

PRESSURES ON THE SYSTEM THAT NEED TO BE ADDRESSED

MODERNIZING THE MEDICARE PHYSICIAN PAYMENT SYSTEM

FIVE PRIMARY FACTORS HAVE PREVENTED THE MEDICARE PAYMENT SYSTEM FROM ENSURING PATIENTS RECEIVE THE BEST CARE

1 BUDGET NEUTRALITY

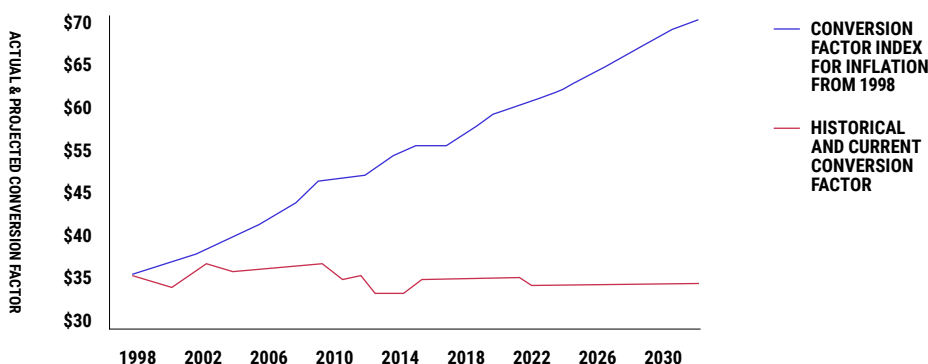
Budget neutrality requires spending on Medicare to have no budgetary impact. Increases in payment for physician services in a given year will require across-the-board decreases in payment for all physicians. This does not take into consideration the varying costs associated with performing these services.

2 INFLATION

Unlike hospitals and nursing homes, investments in physicians lack an automatic annual update and Medicare payments have failed to keep pace with inflation, resulting in a real-world decrease year after year. The cost of running a medical practice has increased 39% between 2001 and 2021. When adjusting for inflation, Medicare payments have actually declined 20% during this same period. The proposed CY 2023 conversion factor is significantly lower than the rate of \$36.6873 paid in 1998 and trending towards the \$31.0010 CF in place in 1992 when CMS first implemented the MPFS.

While Medicare updates to hospital payment have increased roughly 60% over the last two decades, physician payments only increased by 11%. On top of this, high inflation across the economy-at-large has raised operational and staffing costs for health care providers.

ESTIMATED POLICY IMPACTS ON MEDICARE PFS PAYMENTS



TERMS AND DEFINITIONS:

CF Conversion Factor

The conversion factor is a national dollar multiplier that is applied to the geographically adjusted relative value units (RVUs).

That figure is then used to determine the Medicare payment to a physician.

The dollar amount assigned to the CF is calculated annually to achieve budget neutrality.

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.)

PRESSURES ON THE SYSTEM THAT NEED TO BE ADDRESSED

3 STATUTORY PAY-AS-YOU-GO (PAYGO) CUT

Congress uses sequestration as an enforcement mechanism for three budget enforcement rules—one of which is PAYGO. Without congressional action by the end of 2022, Medicare sequestration funding cuts under PAYGO could occur in 2023. If the additional 4% PAYGO sequester is triggered in 2023, patients would be harmed by payment cuts to Medicare providers.

4 LACK OF AN EQUITABLE UPDATE TO BUNDLED SURGICAL SERVICES—GLOBAL CODES

Medicare law requires CMS to pay all physician specialties equally for the same E/M service, whether it is performed as part of a standard office visit or within the 10- or 90-day global surgical package – known as a global surgical payment code. CMS increased payments for E/M visits, but did not apply this increase to hospital and office visits provided as part of the global surgical codes. This creates specialty differentials by paying physicians differently for the same work.

5 SEQUESTER CUT

Sequestration is the automatic reduction of certain types of spending in the federal budget. The Budget Control Act of 2011 was passed to reduce the deficit and included a requirement of 2% annual cuts to Medicare payments. While Congress temporarily suspended these cuts, the full 2% sequester took effect on July 1.

TERMS AND DEFINITIONS:

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.

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.