CHAPTER 7

Reviewing the estimated payment update for physician services

RECOMMENDATION

7A When preparing the final 2001 update to the physician fee schedule's conversion factor, the Secretary should review the data and methods used to project growth in enrollment in traditional Medicare and explain the methods used to project that growth.

CHAPTER 7

Reviewing the estimated payment update for physician services

In this chapter

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- Estimate of the sustainable growth rate and update for 2001

Medicare payments for physician services are updated annually based on a formula designed to control overall spending while accounting for factors that affect the cost of providing care. As required by the Balanced Budget Refinement Act of 1999, the Health Care Financing Administration (HCFA) recently released a preliminary estimate of the update for payments to physicians in 2001. The Medicare Payment Advisory Commission (MedPAC) has reviewed the preliminary update and believes it is based on an underestimate of growth in traditional Medicare enrollment. If HCFA continues to underestimate growth in traditional Medicare enrollment in this way, the final update, to be implemented in January 2001, will be lower than is warranted. We urge HCFA to review the data and methods used to make the estimate and to explain how this and other estimates are prepared as part of the release of future estimates.

To calculate the physician payment update, HCFA must estimate a number of factors, including traditional Medicare enrollment, actual spending for physician services, and changes in the cost of providing those services. In releasing its preliminary update, HCFA emphasized that early estimates may not be good predictors of the final update the agency will use to make payments in 2001 (Berenson 2000). However, release of a preliminary update was recommended by MedPAC to give the Commission and others an opportunity for review and comment before the final update is issued.[1] Reviewing the preliminary update, and the estimates upon which it is based, permits us to assess the magnitude of the estimates and gives us an opportunity to review the methods used to develop those estimates.

This chapter first provides some background on Medicare's payments to physicians and then presents our comments and a recommendation on HCFA's preliminary estimate of the physician payment update.

Background on physician payment

Medicare's payments for physician services are made according to a fee schedule. Under the fee schedule, services are given relative weights, reflecting resource requirements. These weights are adjusted for geographic differences in practice costs and are multiplied by a dollar amount—the conversion factor—to determine payments. The conversion factor is updated annually, based on a formula designed to control overall spending over time while accounting for factors that affect the cost of providing the care covered under the program.

Calculating the update for the conversion factor is a two-step process. First, HCFA must estimate the sustainable growth rate (SGR). The SGR is the target rate of growth in spending for physician services and is based on a formula defined in law. It is a function of the percentage changes in:

- input prices for physician services,[2]
- traditional Medicare enrollment,

How the Balanced Budget Refinement Act modified the sustainable growth rate system

In its March 1999 report to the Congress, the Commission recommended a number of improvements to the sustainable growth rate (SGR) system (MedPAC 1999). First, we recommended revising the SGR to include measures of changes in the composition of traditional Medicare enrollment. Second, we recommended revising the SGR to include a factor of growth in real gross domestic product per capita plus an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology. Third, we recommended that the Secretary of Health and Human and Services publish an estimate of conversion factor updates by March 31 of the year before their implementation. Fourth, we recommended calculating the SGR and the update adjustment factor on a calendar-year basis. Finally, we recommended that the Secretary be required to correct estimates used in SGR system calculations every year.

In the Balanced Budget Refinement Act of 1999 (BBRA), the Congress acted on all five of the Commission's recommendations. The BBRA requires the Secretary, acting through the administrator of the Agency for Healthcare Research and Quality, to submit a report to the Congress by November 2002 on the use of physician services by Medicare beneficiaries. MedPAC will then have six months to analyze and evaluate the report and submit its own report to the Congress. The BBRA specifies consideration of three factors addressed by the Commission's recommendations—improvements in medical capabilities, advancements in scientific technology, and demographic changes in the types of beneficiaries receiving benefits under Medicare.

The BBRA also requires the Secretary to make publicly available, by March 1 of each year, an estimate of the SGR and conversion factor for the succeeding year. Finally, the BBRA changes how the SGR is calculated. It requires the Secretary to correct previously issued SGRs with the best available data.[3] This SGR correction requirement applies to the SGRs for fiscal year 2000 and later time periods. It also includes provisions intended to reduce the volatility of conversion factor updates by moving calculations to a calendar-year basis and changing the calculation of the update adjustment factor.[4] ■

3 The requirement that the Secretary correct previously issued SGRs applies to SGRs only and not to previously implemented conversion factor updates.

4 The BBRA altered the calculation of the update adjustment factor by separating its two components: a prior-year adjustment and a cumulative adjustment. Weights are then applied to each of these components. The prior-year weight is 0.75, and the cumulative weight is 0.33. This set of weights was developed by HCFA actuaries after conducting a series of simulations to find weights that would minimize the volatility of conversion factor updates and minimize the time necessary to align actual spending with the SGR target.

1 The Balanced Budget Refinement Act of 1999 requires publication of the final update by November 1.

2 For purposes of the SGR, physician services include services commonly performed by a physician or performed in a physician's office. They include services paid for under the physician fee schedule and other services, such as diagnostic laboratory tests and outpatient therapy services.

- real gross domestic product (GDP) per capita, and
- spending attributable to changes in law and regulation.

Second, HCFA calculates the update to the conversion factor. This update is a function of:

- the change in input prices for physician services,[5]
- a legislative adjustment required by the Balanced Budget Refinement Act of 1999 (BBRA),
- an adjustment to account for expected changes in physician behavior in response to payment changes, and
- an update adjustment factor that increases or decreases the update as needed to align actual spending with the SGR target.

Estimate of the sustainable growth rate and update for 2001

HCFA's preliminary estimate of the SGR for 2001 is 2.8 percent, which is predicted to yield an update to the conversion factor of 1.8 percent when combined with the other factors that determine the update. As noted by HCFA, the final update is likely to differ from this estimate due to availability of more complete data. Nonetheless, the Commission is concerned that HCFA's estimates of an SGR factor—traditional Medicare enrollment—are too low. If HCFA continues to underestimate growth in traditional Medicare enrollment in this way, conversion factor updates will be too low.

RECOMMENDATION 7A

When preparing the final 2001 update to the physician fee schedule's conversion factor, the Secretary should review the data and methods used to project growth in enrollment in traditional Medicare and explain the methods used to project that growth.

HCFA's preliminary SGR for 2001 includes a change in input prices for physician services of 1.5 percent, a change in traditional Medicare enrollment of −0.6 percent, a change in real GDP per capita of 1.9 percent, and no change in spending due to law and regulation (Table 7-1). The estimated changes in three of these factors appear reasonable. The change in input prices is based primarily on the Medicare Economic Index (MEI), which has always been an accepted component of updates of physician fee schedule payments; the change in real GDP per capita is based on estimates from an accepted source—the Bureau of Economic Analysis; and, assuming no changes in the Medicare benefit package later this year, no increases in spending are expected due to changes in law and implementing regulations.

TABLE 7-1 **HCFA estimate of the 2001 sustainable growth rate**

Factor	Percentage
Change in input prices	1.5%
Change in traditional Medicare enrollment	−0.6
Change in real GDP per capita	1.9
Change due to law and regulations	0.0
Estimated SGR	2.8

Note: GDP (gross domestic product), SGR (sustainable growth rate).

Source: Berenson 2000.

HCFA's estimate of the change in traditional Medicare enrollment in 2001 appears too low, however, because the agency's estimate of the change in Medicare+Choice (M+C) is too high. If growth in total Medicare Part B enrollment, including the traditional program and M+C, is 1.1 percent per year, as expected, a −0.6 percent reduction in traditional Medicare enrollment means M+C enrollment would have to grow by 9.6 percent.[6]

Recent experience suggests that growth in M+C enrollment could be much lower than HCFA's estimates. M+C enrollment growth slowed to 5 percent in 1999 from a high of more than 35 percent in 1995 (MedPAC 2000).[7] This year, M+C enrollment growth has remained low: for the year ending March 1, 2000, it was less than 3 percent. The M+C program has experienced this low rate of growth despite provisions in the BBRA intended to help expand choices for beneficiaries.[8]

HCFA acknowledges that projecting changes in enrollment has been difficult in recent years despite efforts of the agency's actuaries (HCFA 2000). When making SGR revisions for release this fall, the actuaries will be able to improve their projections with more complete data.

The Commission believes that the problem with HCFA's enrollment estimates goes beyond data issues, however. Given the difference between recent experience with M+C enrollment and HCFA's projections, the Commission recommends that HCFA review the data

5 For purposes of the update, physician services include only those services paid for under the physician fee schedule.

6 In addition to the estimate for 2001, HCFA's estimate of the change in traditional Medicare enrollment for 2000 also appears to be too low. That estimate is the same as the estimate for 2001: −0.6 percent. The estimate for 2000 assumes an increase in Medicare+Choice enrollment of 8.9 percent (HCFA 2000).

7 MedPAC's calculations of M+C enrollment growth are based on enrollment during the last month of each year. HCFA's calculations are based on average enrollment during each year.

8 The BBRA provisions affecting the M+C program are discussed in MedPAC's March report to the Congress (MedPAC 2000).

TABLE 7-2 **HCFA estimate of the 2001 conversion factor update**

Component	Percentage
Medicare Economic Index	1.7%
Update adjustment factor	0.5
Legislative adjustment	−0.2
Volume and intensity adjustment	−0.2
Update	1.8

Note: The legislative adjustment is a requirement of the BBRA. The volume and intensity adjustment is based on a HCFA assumption that physicians will increase the volume of services to offset a portion of revenue reductions associated with implementation of resource-based practice expense relative value units.

Source: Berenson 2000.

and methods used to make the projections when preparing the final update. We further recommend that the Secretary provide an explanation of the methods used to develop estimates of changes in enrollment growth as part of the release of those estimates. To date, the Secretary has identified her enrollment estimates as actuarial estimates. She has not, however, described the methods used to prepare these estimates or others that are part of the SGR, such as the estimated change in spending due to law and regulations. An explanation of these methods would permit MedPAC and others to conduct an informed review of the estimates.

Based partly on the preliminary SGR for 2001, HCFA's estimate of the physician payment update for 2001 is 1.8 percent. It includes an estimated change in the Medicare Economic Index (MEI) of 1.7 percent and an estimate of the update adjustment factor of 0.5 percent (Table 7-2). It also includes a legislative adjustment of −0.2 percent, required by the BBRA, and a volume and intensity adjustment of −0.2 percent.

The Commission has no comments on three of the four components of the update. As noted earlier, the MEI has always been a component of conversion factor updates. The legislative adjustment is a requirement of the BBRA to maintain the budget neutrality of the change in the calculation of the update adjustment factor. The volume and intensity adjustment is based on a HCFA assumption that physicians will increase the volume of services to offset a portion of revenue reductions associated with implementation of resource-based practice expense payments to physicians.

The Commission believes, however, that the update adjustment factor is too low, making the update estimate too low. The update adjustment factor is determined partly by the SGR for 2001 and earlier time periods. As explained earlier, MedPAC believes HCFA's SGR estimates are too low because its estimates of growth in traditional Medicare enrollment appear to be too low.

Whether higher SGRs will lead to a higher update this fall is unclear, however. The update adjustment factor adjusts for the difference between allowed spending for physician services, as determined by the SGR, and actual spending for those services. HCFA had no data on actual spending during 2000 when making the preliminary estimate of the update.[9] Before HCFA issues the final update this fall, data will be available on spending for physician services during the second quarter (and possibly the third) of 2000. Those data will permit a more accurate estimate of actual spending in 2000 which could be higher or lower than the estimate used to calculate the preliminary update. ■

9 To estimate the update, HCFA projected actual spending in 2000 to be $54.8 billion, or $13.7 billion per quarter. Spending at that level would be 7.6 percent higher than average spending during the first three quarters of 1999. Factors HCFA considered when making this projection included an increase in spending due to a new prostate screening benefit, growth in the volume and intensity of services, and the 2000 physician payment update (5.5 percent).

References

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