Surgical Care Coalition

THE ABCs OF MEDICARE

EVERY ACRONYM AND WORD YOU NEED TO KNOW

TERM	DEFINITION
BUDGET NEUTRALITY	**Budget Neutrality** Budget neutrality is a federal policy that requires spending on federal programs to have no budgetary impact. In the context of the Medicare Physician Fee Schedule (MPFS), increases in payment for physician services in a given year will require across-the-board decreases in payment for all physicians.
CF	**Conversion Factor** Conversion Factor is a figure used to determine the Medicare payment to a physician. The dollar amount assigned to the CF is calculated annually to achieve budget neutrality.
CMS	**Centers for Medicare & Medicaid Services** The Centers for Medicare & Medicaid Services is the federal agency within the United States Department of Health and Human Services (HHS) that administers Medicare, Medicaid, Children's Health Insurance Programs (CHIP) and health insurance portability standards.
E/M	**Evaluation and Management** Evaluation and Management (E/M) codes are used by physicians to bill for E/M services. These services could include a patient visiting a physician in an office, hospital or other health care facility to evaluate and manage that patient's medical needs.
FFS	**Fee-for-Service** Under Medicare fee-for-service, or traditional Medicare, physicians are paid separately for each service rendered to patients. Fee-for-service differs from Medicare Advantage (private insurers who contract with CMS) or alternative payment models, such as value-based or bundled payments.
GLOBALS / GLOBAL PAYMENT	**Globals / Global Payment** A single fee covering the physician costs of performing surgery or other procedures, plus related care provided before the surgery, and follow-up care within a 10- or 90-day timeframe. Medicare allocates a number of post-operative days to a procedure, based on the procedure's severity, and each global service is valued to include a specific number and type of post-operative E/M service.
GPCI	**Geographic Practice Cost Index** Medicare Physician Fee Schedule pricing is adjusted to reflect the variation in practice costs from area to area. CMS incorporates a geographic practice cost index (GPCI) into the resource-based relative value scale (RBRVS) used to determine physician payment in order to account for regional economies.
MA	**Medicare Advantage** Medicare Advantage (sometimes called Medicare Part C or MA) is a type of health insurance plan in the United States that provides Medicare benefits through a private-sector health insurer. In 2020, about 40% of Medicare beneficiaries were covered under Medicare Advantage plans.
MACRA	**Medicare Access and CHIP Reauthorization Act** The Medicare Access and CHIP Reauthorization Act, sometimes called the "Doc Fix," changed how the federal government pays physicians. The law permanently repealed the sustainable growth rate (SGR) — the previous system for reimbursing physicians in Medicare fee-for-service — and set up the two-track quality payment program (QPP) that emphasizes value-based payment models.

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MPFS	**Medicare Physician Fee Schedule** The Medicare Physician Fee Schedule is the fee-for-service system under which physicians and other health care professionals are paid. It provides more than 10,000 physician services with: • The associated relative value units (RVUs) • A fee schedule status indicator • Various payment policy indicators needed for payment adjustments (i.e. payment of assistant at surgery, team surgery, bilateral surgery, etc.)
PAYGO	**Pay-As-You-Go** PAYGO is a budget rule that Congress uses to ensure spending increases do not increase the budget deficit. For example, if Congress wants to pay for a new program, it must find a place in which to cut funding.
PTAC	**Physician-Focused Payment Model Technical Advisory Committee** The Physician-Focused Payment Model Technical Advisory Committee is an independent federal advisory committee that makes recommendations to the Secretary of Health and Human Services (HHS) on stakeholder-submitted physician-focused payment models and other related topics.
RBRVS	**Resource-Based Relative Value Scale** The Resource-Based Relative Value Scale is a methodology used by the Centers for Medicare & Medicaid Services and private payers to determine physician payments for services. The federal government established the scale in 1992 to standardize the way Medicare paid physicians for patient care. The RBRVS is comprised of three categories of relative value units (RVUs) — physician work, practices expenses and malpractice expenses.
RVUs	**Relative Value Units** Relative Value Units are the basic component of the Resource-Based Relative Value Scale (RBRVS), and they are divided into three components: • Physicians work • Practice expenses • Malpractice expenses RVUs do not directly define physician compensation in dollar amounts, but define the value of a service relative to all other services.
SEQUESTRATION	**Sequestration** Sequestration is the automatic reduction of certain federal spending, generally by a uniform percentage. Sequestration is currently used as an enforcement mechanism for three budget enforcement rules created by the Statutory Pay-As-You-Go Act of 2010 and the Budget Control Act of 2011. Medicare funding is impacted by any sequestration order.
UNITS (ANESTHESIA)	**Units (Anesthesia)** Anesthesia units are the basic components of Medicare's payments for anesthesia services: • Base units • Time units Base units reflect the relativity of the service to other anesthesia services and are combined with a patient status modifier and time units for total procedure units.