

A P P E N D I X

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**Review of CMS's preliminary
estimate of the 2012 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 2012 payment update is –29.5 percent (Blum 2011). Most of the prescribed reduction is due to a series of temporary increases enacted over several years that—under current law—expire at the end of 2011. 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 professional services. If the temporary increases expire, the physician fee schedule's conversion factor must decrease by 25.0 percent. The remainder of the reduction would be the formula's update—specific to 2012—of –6.1 percent. This further reduction would be applied to the conversion factor after it had been reduced by 25.0 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 2012 are very unlikely to produce an update that differs substantially from –29.5 percent. The temporary increases—by far, the largest factor influencing the payment reduction—were specified in law. The estimate of an SGR formula's update of –6.1 percent for 2012 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.

While this appendix is limited to technical issues, the Commission has concerns about the SGR formula as a payment policy. Those concerns are discussed in Chapter 1 of this report.

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

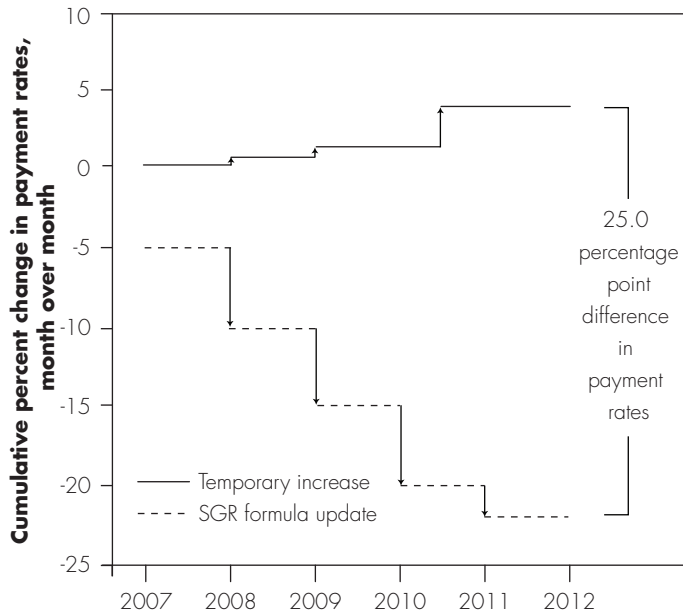
The SGR formula is intended to limit growth in Medicare spending for physician and other professional services. If aggregate spending—accumulated since 1996—exceeds the specified target spending accumulated in the same time period, the formula calls for a downward adjustment in the physician fee schedule's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

In recent years, spending has 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

**FIGURE
A-1**

**Temporary increases prevented the
SGR formula's negative updates**



Note: SGR (sustainable growth rate). The 25.0 percentage point difference is the ratio of the cumulative SGR formula updates to the cumulative temporary bonuses ($0.778/1.038 = 0.750$ or -25.0 percent).

Source: Blum 2011 and Office of the Actuary 2011.

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 2011, 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 -22.2 percent. The difference is a 25.0 percent reduction in payment rates required when the temporary increases expire.

In addition to the temporary increases, recent legislation has made further changes in payments for services furnished by physicians and other health professionals. Some provisions lowered payments. As an example, the Patient Protection and Affordable Care Act of 2010 (PPACA) changed the reduction for imaging procedures conducted on contiguous body parts, increasing it from

25 percent to 50 percent. Beginning in 2012, PPACA establishes a penalty for professionals who are not successful electronic prescribers.³ Other legislative provisions raised payments. For instance, beginning in 2011, PPACA established a 10 percent bonus payment for eligible practitioners who furnish two types of services: primary care services and major surgical procedures. Further, PPACA extended Physician Quality Reporting System bonuses through 2014.⁴ PPACA also established an incentive payment for eligible professionals who meet the requirements of a Maintenance of Certification program. And the law required the Secretary—when determining the physician fee schedule's geographic practice cost index (GPCI) for practice expense—to recognize only one-half of the geographic variation in practice expenses. Because this provision of the law included a hold-harmless requirement, it did not lower payments in any geographic area but it raised payments in a number of areas. Other legislation—the Medicare and Medicaid Extenders Act of 2010—extended through 2011 the floor on the GPCI for physician work.

**How CMS estimated the SGR formula's
update for 2012**

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 historical information on actual and target spending.

SGR for 2012

The SGR is a function of projected changes in:

- input prices for practitioner 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 practitioner services.

Allowing for these four factors, CMS’s preliminary estimate of the SGR for 2012 is –17.2 percent (Table A-1).

The first of these factors—the estimated change in input prices of 0.1 percent—is lower than the figure for previous years. Given economic conditions, CMS projects relatively modest increases in practitioner compensation, staff earnings, rent, and the prices of other inputs.

The next factor in the 2012 SGR—growth in real GDP per capita—is a 10-year moving average. It includes estimates of economic growth for 2003 through 2010 and projections for 2011 and 2012. CMS’s estimate of 0.9 percent for this factor is just 0.1 percentage point less than the estimate we calculate when we use Congressional Budget Office projections for 2011 and 2012 to compute a 10-year moving average of growth in real GDP per capita (Congressional Budget Office 2011).

For the factor on the change in FFS enrollment, CMS is not projecting a change in FFS enrollment because of increases or decreases in enrollment in Medicare Advantage. Instead, the agency projects an increase in FFS enrollment of 3.3 percent, which is the same as the projected growth in Medicare enrollment overall (FFS plus Medicare Advantage).

The remaining factor in the 2012 SGR is a –20.6 percent change in spending due to law and regulation. For this factor, expiration of the temporary increases is the primary source of CMS’s estimate of the 20.6 percent decrease in spending. Other changes in spending due to law and regulation—such as expiration of the floor on the work GPCI and expiration of the provision limiting variation in the practice expense GPCI—would be relatively small.

Why is the change in spending due to law and regulation a smaller reduction than the 25.0 percent reduction in payments that would occur when the temporary increases expire? There are two reasons for the difference. First, if the temporary increases expire, payment rates in the physician fee schedule would go down. However, payment rates in the laboratory fee schedule would not be affected. The law and regulation factor in the SGR accounts for changes in spending under both of these payment systems.⁷ Second, the law and regulation factor 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

**TABLE
A-1**

Preliminary estimate of the sustainable growth rate, 2012

Factor	Percent
2012 change in:	
Input prices*	0.1%
Real GDP per capita	0.9
Fee-for-service enrollment	3.3
Change due to law or regulation	–20.6
Sustainable growth rate	–17.2

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 2011.

third to account for a volume increase, consistent with the agency’s research (Codespote et al. 1998).⁸

Calculating the SGR formula’s update specific to 2012

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 Medicare Economic Index (MEI);⁹ 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 2012 update is 0.3 percent (Table A-2, p. 186). This factor could change by November 2011 when CMS finalizes the update for 2012. By then, the MEI could be somewhat higher or lower than 0.3 percent as further data become available on changes in input prices for physician and other professional services.

The UAF is projected to have a larger effect on the update calculation. For 2012, CMS estimates a UAF of –6.4 percent. Combining this adjustment with the estimated change in input prices results in an update estimate of

**TABLE
A-2**

Preliminary estimate of the SGR formula's update specific to 2012

Factor	Percent
Change in MEI*	0.3%
Update adjustment factor	-6.4
Update	-6.1

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 2011.

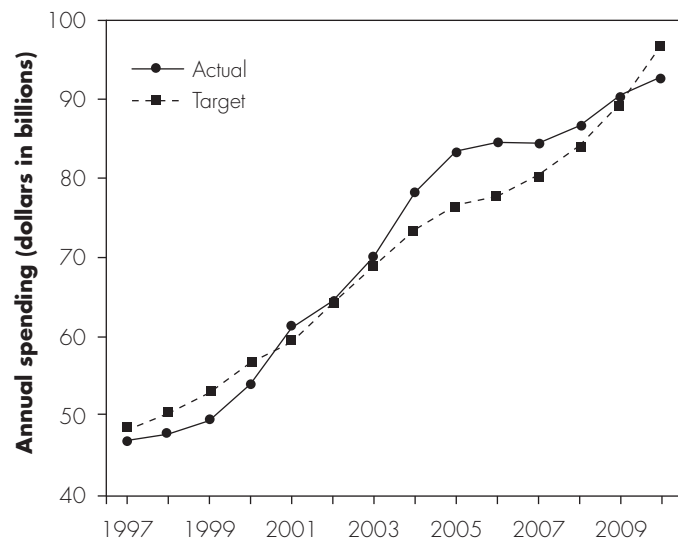
-6.1 percent. The UAF is negative because from 2001 to 2009 actual spending for physician and other professional services exceeded the target (Figure A-2).¹⁰

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 2012 update, CMS had data on actual spending that were nearly complete for the first three quarters of 2010 but less so for the last quarter of that year. As more data become available, the estimate of actual spending in 2010 may change somewhat before CMS issues a final rule on the update in November. The estimates of actual spending for 2011 could also change. Nonetheless, changes in the UAF are not likely to have a large impact on the update calculations. By law, the update adjustment is limited to a maximum reduction of -7.0 percent, so it can go no lower 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 increases at a slower rate than CMS anticipates. For instance, if spending in 2011 were 1 percent lower than CMS projects, the update adjustment for 2012 would be -5.3 percent instead of -6.4 percent. In turn, the SGR formula's update specific to 2012 would go from -6.1 percent to -5.0 percent. Such changes do not appear large compared with an overall reduction in payment rates—due to expiring temporary increases and the formula's update specific to 2012—of 29.5 percent. ■

**FIGURE
A-2**

From 2001 to 2009, actual spending for physician services 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: Final rule on the physician fee schedule for 2011.

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 29.5 percent is the arithmetic product of the 2012 update (–6.1 percent, or 0.9388) and the expiration of the temporary increases (–25.0 percent, or 0.7505). The multiplication is $0.9388 \times 0.7505 = 0.7046$, or –29.5 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.
- 3 To determine who is a successful electronic prescriber, the Secretary is authorized to use one of two possible criteria. First, eligible professionals must meet a threshold for reporting on quality measures for electronic prescribing. Second, eligible professionals must submit electronically a sufficient number of prescriptions under Medicare Part D.
- 4 Beginning in 2015, PPACA establishes a penalty for professionals who do not report on quality measures.
- 5 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.
- 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 the SGR, practitioner services are defined as services furnished by a physician or other health professional or furnished in the office of a physician or other health professional.
- 8 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.
- 9 For the update, practitioner services include only those services billable under the physician fee schedule.
- 10 Starting with the update for 2010, CMS removed physician-administered drugs from the SGR definition of practitioner services. This change narrowed the gap between actual spending and the target.

References

Blum, Jonathan D., Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2011. Letter to Glenn M. Hackbarth, Medicare Payment Advisory Commission. March 7. <http://www.cms.hhs.gov/SustainableGRatesConFact>.

Codespote, S. M., W. J. London, and J. D. Shatto. 1998. Physician volume and intensity response. Baltimore, MD: CMS. <http://www.cms.hhs.gov/ActuarialStudies/downloads/PhysicianResponse.pdf>.

Congressional Budget Office. 2011. *The budget and economic outlook: Fiscal years 2011 to 2021*. Washington, DC: CBO. <http://www.cbo.gov/doc.cfm?index=12039>.

Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2011. *Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2012*. Baltimore, MD: CMS. <http://www.cms.gov/SustainableGRatesConFact/Downloads/sgr2012p.pdf>.