MEDPAC

Advising the Congress on Medicare issues

Reforming physician fee schedule updates and improving the accuracy of relative payment rates

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March 6, 2025

Presentation roadmap

1. Background
2. Concerns with future fee schedule updates
3. Chair's draft recommendation to reform fee schedule updates
4. Concerns with the accuracy of the fee schedule's relative payment rates
5. Chair's draft recommendation to improve the accuracy of relative payment rates
6. Commissioner discussion and feedback

Background

Physician fee schedule

- Pays for about 9,000 different clinician services
  - Provided in a wide variety of settings (e.g., offices, hospitals)
  - Can be discrete services or a bundle of services (e.g., surgery and postoperative visits)
- Payment rates for fee schedule services are determined based on RVUs, the conversion factor, and other adjustments
- RVUs vary across services, can change based on where a service is provided, and are broken down into three components:
  - Work
  - Practice expenses—direct and indirect
  - Malpractice
- RVUs are multiplied by a conversion factor to calculate a payment amount

Note: RVU (relative value unit).

MACRA provides specified updates to physician fee schedule payment rates

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026-on
Fee schedule updates						**+3.75% this year only**	**+3.0% this year only**	**+2.5% this year only**	**+1.25% and then 2.93% this year only**		**0.25%** or **0.75% if in A-APM**
	0.5% per year			**0.25%**	**0% per year**						

Notes: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), A-APM (advanced alternative payment model). Fee schedule updates for 2021 through 2024 apply for one year only and are not incorporated into the following year's conversion factor. In 2024, fee schedule rates were updated by 1.25% through March 8, 2024, and then were instead updated by 2.93% from March 9, 2024, through December 31, 2024. Statutory changes to MACRA's original provisions are shown in orange.

Source: MedPAC analysis of MACRA and subsequent legislation.

Commission principles for assessing the adequacy of physician fee schedule rates

- Principles for assessing payment adequacy:
  - Ensure beneficiary access to care
  - Reflect efficient care delivery
  - Promote high-quality care
- Payment rates should also reflect good stewardship of taxpayer resources
- From 2016 to 2022, the Commission recommended current-law updates in its annual reviews of payment adequacy
- From 2023 to 2025, the Commission recommended updates of:
  - A portion of the growth in the MEI (a common inflation metric for clinician services)
  - Safety-net add-on payments for treating low-income beneficiaries

Note: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), MEI (Medicare Economic Index).
Source: MedPAC annual March reports to the Congress.

Medicare beneficiary access to care has been comparable with the privately insured over many years

Key measures of access to care

- Survey data suggest beneficiaries' access to care is comparable with that of the privately insured
- Clinicians accept Medicare at rates similar to commercial insurance despite lower payment rates from Medicare
- Volume and intensity of care per beneficiary has increased

Longer-term indicators of access

- The number of applicants to medical schools has grown
- The number of clinicians billing the fee schedule has increased substantially
- Clinician incomes have kept pace with inflation over the long term

Source: MedPAC annual March reports to the Congress, medical school application data from the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, and Gottlieb, J. D., M. Polyakova, K. Rinz, et al. 2023. *Who values human capitalists' human capital? The earnings and labor supply of U.S. physicians*. NBER working paper no. 31469. Cambridge, MA: National Bureau of Economic Research.

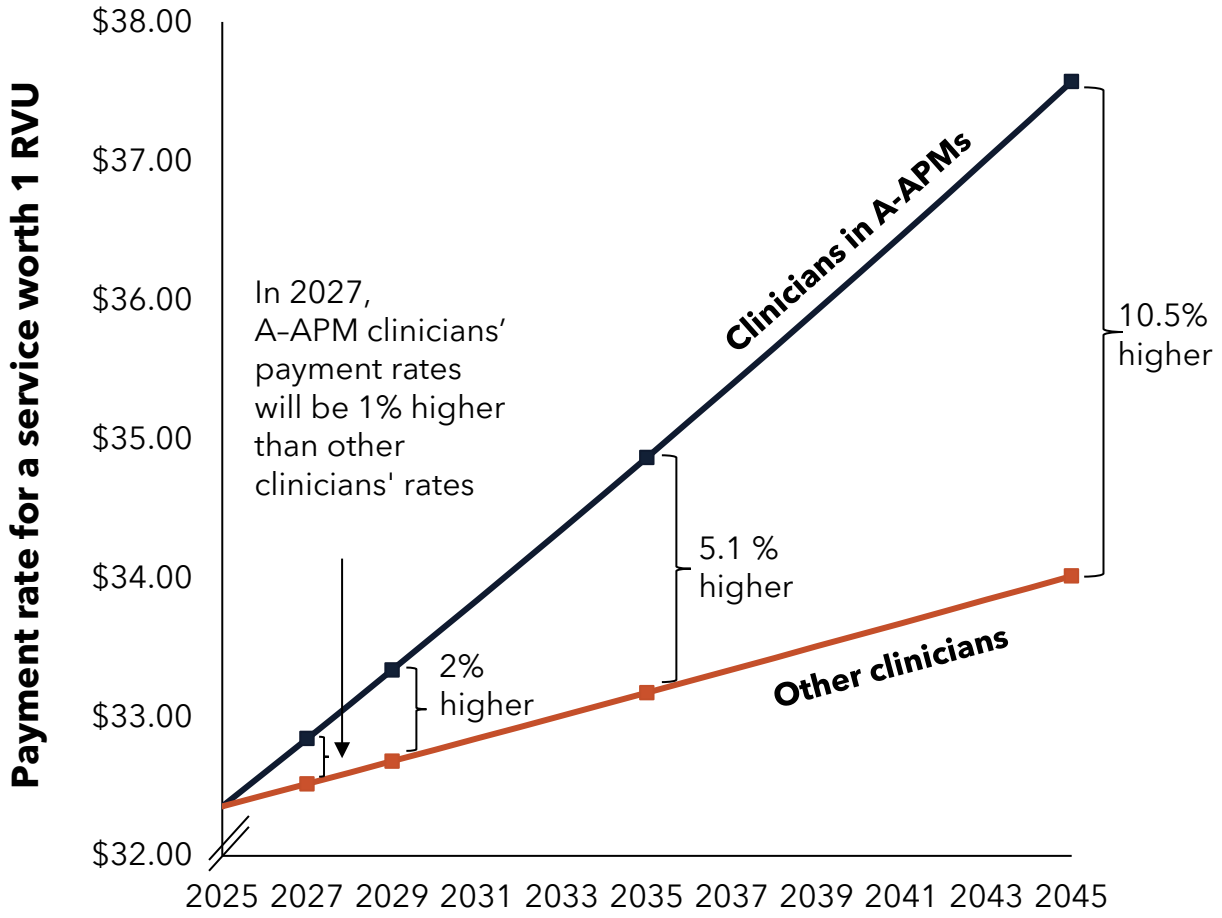
Concerns with current physician fee schedule updates

Concern 1: MEI growth is projected to exceed fee schedule updates by more than it did in the past

- MEI growth outpaced fee schedule updates by just over 1 percentage point per year for the two decades prior to the pandemic in 2020
- MEI growth likely substantially exceeded updates from 2020 to 2025
- From 2025 to 2034, the average annual difference between projected MEI growth and current-law fee schedule updates is larger than prepandemic:
  - 1.5% per year for clinicians in A–APMs
  - 2.0% per year for clinicians not in A–APMs
- Historically, the Commission has found that Medicare beneficiaries have similar access to care relative to the privately insured, but the larger gap between MEI growth and PFS updates could negatively affect access in the future

Note: MEI (Medicare Economic Index), PFS (physician fee schedule), A–APM (advanced alternative payment model).

Concern 2: Differential updates will provide an incentive to participate in A–APMs that is very small and then very large



- Differential updates for clinicians in A–APMs vs. others (0.75% vs. 0.25%) will produce incentives to participate in A–APMs that grow over time:
  - 2020s: Very small incentive
  - 2040s: Very large incentive

Note: A–APM (advanced alternative payment model), RVU (relative value unit). Graph does not show expiration of 2% sequester.

Source: MedPAC analysis of current law.

Commission has discussed policy option to reform PFS updates

- Replace the dual PFS updates based on A–APM participation with a single update based on a portion of MEI growth
- The Commission has been broadly supportive of this approach over the last two years
- Policymakers could consider a range of reasonable options
  - E.g., MEI minus 1 percentage point with a minimum update floor
- Key concept: Historical evidence suggests that a full MEI update has not been needed to maintain access to care

Note: PFS (physician fee schedule), MEI (Medicare Economic Index), A–APM (advanced alternative payment model).

Rationale for updating PFS rates annually by a portion of MEI growth

- Intended to ensure continued beneficiary access to care while limiting financial burden on beneficiaries and taxpayers
- Updates based on a portion of MEI growth (e.g., MEI minus 1 percentage point) have multiple benefits:
  - Automatically adjust to changes in inflation
  - Improve predictability
  - Balance beneficiary access with beneficiary and taxpayer financial burden
  - Simple to administer
- The Commission would continue to monitor access to care each year and recommend higher or lower updates, as needed

Note: PFS (physician fee schedule), MEI (Medicare Economic Index).

Chair's draft recommendation 1

Chair's draft recommendation 1

The Congress should:

- Replace the current-law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (such as MEI minus 1 percentage point).

Implications

Spending

- Would increase program spending relative to current law

Beneficiary and provider

- Should maintain beneficiaries' access to care by maintaining or improving clinicians' willingness and ability to treat them
- Would increase cost sharing and premiums for beneficiaries

Concerns with the accuracy of the fee schedule's relative payment rates

Prior MedPAC work on accuracy of fee schedule RVUs

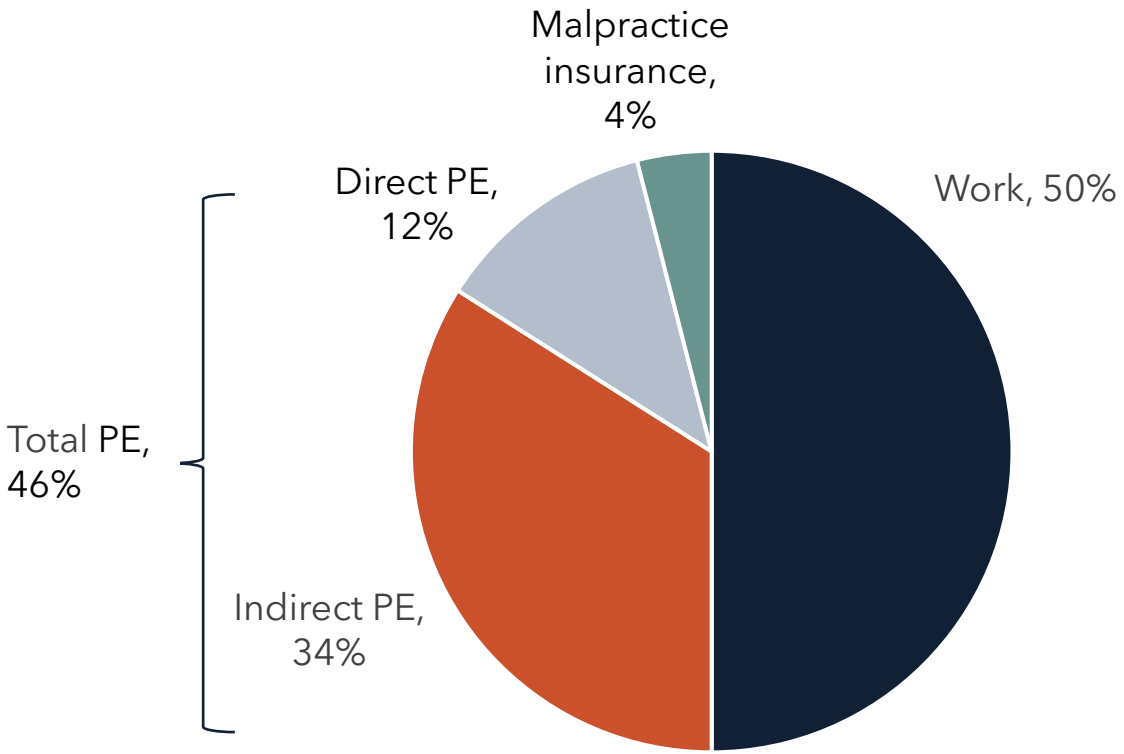
- Accuracy of RVUs is important because misvaluation has multiple effects
  - Can incentivize oversupply or undersupply of services
  - Can influence decisions about vertical consolidation
  - Non-Medicare payers are basing payments on misvalued codes
- Recommendations in 2006 and 2011
  - Establish expert panel to help CMS review recommendations from RUC
  - CMS should regularly collect data from cohort of efficient practices

Note: RVU (relative value unit), Relative Value Update Committee (RUC).

Additional concerns with accuracy of relative payment rates

- Timeliness and accuracy of data used to determine practice costs
- May not accurately reflect current practice patterns
- Does not account for whether a clinician maintains an independent practice or practice is owned by a hospital

How different types of costs are allocated among total fee schedule RVUs



- On average, 46% of a practice's total costs are devoted to practice expenses
  - 34% for indirect PE (overhead)
  - 12% for direct PE (medical equipment, supplies, and nonphysician clinical labor)
- Work accounts for 50%, and malpractice insurance accounts for 4%

Notes: Relative value unit (RVU), practice expense (PE).
Source: MedPAC summary of Actuarial Research Corporation analysis of 2023 Medicare claims and payment data.

Three illustrative examples of policies that could address concerns about relative values

- Updating allocation of work, practice expense, and malpractice insurance RVUs
- Improving the accuracy of global surgical payment codes
- Improving the accuracy of relative payments for indirect practice expense

- Not an exhaustive list

Note: RVU (relative value unit).

Example 1: Updating allocation of RVUs

- On an aggregate basis, allocation of work, PE, and MP RVUs should reflect distribution of practice costs across physician practices
- MEI cost shares are used as the basis for allocation of RVUs
- The most recent MEI uses 2017 data, but CMS continues to use MEI based on 2006 data to allocate RVUs
- Updating cost shares on a more regular basis would help ensure that RVUs reflect most up-to-date information about practice costs and would reduce chances that RVUs will experience large changes each time the MEI is updated

Note: RVU (relative value unit), PE (practice expense), MP (malpractice insurance), MEI (Medicare Economic Index).

Example 2: Improving the relative accuracy of global surgical codes

- Intended to pay for all care provided on day of procedure and postoperative visits with performing physician
- RVUs for these codes are based on assumptions about how many postoperative visits are furnished by performing clinician
  - Postoperative visits furnished by other clinicians are paid separately
- RAND studies show that for most global codes, performing clinicians furnish fewer postoperative visits than are assumed
- Approach A: Convert 10- and 90-day global codes to 0-day codes
  - Remove portion of global RVUs attributed to postoperative visits
- Approach B: Revalue global codes
  - Retain 10- and 90-day global codes but base RVUs on more accurate data about postoperative visits

Source: Crespin, D.J., et al. *Claims-based reporting of post-operative visits for procedures with 10- or 90-day global periods: Updated results using calendar year 2019 data.* Santa Monica, CA: RAND.

Example 3: Improving the accuracy of relative payment rates for indirect practice expenses

Type of payments for clinician services, by payment system and setting (current)

Type of payment	Office	Hospital	
	PFS nonfacility	PFS facility	OPPS
Work	✓	✓	
Indirect expenses	✓	✓	✓
Direct expenses	✓		✓
Malpractice insurance	✓	✓	

- Nonfacility RVU when service is performed in office setting
  - Indirect and direct PE
- Facility RVU when service is performed in facility setting (e.g., HOPD or ASC)
  - Indirect PE but not direct PE
- When service is furnished in HOPD, indirect PE is paid to both the clinician and the hospital

Note: OPPS (outpatient prospective payment system), RVU (relative value unit), PE (practice expense), HOPD (hospital outpatient department), ASC (ambulatory surgical center). Direct PE is included for certain facility services, such as global surgical codes.

Example 3, cont.: Growth in physician/hospital affiliations may necessitate new approach to payment for indirect PE

Ownership structure	Percentage of physicians	
	2012	2022
Wholly owned by physicians (private practice)	60.1%	46.7%
Direct hospital employee/contractor	5.6	9.6
At least some hospital ownership	23.4	31.4
Other	10.9	12.5

Note: PE (practice expense). "Other" ownership arrangements include managed care organizations, private equity, and nonprofit foundations. Components may not sum to 100% due to rounding.

Source: American Medical Association.

- Growing share of practices are owned by hospitals or physicians are employed by them
- Paying both clinicians and hospitals for indirect PE:
  - Could result in double payment
  - May encourage vertical consolidation
- Could exclude indirect PE from fee schedule facility payment if clinician is not financially independent from hospital

Example 3 cont.: Impact of reducing facility indirect PE for certain clinicians or services

- Impact depends on how policy is implemented
  - PE payments would decline by between $1 billion and $4.5 billion
- Decrease in payments for some services when furnished in a facility
  - Average reduction in total facility payments between 2% and 11% in simulations
- Reductions in payments would be redistributed to all other services
  - Average increase in total nonfacility payments between 1% and 7%
- Addressing duplicative payments by reducing indirect PE could:
  - Increase incentives to provide those services in a nonfacility setting
  - Reduce incentives for independent practices to consolidate with hospitals

Note: PE (practice expense).
Source: MedPAC summary of Actuarial Research Corporation analysis of 2023 Medicare claims data.

Chair's draft recommendation 2

Chair's draft recommendation 2

The Congress should direct the Secretary to improve the accuracy of relative payment rates for clinician services by:

- updating cost data regularly and
- ensuring that the methodology used to determine payment rates for different services reflects the settings in which clinicians practice medicine.

Implications

Spending

No expected effect on total program spending due to required budget-neutrality implementation

Beneficiary and provider

Could benefit beneficiaries by reducing incentives for clinicians to overprovide or underprovide certain services

Could have redistributive effects on payments to providers

Chair's draft recommendations

Chair's draft recommendation 1

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