PHYSICIAN AND OTHER HEALTH PROFESSIONAL PAYMENT SYSTEM

*payment***basics**

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The policies discussed in this document were current as of September 30, 2024. This document does not reflect proposed legislation or regulatory actions.

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Physician and other health professional services include office visits, surgical procedures, and a broad range of other services. These services are furnished in all settings, including physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, plus hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Among the almost 1.3 million clinicians who bill Medicare, 51 percent are physicians. The remainder includes health professionals such as nurse practitioners, physician assistants, and physical therapists.[1] These health professionals may bill Medicare independently or provide services under physician supervision.

Physician services are paid under Part B. Medicare program payments in 2022 for these services (about $70.9 billion) accounted for just under 17 percent of all Medicare fee-for-service (FFS) spending.

Medicare pays for physician and other health professional services based on a list of services and their payment rates, called the physician fee schedule. CMS determines the payment rate for each service based on the clinician work required to provide the service, expenses related to maintaining a practice, and professional liability insurance (PLI) costs. Payments are adjusted to account for variations in the input prices in different markets. Medicare's payment rates also may be adjusted based on provider characteristics, additional geographic designations, and other factors. Medicare pays the provider the final calculated amount, less any beneficiary cost sharing.

Defining the services Medicare buys

Under the physician fee schedule, the unit of payment is generally the individual service, such as an office visit or a diagnostic procedure. These range from narrow services (e.g., an injection) to broader bundles of services associated with surgical procedures, which include the surgery and related preoperative and postoperative visits. All services—surgical and nonsurgical—are classified according to the Healthcare Common Procedure Coding System (HCPCS), which contains codes for about 8,000 distinct services.

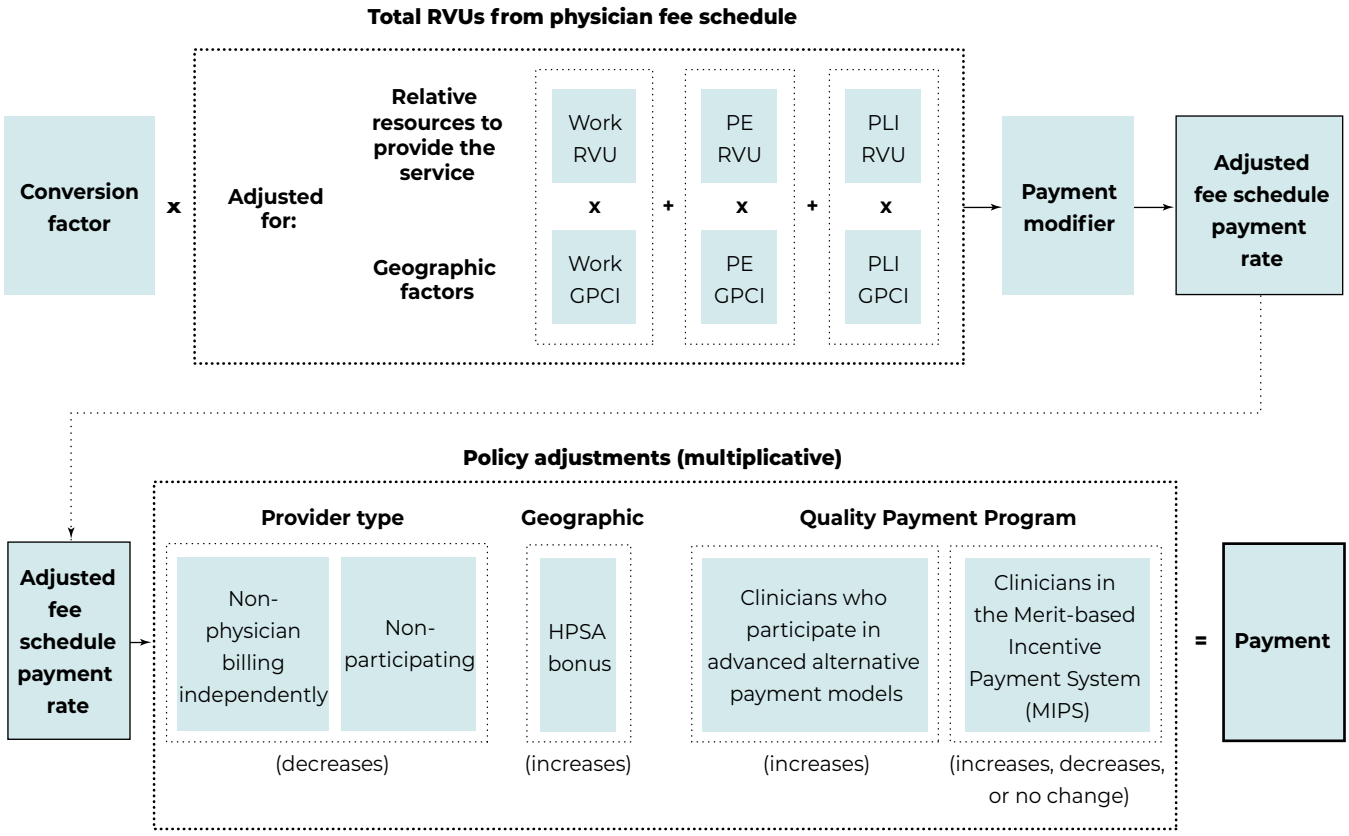
Setting the payment rates

Under the fee schedule, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide clinician services: clinician work, practice expenses, and PLI. The RVUs for clinician work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expenses are based on the cost of renting office space, buying supplies and equipment, and hiring nonphysician clinical and administrative staff. The PLI RVUs are based on the premiums clinicians pay for professional liability insurance, also known as medical malpractice insurance.

In calculating payment rates, each of the three RVUs is adjusted to reflect the price of inputs in the local market where the service is furnished. Separate geographic practice cost indexes (GPCIs) are used for this purpose. CMS determines the fee schedule payment amount by summing the adjusted weights and multiplying the total by a fixed dollar amount (the conversion factor, which is $33.29 at the end of 2024) (Figure 1).[2] For most fee schedule services, Medicare pays the provider 80 percent of the fee schedule amount. The beneficiary is liable for the remaining 20 percent coinsurance.

Through payment modifiers, Medicare may adjust its payment for a service because of special circumstances. For example,

Figure 1 Physician and other health professional payment system, 2024



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance), HPSA (health professional shortage area). This figure depicts Medicare program payments only. The fee schedule lists separate PE RVUs for facility and nonfacility settings. Fee schedule payments are often reduced when specified nonphysician practicioners bill Medicare independently but not when services are provided "incident to" a physician's service and billed under a physician's billing number. Clinicians who participate in advanced alternative payment models receive an incentive payment of 5 percent of their professional services payments. Clinicians in MIPS receive a positive or negative payment adjustment (or no change) based on their performance in four areas: quality, resource use, advancing care information, and clinical practice improvement.

physicians use a modifier to bill for a service when they assist in a surgery; payment for an assistant surgeon is 16 percent of the fee schedule amount for the primary surgeon. Other modifiers apply to multiple procedures performed for the same patient on the same day, preoperative or postoperative management without surgical care, and bilateral surgery.

There is a downward adjustment if services are furnished by certain nonphysician practitioners. For example, services billed independently by advanced practice registered nurses and physician assistants are paid at 85 percent of the full fee schedule amount. When nonphysician practitioners perform a service "incident to" a physician's service and the service is billed under the physician's billing number, Medicare pays the full fee schedule amount for the service as if the physician had personally furnished it.

Medicare also adjusts fee schedule payments downward when services are furnished by clinicians who are not in Medicare's participating provider program.[3] Payment rates for services provided by nonparticipating providers are 95 percent of the full fee schedule amount.

Physicians may receive higher payments for services they provide in underserved

areas. Physicians who provide services in health professional shortage areas (HPSAs) receive a 10 percent bonus payment. These payments are intended to attract more physicians to HPSAs.

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program for clinicians. Under this program, from 2019 through 2024, clinicians who participate in advanced alternative payment models (A–APMs) have received an incentive payment of 5 percent of their professional services payments. This incentive payment declines in size in subsequent years: In 2025, it will be worth 3.5 percent of clinicians' payments, and in 2026, it will be worth 1.88 percent of their payments.[4] Many other clinicians are subject to the Merit-based Incentive Payment System (MIPS) and receive a positive or negative payment adjustment (or no change) based on their performance in four areas: quality, cost, promoting interoperability, and improvement activities. The largest negative adjustment is always −9 percent and the largest positive adjustment is usually around +2 percent.[5] Both the A–APM incentive payment and MIPS adjustments apply for one year only and are not built into subsequent years' payment rates.

Updating payments

CMS reviews the RVUs of new, revised, and some potentially misvalued services annually. HCPCS codes and the conversion factor are also updated annually. The update of RVUs includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In updating the RVUs, CMS receives advice from a group of physicians and other health professionals sponsored by the American Medical Association and specialty societies.

The conversion factor is updated according to a schedule set by MACRA, which specified no update in 2024. However, the Consolidated Appropriations Act, 2024, overrode MACRA and mandated for 2024 a one-time increase in payments of 2.93 percent above what would have otherwise been in effect.[6] Since rates were originally supposed to be reduced by 4.6 percent due to budget-neutrality adjustments scheduled to take effect and expiration of the temporary 2.5 percent increase, rates instead were reduced by a net of 1.77 percent for 2024. In 2025, MACRA specifies no update to payment rates, and the 2.93 percent temporary increase in effect during 2024 will expire. When a small budget-neutrality adjustment is factored in, the net result will be a 2.8 percent decrease in the conversion factor in 2025. ■

1 The other types of nonphysician practitioners are audiologists, chiropractors, clinical psychologists, clinical social workers, certified registered nurse anesthetists, optometrists, occupational therapists, speech–language pathologists, certified clinical nurse specialists, certified nurse midwives, and registered dietician/nutrition professionals.

2 Anesthesia services are reimbursed differently from other clinician services. The payment for anesthesia is based on base units, which CMS assigns to anesthesia HCPCS codes, and time units, which are based on the length of time the patient was under anesthesia. The sum of the base units and time units are then multiplied by an anesthesia conversion factor, which is different from the fee schedule conversion factor.

3 Almost all clinicians billing the physician fee schedule do so as participating providers, meaning they agree to accept Medicare's fee schedule amount as payment in full. Clinicians who wish to sign up as a nonparticipating provider and not "take assignment" can collect 95 percent of what Medicare would normally pay for a claim and "balance bill" patients for additional cost sharing up to a total of 109.25 percent of Medicare's fee schedule amount.

4 CMS estimates that between 8.5 percent and 11 percent of clinicians will receive a 3.5 percent A–APM bonus in 2025 based on their A–APM participation in 2023.

5 CMS estimates that about 42 percent of clinicians in 2023 were subject to MIPS (affecting their payment adjustments in 2025). Clinicians are exempt from MIPS if they are newly enrolled in the Medicare program, serve only a low volume of Medicare beneficiaries, have a sufficiently high share of patients or payments in an A–APM, or meet another exclusion criterion.

6 The 2.93 percent temporary update applies to physician fee schedule payment rates from March 9, 2024, through December 31, 2024. This update replaced a 1.25 percent temporary update that was in effect during the earlier part of 2024 pursuant to the Consolidated Appropriations Act, 2023.