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What Will Medicare Reimbursement Look Like in 2013?

By Matt Zaborski, Regional Account Executive

With the recent announcement of cuts to the Technical Component (TC) of multiple surgical pathology services, Independent Laboratories and hospital based pathology groups nationwide are facing a reality of decreased reimbursement for services provided. Determining the final damage to your bottom-line is impossible, as there are still 4 separate scheduled events, which are slated to take effect on or around January 1, 2013 and can negatively affect payment. These include:

1. Cuts in provider payments due to sequestration
2. GPCI Floor
3. Adjustment to the Medicare conversion factor (SGR)
4. Implementation of RVU changes

Factor 1: Sequestration

As part of the Budget Control Act (BCA), enacted in 2011, Congress and the President authorized a sequestration order, which allows for across the board cuts in virtually every federal program if Congress and the President failed to agree on long-term cuts in federal spending totaling $1 Trillion. To date, an agreement on spending reductions has not been reached, triggering the sequestration process called for in the BCA. In order to reach the reductions called for in the BCA, defense and non-defense programs will require budget reductions of approximately 8%.

Medicare spending is covered under the BCA agreement; however, Congress and the President did place a cap on the percentage of reduction applied to Medicare at 2%. Total cuts to physician payments will total around $11 Billion, once this reduction comes into effect as the law also stipulates that spending reductions must come from **provider payments** and cannot come from reductions in Medicare benefits or increases in beneficiary out-of-pocket expenditures. The 2% cut to provider payments will take place on January 2, 2013, unless Congress intervenes to prevent the sequestration.

Factor 2: GPCI Floor

Under current law, CMS develops Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average. Each component that makes up the RVU; physician work, practice expense and malpractice, is then multiplied by this GPCI to determine the total RVU for each CPT; which is multiplied by a conversion factor to ultimately determine payment.

It is generally acknowledged that there are cost differences from locality to locality around the country, however many Members of Congress have objected to the GPCI's that apply in their areas arguing that it artificially drives down Medicare payments for certain providers, which can make it difficult to attract and retain physicians in "low-cost" areas. This goes noticed in areas where the GPCI multiplier is less than 1, which can result in payments below the Fee Schedule amount. As a result, a "floor" was put into place so that no locality adjustment would result in lower payments than the fee schedule amount. This allows for higher payment levels still in "high-cost" areas, but does not allow the GPCI to fall below 1 for any locality.

On December 31, 2012, the law authorizing the GPCI floor is set to expire, unless Congress votes to extend it. CMS did not propose any changes to the data or methodology used to calculate GPCI, but 2013 is the final year of the current methodology. CMS does intend to propose revisions next year (2014).

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Factor 3: Adjustments to Medicare Conversion Factor

To determine Medicare's reimbursement for any CPT code, a total RVU for the CPT is multiplied by the Conversion Factor (CF). Each year, by law, the CF is supposed to be adjusted for medical inflation using the Medicare Economic Index (MEI); however, law also stipulates that if the growth in total physician payments in the current calendar year increases more than what had been budgeted, physician payments next year must be reduced to account for "faster than expected" growth. This is known as the Sustainable Growth Rate (SGR) adjustment.

Authorized in 1997, the SGR is a formula for controlling volume growth and it appeared to be working well over the first 5 or 6 years. Use of the SGR was allowing for physicians to receive annual increases that appeared to be in line with the cost of operating a medical practice. In 2002, the SGR formula projected a negative adjustment for the next year, for the first time. This would provide lower payments for the same service in the 2003 vs. 2004 calendar year. Congress intervened to override the formula, but not without a cost.

With this intervention, Medicare's expenditures were above what had been budgeted for the year and Congress was required by law to made reductions to account for the higher than budgeted physician payments. In lieu of such cuts, Congress issued a legislative IOU and said they will come up with the money to pay for the 2003 SGR fix in 2004. This never happened and over the past 8 years the SGR formula has consistently resulted in a cut in physician fee schedule payments and Congress has consistently intervened to prevent the cuts from taking place, writing additional IOU's totaling several hundred million dollars.

For calendar year 2012, the MEI adjustment should have allowed for an across the board increase of 0.6%. Due to growth in Medicare Part B spending increasing higher than budgeted, the MEI increase was eliminated and the cost of previous year's cumulated "SGR fix" is estimated to lead to a 26.5% reduction in physician fee schedule payments. This will take effect January 1, 2013; unless Congress acts. If there is no action, the CF for 2013 will adjust to $28.8441, down from $34.0376 in 2012.

Factor 4: Implementation of RVU Changes

In 2012, CMS and the specialty societies conducted a review of the physician work component of RVU's for all CPT codes. The work RVU is a factor (along with practice expense and malpractice expense values) used to determine total RVU's assigned to each CPT code. Under current procedures, this total RVU is then multiplied by a GPCI and CF to determine reimbursement. Every 5 years, CMS completes a review of the "physician work" component of the RVU and makes adjustments to the codes to reflect the changes. This code review is used to determine if physicians work more or less to produce a unit of service or if physicians have become more efficient over the last 5 years.

CMS works with specialty societies to conduct the review on the physician work component of RVU's for each CPT. This system seeks to establish relativity amongst various code values. This means that when a code goes up in value, it almost always results in another code (typically in another specialty) to go down in value; as a means to maintain revenue neutrality. The final results have not been released to date, but any changes in work RVU value will affect total reimbursement and is independent of the SGR and other factors indicated in this article.