Weekly Checkup

Didn't We Fix the Doc Fix?

JOHN WALKER | OCTOBER 11, 2024

If you thought Congress had finally taken care of the "doc fix" issue, I have some bad news. In early June, the Centers for Medicare and Medicaid Services (CMS) announced a 2.8-percent cut to Medicare provider payments. As with the past five years, unless Congress acts to pass a last-minute override, providers will receive a significant hit to their Medicare payments.

First, the history: **The Medicare "doc fix" was a temporary legislative fix undertaken 17 times between 2003 and 2014 to block the implementation of provider reimbursement cuts.** Finally, in 2015, Congress acted to fix this issue by replacing the flawed sustainable growth rate (SGR) – a formula designed to calculate annual Medicare physician fee schedule (MPFS) updates, but which was frequently outpaced by the rapid growth in health care costs – with a new merit-based incentive payment system (MIPS) in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This system came with a new formula that could more accurately translate private-sector price to Medicare using a flat Medicare conversion factor and a relative value unit (RVU) tied directly to the value of a service. But **while MACRA changed a lot, it ultimately failed to prevent provider reimbursement cuts.** The underlying issue is a 35-year-old statute buried in the Omnibus Budget Reconciliation Act of 1989 – the budget neutrality provision (more on this below) – which has the effect of cutting providers' Medicare payments if CMS overvalues a service.

To understand how the budget neutrality provision has gone awry, we first need to understand how MACRA was crafted. When Medicare pays a provider, it multiplies a geographically adjusted RVU by the Medicare conversion factor to determine how much it will pay a provider for a given service. What's important to understand about RVUs is that because they are tied to a direct service, rather than applied broadly, **RVUs can significantly fluctuate each year based on changes to billing codes, new market innovations, and what CMS determines as the relative value (mostly determined by the level of utilization) of a given service.**

While the RVU system is effective, the real issue arises when it's applied to Medicare and becomes subject to that budget neutrality provision mentioned earlier. Per the statute, should total Medicare spending increase or decrease by more than $20 million, CMS is required to adjust service prices to reach budget neutrality (often by altering the Medicare conversion factor). This means that **if CMS overestimates the relative utilization of a service and preemptively cuts prices, services are *still* locked in at that given price, leaving providers to absorb the costs if utilization is lower than expected.** This interplay often results in relatively low-priced, high-volume services such as physician visits generally receiving cuts, while high-priced, low-volume services such as surgery receive increases.

If any of that explanation confused you, here's the gist: **Twice now, Congress has tried a formulaic approach to setting doctors' payments in Medicare. Twice now it has failed. It has the option to either try for a third time or consider a different approach.**