Medicare Payment
Advisory Commission

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July 12, 2024

The Honorable Sheldon Whitehouse
The Honorable Bill Cassidy, M.D.
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Whitehouse and Cassidy,

Thank you for the opportunity to respond to the Request for Information (RFI) on primary care provider payment reform issued on May 15, 2024. The Commission agrees that it is critically important to improve Medicare's clinician payment policies to ensure beneficiaries' access to primary care while promoting good value for Medicare's resources.

Over the past two decades, MedPAC's work on improving the provision of primary care services has focused on issues related to inaccuracy of payments in Medicare's physician fee schedule (PFS) and on supporting value-based models for care delivery. Below, we highlight selected publications and recommendations related to each of these areas.

Payment rates for different services under the fee schedule are based on relative weights, called relative value units (RVUs), which account for the amount of work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. Work RVUs are based on an assessment of the amount of time and intensity that services require relative to one another. Over time, these values can become inaccurate, particularly for procedures. For example, when a new procedure is first introduced, it may require a lot of time and intensity to perform. Eventually, physicians may become more experienced, and thus more efficient, at performing it. If estimates of the time and intensity are not updated to reflect that change in efficiency, Medicare's valuation of the service will be too high relative to other services.

To establish work RVUs for specific services, CMS relies on recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (the RUC). Problems with the data and approaches used by the RUC to arrive at values for

services are well documented.[1,2,3,4,5] The RUC's recommendations are informed, in part, by estimates provided by clinicians surveyed by specialty societies. Clinicians who complete these surveys have a financial incentive to inflate their estimates of the time and intensity associated with the services being valued, which raises concerns about bias in the data. In addition, these surveys typically have low response rates and a low total number of responses, which raises questions about the representativeness of the results. The flawed data and other problems with the valuation process have resulted in misvalued billing codes. Studies have shown that the amount of time the fee schedule assumes is needed to deliver a service is often quite different from the amount of time clinicians actually spend delivering the service.[6]

Misvalued services in the fee schedule can have several adverse effects. First, when codes are overvalued, Medicare pays more than it should for them, as do beneficiaries in their cost sharing. Second, misvaluation creates incentives for clinicians to provide more of the overvalued services and less of the undervalued ones, potentially affecting the amount and type of care that patients receive. Over time, if certain types of services become undervalued relative to others, the specialties that perform those services may become less financially attractive, which can affect the supply of physicians in certain specialties.

In our March 2006 report to the Congress, after finding that the RUC usually did not reduce the values of codes it reassessed, the Commission recommended that CMS take a lead role in identifying misvalued services for the RUC to revalue.[7] We recommended that the Secretary establish a standing permanent panel of experts to help CMS identify overvalued services and review recommendations from the RUC. We further specified that the standing panel of experts should include members with expertise in health economics and physician payment, as well as members with clinical expertise. And the Commission recommended that the Secretary ask the RUC to review and, if needed, update the values of services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may indicate changes in

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[1] Government Accountability Office. 2015. *Medicare physician payment rates: Better data and greater transparency could improve accuracy.* GAO-15-434. Washington, DC: GAO.
[2] Medicare Payment Advisory Commission. 2006. "Reviewing the work relative values of physician fee schedule services," in *Report to the Congress: Increasing the value of Medicare.* Washington, DC: MedPAC.
[3] Medicare Payment Advisory Commission. 2018. "Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services," in *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[4] Berenson, R.A., P. B. Ginsburg, K. J. Hayes, et al. 2022. Comment letter on the CY 2023 Medicare physician fee schedule proposed rule. September 2. https://www.urban.org/sites/default/files/2022-09/Medicare%20Physician%20Fee%20Schedule%20Comment%20Letter.pdf.
[5] Medicare Payment Advisory Commission. 2011. "The sustainable growth rate system: Policy considerations for adjustments and alternatives," in *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[6] Medicare Payment Advisory Commission. 2024. "Approaches for updating clinician payments and incentivizing participation in alternative payment models," in *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[7] Medicare Payment Advisory Commission. 2006. "Reviewing the work relative values of physician fee schedule services," in *Report to the Congress: Increasing the value of Medicare.* Washington, DC: MedPAC.

physician work, as well as services that are new and likely to need to be revalued over time as clinicians become more familiar with a service and more efficient at furnishing it. We also recommended that the relative values of all services be reassessed periodically since some codes have not been reassessed after their initial valuation.

In October 2011, the Commission recommended that the Secretary improve the accuracy of Medicare's fee schedule by regularly collecting data from a cohort of efficient clinician practices and using those data to reduce payments for overpriced services.[8] The Commission discussed how participating clinician practices and other health care settings could be identified through a process that would require participation in data reporting among those selected, thus reducing concerns with selective participation. The cohort of providers would consist of clinician practices with a range of specialties, practitioner types, patient populations, and furnished services to ensure broad clinician representation.

The Commission continued working on improving payment accuracy in the fee schedule in our June 2018 report to the Congress.[9] In this report, the Commission described a budget-neutral approach to rebalance the fee schedule that would increase payment rates for ambulatory evaluation and management (E&M) services while reducing payment rates for other services (e.g., procedures, imaging, and tests). Under this approach, the increased payment rates would apply to ambulatory E&M services provided by all clinicians, regardless of specialty. In 2021, CMS increased the payment rates for office and outpatient E&M visits, based on the recommendation of the RUC and consistent with the goals of our June 2018 report. The increase for E&M services was substantial. The Commission will continue to monitor the effects of this increase, as well as other changes to the fee schedule.

Recognizing that changes to fee schedule payment rates alone may be insufficient to adequately promote coordinated, high quality and efficient care, the Congress created new incentives for clinicians to participate in payment models called advance alternative payment models (A-APMs) in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Commission asserts that, designed correctly, APMs offer a promising avenue for lowering fee-for-service spending while preserving or improving care quality. Thus in June 2021, we recommended that the Secretary implement a more harmonized portfolio of fewer APMs that are designed to work together.[10] The Commission continued this work in our June 2022 report to the Congress, in which we described options for operationalizing a harmonized APM portfolio.[11]

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[8] Medicare Payment Advisory Commission. 2011. Letter to congressional leaders re: moving forward from the sustainable growth rate (SGR) system. Washington, DC: MedPAC.
[9] Medicare Payment Advisory Commission. 2018. "Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services," in *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[10] Medicare Payment Advisory Commission. 2021. "Streamlining CMS's portfolio of alternative payment models," in *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[11] Medicare Payment Advisory Commission. 2022. "An approach to streamline and harmonize Medicare's portfolio of alternative payment models," in *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

We appreciate the opportunity to discuss the importance of primary care for Medicare beneficiaries, and we remain available to assist the Committee as you work to support Medicare beneficiaries' access to high-quality clinician care.

Sincerely,

Michael Chernew, Ph.D.
Chair