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Medicare Physician Fee Schedule 2016 Updates

In November 2015, many healthcare providers were surprised to learn that Medicare payments for all physician services would receive a small cut for calendar year 2016.[1] Only a few months before, physicians had celebrated the passage of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA). MACRA removed the threat of a massive cut and promised a small increase to Medicare's physician payments in 2016.[2] However, provisions from other, lesser-known laws included reductions sufficient to override the raise included in MACRA.[3] This Health Capital Topics article will explore Medicare physician reimbursement for 2016—including these additional provisions and their ultimate impact on physician practices.

Physicians who furnish healthcare services to Medicare beneficiaries are paid for their efforts under the *Medicare Physician Fee Schedule* (MPFS). MPFS is a *fee-for-service* (FFS) payment system that seeks to reimburse physicians based on the resources that providers expend in order to deliver healthcare services.[4] In order to represent the resources expended in the provision of any given service, the *Centers for Medicare and Medicaid Services* (CMS) utilizes three categories of *Relative Value Units* (RVUs): (1) *physician work* RVUs (wRVUs), which represent a provider's labor expense associated with any given procedure; (2) *practice expense* RVUs (PE RVUs), which represent the equipment and overhead necessary to provide any given procedure; and, (3) *malpractice expense* RVUs (MP RVUs), which represent the costs of professional liability insurance associated with the provision of any given procedure.[5] Further, when calculating payments under the MPFS, CMS adjusts each of the three RVU components using *geographic practice cost indices* (GPCIs), which modify the wRVUs, PE RVUs, and MP RVUs to reflect geographic variations in the price of these resources.[6]

After each of the three RVU components are individually adjusted for local market conditions, the geographically adjusted RVUs are summed, and then converted into a dollar amount by multiplying the total RVUs by a *conversion factor* (CF).[7] It should be noted that, with limited exceptions, the CF applies to all physician services that are reimbursed under the MPFS, allowing CMS to make global adjustments to Medicare expenditures for all physician services, regardless of an individual physician's specialty or locality.[8] As part of the annual revisions to the MPFS, CMS updates the CF, which until recently was determined by a statutory formula.[9] However, in April 2015, Congress passed MACRA, which specifies a predetermined schedule of updates to the MPFS CF.[10] For the years 2016 through 2019, MACRA calls for annual 0.5% updates to the MPFS CF,[11] which may lead observers to assume that, independent of adjustments to the RVUs and GPCIs associated with individual procedures and localities (respectively), Medicare payments to physicians will rise by 0.5% every year for the next several years.

However, MACRA is not the only legislation that contributes to the determination of the updates to the MPFS CF. In November 2015, CMS released the 2016 MPFS final rule. Rather than *increasing* the MPFS CF by 0.5%, as set out in MACRA, CMS finalized a 2016 MPFS CF of $35.8279, approximately 0.3% *lower* than the 2015 MPFS CF.[12] This result is a product of three separate updates to the MPFS CF: (1) the 0.5% increase scheduled by MACRA; (2) a 0.02% reduction resulting from a *"budget neutrality adjustment"* (a simple bookkeeping procedure to reduce the volatility of changes in Medicare expenditures); and, (3) a 0.77% reduction, which is a result of provisions in the *Patient Protection and Affordable Care Act* (ACA), the *Protecting Access to Medicare Act of 2014* (PAMA), and the *Achieving a Better Life Experience Act of 2014* (ABLE).[13]

The original ACA provision, which was modified by both PAMA and ABLE, requires CMS to reassess the *Relative Value Units* (RVUs) associated with individual procedures that may be overvalued or undervalued.[14] PAMA's modification to the ACA provision introduced a *target recapture amount*, which is equal to the difference between a statutory percentage of MPFS expenditures and the reduction in MPFS expenditures resulting from CMS's modifications to misvalued codes.[15] For each year from 2017 to 2020, PAMA set the statutory target at 0.5% of MPFS expenditures.[16] Further, ABLE's additional modification to the ACA provision accelerated the implementation of the *target recapture amount*, modifying the program's effective period to begin in 2016 (rather than 2017) and end in 2018 (rather than 2020).[17] ABLE's modification also increased the target from 0.5% to 1.0% in 2016.[18] The result of the aforementioned provisions of the ACA, PAMA, and ABLE is that in 2016, CMS is required by statute to reduce the MPFS CF by an amount equal to

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the difference between 1.0% of MPFS expenditures and the reduction in MPFS expenditures resulting from CMS's modifications to misvalued codes.[19]

Through 2015, CMS has utilized this process of re-valuing individual procedures to reduce Medicare expenditures on physician services by 0.23%.[20] This is 0.77% short of CMS's congressionally-mandated 1.0% target for 2016, and as such, CMS is required to reduce the MPFS CF by the remaining 0.77%.[21] Taken together, the 0.5% increase mandated by MACRA, the 0.02% reduction resulting from a budget neutrality adjustment, and the 0.77% reduction resulting from the ACA, PAMA, and ABLE, result in a 0.29% reduction to the MPFS CF, reducing it from $35.9335 in 2015 to $35.8279 in 2016.[22]

It is important to note that although CMS has only reduced *Medicare* payments as a result of this rule, physicians may also receive a payment cut from third-party payors. This is because the Medicare program accounts for such a large portion of healthcare payments that it often acts as a *price setter* in the market for healthcare services.[23] In short, commercial payors often follow where Medicare leads, indicating that a reduction in Medicare's physician payments could extend to other sources of physician reimbursement.

Ultimately, physicians will receive a reduction to their Medicare payments for 2016. While this cut is small, it may be significant, due its deviation from the *"promised"* pay raise that physicians were expecting as a result of MACRA, as well as the implications of Medicare's payment policies for commercial reimbursement. Physicians would benefit from monitoring the CMS release of the proposed rules regarding physician reimbursement for calendar year 2017 as well as study its potential implications upon their release this summer.

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5 MedPAC, October 2015, p. 1-2.
6 *Ibid*, p. 2.
7 CMS, December 2014, p. 2-3.
8 "Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System" By Jim Hahn, Congressional Research Service, Report for Members and Committees of Congress, June 12, 2014, http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/R40907_gb.pdf (Accessed 4/28/2015) p. 2.
9 CMS, December 2014, p. 3.
10 "Medicare Access and CHIP Reauthorization Act of 2015" Pub. L. No. 114-10, § 512, 129 Stat. 87, 89-90 (April 16, 2015).
11 *Ibid*, p. 90.
12 "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rule" Federal Register Vol. 80, No. 220 (November 16, 2015) p. 70885, 71357.
13 *Ibid*; Lowes, November 3, 2015.
14 "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, § 3134, 124 Stat. 119, 434 (March 23, 2010).
15 "Protecting Access to Medicare Act of 2014" Pub. L. No. 113-93, § 220, 128 Stat. 1040, 1073 (April 1, 2014).
16 *Ibid*.
17 "Achieving a Better Life Experience Act of 2014" Pub. L. No. 113-295, Division B, § 202, 128 Stat. 4056, 4065 (December 19, 2014).
18 *Ibid*.
19 Federal Register Vol. 80, No. 220, November 16, 2015, p. 70885, 71357; Robert Lowes, November 3, 2015.
20 Federal Register Vol. 80, No. 220, November 16, 2015, p. 70885, 71357.
21 *Ibid*.
22 *Ibid*.
23 "Medicare's Role in Determining Prices throughout the Health Care System: Mercatus Working Paper" By Roger Feldman et al., Mercatus Center, George Mason University, October 2015, http://mercatus.org/sites/default/files/Feldman-Medicare-Role-Prices-oct.pdf (Accessed 12/11/2015), p. 3-5.

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