APPENDIX A

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In CMS's annual letter to the Commission on the payment update for physician services, the agency's preliminary estimate of the 2009 update is –5.4 percent (Rich 2008). A negative update in 2009 would be in addition to a 10.6 percent decrease to occur on July 1, 2008, at the end of a temporary six-month bonus that was included in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA).

These reductions are required under the sustainable growth rate (SGR) formula, which is defined in statute as the policy for updating Medicare's payment rates for physician services. The formula has a spending target for physician services, and spending has exceeded the target in recent years. CMS estimates that the accumulated deficit between spending and the target will reach $57.8 billion by the end of 2008.

As the deficit has grown, the formula has been calling for payment reductions. Meanwhile, the Congress has overridden the formula. According to CMS's estimates, the formula is now calling for a payment adjustment of –26.5 percent. With a payment adjustment this large, the accuracy of CMS's estimates becomes less important than it would be otherwise. Although the formula may show an adjustment of –26.5 percent, the statute also includes a limit on how large the reduction can be in any one year. The limit is –7.0 percent. Because the calculated adjustment exceeds the limit by such a wide margin, it is very unlikely that there are any inaccuracies in CMS's estimates sufficient to make the adjustment anything other than –7.0 percent.

In turn, the update is unlikely to differ much from the –5.4 percent that CMS has calculated. Arithmetically, the estimate of –5.4 percent is a function of expected inflation in input prices of 1.7 percent and the update adjustment of –7.0 percent. The inflation estimate is the only factor in the calculation with any meaningful likelihood of changing, and it may change somewhat between now and November when CMS publishes the update that would actually occur.

It is in this context that the Commission fulfills its requirement to review CMS's estimate of the 2009 update for physician services. In examining the technical details involved in estimating the update under the SGR formula (in accordance with current law), we find that CMS used estimates in calculating the update that are consistent with recent trends.[1]

Before presenting these findings, we note that, in communicating the update estimate to the Commission, CMS states that it is engaged in a number of activities that would link payments to the value of care provided and transform Medicare from a passive payer for services into an active purchaser of high-quality care. The Commission concurs with CMS that Medicare should initiate strategies to improve the program's value. CMS's estimate comes at a time when Medicare and other purchasers of health care face enormous challenges (MedPAC 2008). Health care

TABLE A–1 **Preliminary estimate of the sustainable growth rate, 2009**

Factor	Percent
2009 change in:	
Input prices for physician services*	2.1%
Real GDP per capita	1.8
Fee-for-service enrollment	–0.2
Change due to law or regulation	–2.9
Sustainable growth rate	0.7

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 costs includes inflation measures for services furnished by a physician or in a physician's office. It is adjusted for productivity growth.

Source: Rich 2008.

costs are growing faster than the economy and incomes, and quality frequently falls short of patients' needs. Unexplained variations in the use and quality of care in the current system suggest that opportunities exist for reducing waste and improving quality.

In presenting this review of CMS's update estimate, we remind readers that previously the Commission discussed flaws in the SGR formula (MedPAC 2007). As mandated by the Congress, the Commission examined alternative approaches to the SGR system, many of which included frameworks with expenditure targets. In the end, Commissioners disagreed on the utility of expenditure targets. On the one hand, they neither reward physicians who restrain volume growth nor penalize 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. On the other hand, it may be better to think of an expenditure target as a tool for altering the behavior of policymakers than as a tool for improving how providers deliver services. That is, an expenditure target first alerts policymakers that spending is rising more rapidly than anticipated and then makes it more difficult for them to increase payment rates. Despite the disagreement, 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 establishing pay-for-performance programs for quality, improving payment accuracy, measuring physician resource use, and bundling payments to reduce overutilization. Nonetheless, it is understood that the underlying incentives in current fee-for-service (FFS) payment systems and the structure of the delivery system will make significant gains in value difficult to realize.

Prefacing our review of CMS's estimate, we first summarize certain provisions in the MMSEA. An awareness of these provisions helps with interpreting next year's update. We also review the steps in the update calculation.

How the MMSEA affects 2008 and 2009 updates for physician services

The MMSEA included several provisions that affect physician payments in 2008 and 2009. To avert a cut in the fee schedule's conversion factor that would have been effective January 1, 2008, under the SGR, it provided for a temporary 0.5 percent increase in the fee schedule conversion factor for the first six months of 2008. If this change had not been enacted, the 2008 update would have been –10.1 percent.[2]

For payments after the first six months of 2008, the MMSEA requires that the conversion factor be calculated as if the temporary increase had never been applied. Thus, the conversion factor is scheduled to decline by a total of 10.6 percent on July 1, 2008. The reduction would remove the temporary 0.5 percent increase, and it would implement the 10.1 percent decrease that would have occurred in the absence of the MMSEA.

The MMSEA also extended two payment policies that were scheduled to expire at the end of 2007: the floor on the geographic practice cost index (GPCI) for physician work and a 5 percent bonus payment to physicians practicing in designated physician scarcity areas. Both extensions are effective through the first six months of 2008.

The Congressional Budget Office (CBO) scored these MMSEA provisions—the temporary 0.5 percent increase and the extensions of the GPCI floor and the scarcity area bonus—as an increase in Medicare spending totaling $3.1 billion in fiscal year 2008. To help pay for this

increase, the MMSEA eliminated almost all of a $1.35 billion Physician Assistance and Quality Initiative Fund. This fund was created under the Tax Relief and Health Care Act of 2006 (TRHCA) for physician payment and quality improvement initiatives. Use of the fund to help pay for the temporary increase was consistent with the Commission's position on how to apply it.[3]

The MMSEA did not eliminate a current quality improvement initiative, the Physician Quality Reporting Initiative (PQRI), however. It was extended for another year—through 2009—but with a different funding source. Instead of the fund created under TRHCA, PQRI payments to physicians are now funded directly from the Part B Trust Fund without the $1.35 billion cap on total spending that was imposed under TRHCA. The payments remain equal to 1.5 percent of a physician's total allowed charges.

One last MMSEA provision is relevant to physician updates. The MMSEA established a fund of nearly $5 billion for future physician updates. We anticipate that future legislation will define when and how to apply this new funding.

TABLE A–2 **Preliminary estimate of the physician update, 2009**

Factor	Percent
***Excluding* MMSEA bonus**	
2008 update per SGR formula	–10.1%
2009 update factors per SGR formula:	
MEI	1.7
Update adjustment factor	–7.0
2009 update per SGR formula	**–5.4**
***Including* MMSEA bonus**	
2008 updates	
January–June	0.5
July–December	–10.6
2009 update	**–5.4**

Note: MMSEA (Medicare, Medicaid, and SCHIP Extension Act of 2007), SGR (sustainable growth rate), MEI (Medicare Economic Index). Percentages 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. Payment changes are changes from the previous period. Estimates shown are preliminary.

Source: Rich 2008.

Calculating the update

Calculating the physician update is a two-step process. CMS first estimates the target growth rate—the SGR—and 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,[4]
- real gross domestic product (GDP) per capita—an allowance for growth in the volume of services,[5]
- enrollment in 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 for 2009 is 0.7 percent (Table A-1).

For the second step, CMS calculates the update, which is a function of:[6]

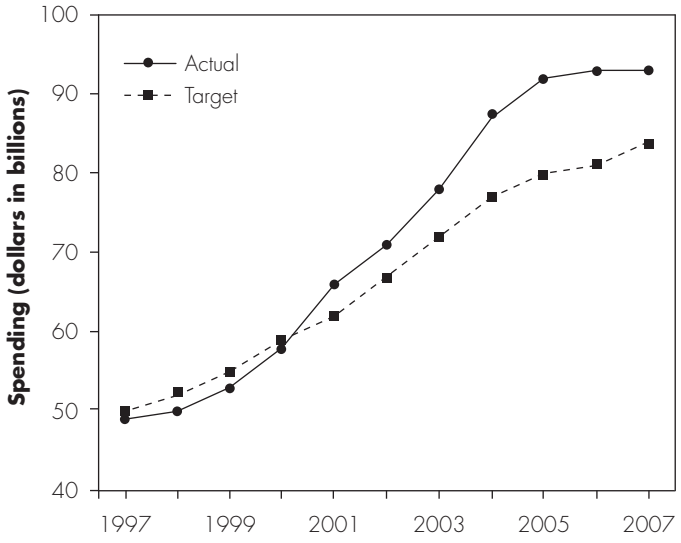
- the change in productivity-adjusted input prices for physician services, as measured by the Medicare Economic Index (MEI); and
- an update adjustment factor (UAF) that increases or decreases the update as needed to align actual spending, cumulated over time, with target spending determined by the SGR.

The estimate of the change in input prices for use in the 2009 update is 1.7 percent (Table A-2).[7] The part of the update calculation that has the larger effect, however, is the UAF, which CMS estimates at –7.0 percent, which is the maximum negative adjustment permitted under current law. Combining this adjustment with the estimated change in input prices results in an update of –5.4 percent. (Note that this calculation of the estimate converts percentages to ratios, which are multiplied rather than summed to produce the update.)

The UAF is negative because actual spending for physician services started to exceed the target in 2001 (Figure A-1, p. 246). As the deficit has grown, the formula has called for payment reductions, but the Congress has

FIGURE A–1

Since 2001, actual spending for physician services has exceeded target



Note: Estimates shown are preliminary.

Source: Office of the Actuary 2008.

overridden the formula. According to CMS's estimates, the UAF would now be –26.5 percent in the absence of the statutory limit. Thus, CMS's update estimate (–5.4 percent) is unlikely to change by a substantial amount because a UAF of –26.5 percent is well beyond the limit (–7.0 percent). For this reason, 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, beginning with the change in input prices.

Reviewing CMS's estimate

Measured by the MEI, CMS's estimate of the change in input prices is within the range during the last 15 years—though it is at the low end of the range.[8] It is low primarily because input prices for physician services have grown at a relatively low rate recently and because productivity has grown. According to the Bureau of Labor Statistics, the measure of productivity growth in the MEI has trended higher in recent years (BLS 2007).

After adjusting for population growth, the change in real GDP per capita of 1.8 percent equals the 10-year moving average of real GDP estimates from the Bureau of Economic Analysis (BEA 2008).

The change in FFS enrollment is a little less certain. CMS assumes a decrease of 0.2 percent for 2009. This figure differs by 1.6 percentage points from CBO's enrollment projection, which is a decrease in FFS enrollment of 1.8 percent for (fiscal year) 2009 (CBO 2008). Because CMS and CBO project similar total Medicare enrollment, the difference is primarily due to difficulties projecting shifts in enrollment from Medicare FFS to Medicare Advantage (MA). For 2009, CMS projects an MA increase of 8 percent, but CBO projects an increase of 15.4 percent. CMS may be better able to project any such shift when MA plans submit bids and identify market areas in June 2008. CMS can then revise the enrollment projection, if necessary, before the update becomes final in November 2008. 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. 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 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.

For the 2009 SGR, CMS anticipates that some statutory and regulatory changes will increase physician spending. However, on net, CMS expects changes in law and regulation to reduce spending by 2.9 percent. This SGR factor is negative because three provisions in the MMSEA—the temporary conversion factor bonus, the floor on the work GPCI, and the physician scarcity bonus—are raising fees in 2008, albeit only for the first six months of the year. The effect of these provisions is to raise fees in 2008—on average—relative to 2009.[9]

Despite an overall reduction in spending due to law and regulation, CMS projects that certain legislative provisions will increase spending in 2009. For instance, in compliance with the MMSEA, PQRI bonus payments will continue in 2009. Although the bonuses will remain at 1.5 percent of allowed charges, CMS sees two reasons for higher spending on the bonuses in 2009 than in 2008.

First, the bonuses paid in 2009 will be for a full year instead of six months of allowed charges, which was the case with the bonuses paid in 2008. Second, CMS expects a greater proportion of physicians to receive the bonuses in 2009 than in 2008.

As was the case with the SGR for 2008, CMS also expects an increase in spending in 2009 due to a change in the effects of a provision in the Deficit Reduction Act of 2005 (DRA). Specifically, for certain imaging services, the DRA requires that Medicare pay the lesser of hospital outpatient department rates or physician fee schedule rates. Because hospital outpatient prospective payment system (OPPS) services will receive a positive update in 2009 while physician fee schedule services are projected to receive a negative update, CMS estimates that total spending will increase. That is, for some imaging services currently subject to the DRA limits, OPPS rates will rise to a level that exceeds the applicable fee schedule rates, thus reducing savings that had previously occurred because of the limits. (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.)

The remaining issue in calculating the update for 2009 concerns CMS's estimates of actual spending in 2007 and 2008. Data on actual spending are nearly complete through the first three quarters of 2007 but are less complete for the last quarter of that year. Therefore, the estimate of actual spending in 2007 may change somewhat before CMS issues a final rule on the update in November 2008. Of course, the uncertainty that accompanies the estimates of actual spending for 2008 is greater than for 2007 because CMS currently has very little information on actual spending in 2008.

Summary

Regardless of what happens with the various estimates that determine the physician update, it is unlikely that any change will overcome an update adjustment factor of –26.5 percent. Therefore, we anticipate that CMS will revise the update calculations this fall, in preparation for implementing the 2009 update on January 1, and that, barring any overriding statutory provisions, the calculations will show the maximum reduction the statute permits: the change in productivity-adjusted input prices (as measured by the MEI) minus 7.0 percentage points, or –5.4 percent. ■

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 2008 report (MedPAC 2008).

2 A 2008 update of −10.1 percent would have been the combination of a negative update calculated with the SGR formula for that year and a negative update for 2007 that would have occurred in the absence of the Tax Relief and Health Care Act of 2006.

3 In addition to the fund, the other budgetary resources necessary for the 0.5 percent increase represent an increase in Part B spending.

4 For calculating the SGR, physician fees include fees for 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.

5 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.

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

7 In its March 2008 report to the Congress, the Commission used a CMS forecast of change in the MEI in 2009 that equaled 2.6 percent. This forecast was not adjusted for productivity growth. If we compare the forecast in the Commission's report with the MEI increase of 1.7 percent in CMS's preliminary estimate of the update for 2009, one reason for the difference is that the increase with the preliminary estimate is adjusted for productivity growth. That is, the 1.7 percentage point increase includes an adjustment for productivity growth of 1.4 percentage points. The other reason the MEI numbers differ is that the increase of 1.7 percent is not a forecast for 2009. Instead, it is an estimate of historical change—in this case, from 2007 to 2008.

8 Since 1992, the MEI has ranged from 1.7 percent to 3.2 percent.

9 Earlier conversion factor overrides explicitly did not require a change in law and regulation for purposes of the SGR calculation. By contrast, the conversion factor bonuses in the TRHCA and the MMSEA allowed a change in law and regulation to be a factor in CMS's update calculation.

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