APPENDIX A

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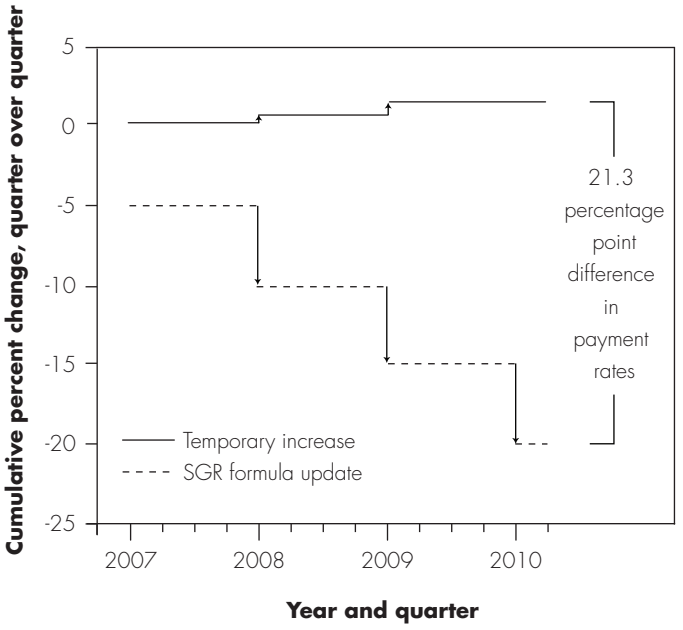
In CMS's annual letter to the Commission on the update for physician services, the agency's preliminary estimate of the 2011 update is –6.1 percent (Blum 2010). This update would follow a 21.3 percent reduction in physician payment rates required under law that was to occur on April 1, 2010, after a series of temporary increases—enacted over several years—expired.[1] Such increases have prevented negative updates under the sustainable growth rate (SGR) formula—the statutory formula for updating Medicare's payment rates for physician services—that would have occurred at the beginning of each of four years: 2007, 2008, 2009, and 2010. Combined, the 2011 update and the expired temporary increases equal a reduction in payment rates of 26.1 percent.[2]

This appendix provides our mandated technical review of CMS's estimate. We find that—absent a change in law—the combined effect of the expired increases and the 2011 update is very unlikely to differ substantially from –26.1 percent. The temporary increases—by far, the largest factor influencing the payment reduction—were specified in law. When they expire, payment rates go down by an amount that is not subject to change. The SGR update for 2011 could change between now and when CMS implements the update in January, but only by a small amount. According to the formula, the update is the projected change in input prices for physician services, adjusted by a factor to align spending with a target.[3] While CMS's estimate of a 0.1 percent change in input prices may change, the agency's estimate of an update adjustment of –6.2 percent is the dominant factor. By law, the update adjustment is limited to –7.0 percent, so it can go no lower than that even if spending goes up faster than projected by CMS. Alternatively, the update adjustment could lead to a somewhat smaller reduction in payment rates if spending goes up more slowly than CMS anticipates. For instance, if spending in 2010 were 1 percent lower than CMS projects, the update adjustment for 2011 would be −5.3 percent instead of −6.2 percent. In turn, the 2011 update would go from −6.1 percent to −5.2 percent. Still, such changes in the 2011 update—whether higher or lower than CMS now estimates—appear small when the context is an overall decrease in payment rates of 26.1 percent.

Before presenting the details of our technical review, we remind readers that the Commission is not satisfied with the current physician payment update mechanism. It does not provide incentives for individual physicians to control volume growth, and it is inequitable to those physicians who do not increase volume unnecessarily. Our report *Assessing Alternatives to the Sustainable Growth Rate System* examined several approaches for updating physician payments and made suggestions to improve the accuracy of Medicare's payments, create incentives for physicians to provide better quality of care, coordinate care across settings, and use resources judiciously (Medicare Payment Advisory Commission 2007).

FIGURE A–1 **Temporary increases prevented the SGR formula's negative updates**



Note: SGR (sustainable growth rate). The 21.3 percentage point difference is the ratio of the cumulative SGR formula updates to the cumulative temporary bonuses (0.79946/1.01606 = 0.78682 or –21.3 percent).

Source: Blum 2010 and Office of the Actuary 2009.

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

The SGR formula is intended to limit growth in Medicare spending for physician services. If aggregate spending—accumulated since 1996—exceeds a specified target in a given year, the formula calls for a downward adjustment in the physician fee schedule's conversion factor.

In recent years, the Congress has overridden the formula's updates. Spending has exceeded the target, and updates calculated with the formula have been negative. However, except for the negative update implemented in 2002, the Congress has passed specific legislation for each year to prevent further negative updates.

Initially, the legislative overrides prescribed a positive update for a given year but did not allow the 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. 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 the first quarter of 2010, the temporary increases totaled a cumulative increase in payment rates of 1.6 percent (Figure A-1).[4] Had the Congress not overridden the formula with these increases, the cumulative change in payments would have been –20.1 percent. The difference is the 21.3 percent reduction in payment rates mentioned earlier.

In addition to the temporary increases, legislation has raised payments for physician services in other ways. For instance, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) increased bonuses under the Physician Quality Reporting Initiative (PQRI) to 2 percent of allowed charges for 2009 and 2010. Previously, the bonuses were 1.5 percent of allowed charges. MIPPA also established incentives for electronic prescribing. This program allowed physicians to receive a 2 percent bonus on their allowed charges in 2009 and 2010 if they met the program's requirements. And MIPPA extended through 2009 higher payments for some areas through the floor on the physician fee schedule's geographic practice cost index for physician work.

How CMS estimated the SGR formula's update for 2011

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

SGR for 2011

The SGR is a function of projected changes in:

- input prices for physician services—an allowance for inflation,[5]
- real gross domestic product (GDP) per capita—an allowance for growth in the volume and intensity of services,[6]

- 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 for 2011 is –0.4 percent (Table A-1).

The first of these factors—the estimated change in input prices of 0.2 percent—is lower than the figure for previous years. Given economic conditions, CMS projects relatively modest increases in physician compensation, staff earnings, rent, and the prices of other inputs.

The next factor in the 2011 SGR—growth in real GDP per capita—is a 10-year moving average. It includes estimates of economic growth for 2002 through 2009 and projections for 2010 and 2011. CMS's estimate of 0.8 percent for this factor is the same as the estimate we calculate when we use Congressional Budget Office projections for 2010 and 2011 to calculate a 10-year moving average of growth in real GDP per capita (Congressional Budget Office 2010).

For the factor on the change in FFS enrollment, CMS projects an increase of 3.1 percent, a growth rate higher than the projected 2.0 percent growth in overall Medicare Part B enrollment. Higher growth in FFS enrollment is projected because the rapidly growing private FFS plans in the Medicare Advantage program will have a new requirement in 2011 to form provider networks, which likely will reduce the availability of these plans. In turn, the growth in enrollment in these plans could diminish, leading to a shift in enrollment from Medicare Advantage to Medicare FFS.

The remaining factor in the 2011 SGR is a –4.4 percent change in spending due to law and regulation. For this factor, CMS's preliminary estimate—subject to change when information on actual spending becomes available—is that some changes in policy will have relatively small effects on spending: expiring PQRI bonuses and a change in payment for certain laboratory services. Expiration of the temporary increases is the primary source of CMS's estimate of the –4.4 percent change in spending.

How does a change in spending of less than 5 percent account for a 21.3 percent reduction in payments that occurred when the temporary increases expired? There are several reasons for the difference. First, because the temporary increases did not expire at the beginning of 2010, the change in spending is not uniform for all 12 months of 2011 compared with all 12 months of 2010. Instead, the change in spending is a weighted average: a decrease in spending for three months—comparing the first three months of 2011 and the first three months of 2010—and no change in spending for nine months. Second, the expiring increases would not affect all the spending accounted for by the SGR. About 9 percent of that spending is for laboratory services. Third, 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). In other words, if volume goes up when the temporary increases expire, spending will fall by less than the reduction in payment rates.

TABLE A–1

Preliminary estimate of the sustainable growth rate, 2011

Factor	Percent
2011 change in:	
Input prices for physician services*	0.2%
Real GDP per capita	0.8
Fee-for-service enrollment	3.1
Change due to law or regulation	–4.4
Sustainable growth rate	–0.4

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 in a physician's office. As defined for the sustainable growth rate, those services include services billable under the physician fee schedule and laboratory services.

Source: Blum 2010.

Calculating the SGR formula's update for 2011

After estimating the SGR, CMS calculates the update, which is a function of:

- the change in productivity-adjusted input prices for physician services, as measured by the Medicare Economic Index (MEI); and

TABLE A–2

Preliminary estimate of the SGR formula's update for 2011

Factor	Percent
Change in input prices*	0.1%
Update adjustment factor	–6.2
Update	–6.1

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

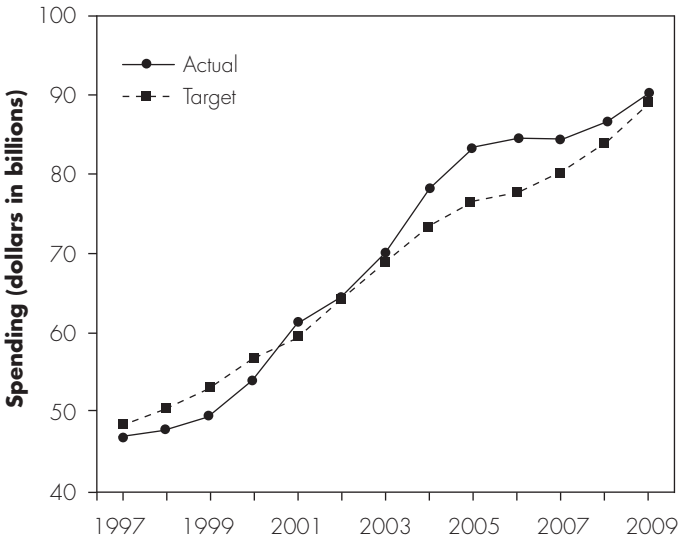
Source: Blum 2010.

- 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 2011 update is 0.1 percent (Table A-2). The part of the update calculation that has the larger effect, however, is the UAF. For 2011, CMS estimates a UAF of –6.2 percent. Combining this adjustment with the estimated change in input prices results in an update estimate of –6.1 percent. The UAF is negative because actual spending for physician services has exceeded the target every year since 2001 (Figure A-2).[7] In the meantime, the deficit has continued—despite the formula's calls for payment reductions—because the Congress has overridden the formula.

FIGURE A–2

Since 2001, actual spending for physician services has exceeded the target



Note: Estimates shown 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 2009 and Blum 2010.

As discussed earlier, both factors that go into the update calculation—the MEI and the UAF—could change by November 2010 when CMS finalizes the update for 2011. By then, the MEI could be somewhat higher or lower than 0.1 percent as further data become available on changes in input prices for physician services. And the UAF could be higher or lower than –6.2 percent. The UAF is partly a function of actual spending for physician services. When calculating the preliminary estimate of the 2011 update, CMS had data on actual spending that were nearly complete for the first three quarters of 2009 but less so for the last quarter of that year. As more data become available, the estimate of actual spending in 2009 may change somewhat before CMS issues a final rule on the update in November. The estimates of actual spending for 2010 could change also. Regardless, such changes in the update calculations are very unlikely to have a large impact in the context of an overall reduction in payment rates—combining both the SGR formula's update for 2011 and expiration of the temporary increases—estimated to total –26.1 percent. ■

Endnotes

1 After CMS sent the letter, another temporary increase was enacted that delayed the reduction until June 1, 2010.

2 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 26.1 percent is the arithmetic product of the 2011 update (–6.1 percent, or 0.939) and the expiration of the temporary increases (–21.3 percent, or 0.787). The multiplication is $0.939 \times 0.787 = 0.739$, or –26.1 percent.

3 For the update, physician services include only those services billable under the physician fee schedule.

4 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. The Continuing Extension Act of 2010 continued the zero update for physician services through May 2010.

5 For calculating the SGR, physician 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.

6 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.

7 For 2010, CMS removed physician-administered drugs from the SGR's definition of physician services (Centers for Medicare & Medicaid Services 2009). This change narrowed the gap between actual spending and the target.

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