4.5 percent (a 30 percent offset of a payment reduction of up to 15 percent). The 15 percent limit was established because that was the largest reduction seen in CMS's volume offset study.

7 For the update, the services of physicians and other health professionals include only those services billable under the physician fee schedule.

8 Starting with the update for 2010, CMS removed physician-administered drugs from the SGR definition of services subject to the SGR. This change narrowed the gap between actual spending and the target.

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