MEDPAC

Advising the Congress on Medicare issues

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

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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.

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

Key measures of access to care

- Commission surveys find that comparable shares of beneficiaries and the privately insured report problems finding a new clinician
- 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.

Concern: 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 ending 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 the two decades ending in 2020:
  - 1.5% per year for clinicians in A–APMs
  - 2.0% per year for clinicians not in A–APMs
- This larger gap between MEI growth and PFS updates could negatively affect access to clinician care in the future

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

Draft recommendation to update PFS rates annually by a portion of MEI growth

- Replace the dual PFS updates based on A–APM participation with an update based on a portion of MEI growth
  - Key concept: Historical evidence suggests that a full MEI update has not been needed to maintain access to care
- Policymakers could consider a range of specific designs (e.g., update floors and ceilings)
- Updates based on a portion of MEI growth have multiple benefits:
  - Automatically adjust to changes in inflation
  - Improve predictability
  - Simple to administer
  - Balance beneficiary access with beneficiary and taxpayer financial burden

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

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

- Relative to current law, would increase spending by between $15 billion and $30 billion over five years

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 base payments on misvalued codes
- Recommendations in 2006 and 2011
  - Establish expert panel to assist CMS's review of RUC recommendations
  - CMS should regularly collect data from cohort of efficient practices

Note: RVU (relative value unit), Relative Value Update Committee (RUC).
Source: Medicare Payment Advisory Commission, 2006, *Report to the Congress*. Medicare Payment Advisory Commission, 2011, Moving forward from the sustainable growth rate system.

Three illustrative examples of approaches 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 that this is not an exhaustive list of ways relative valuation could be improved

Note: RVU (relative value unit).

Example 1: Updating aggregate allocation of RVUs

- On an aggregate basis, allocation of work, PE, and MP RVUs should reflect the distribution of the costs of running a clinician practice
- MEI cost share data from 2006 are used as basis for allocation of work, PE, and MP RVUs, though more recent data are available.
- Using more recent data that appropriately reflects the cost of running a practice would:
  - help ensure that RVUs accurately reflect how costs are distributed
  - 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
- 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

Medicare payments when clinician services are furnished in HOPD

Type of payment	Included in PFS facility payment	Included in OPPS payment
Work	✓	
Indirect expenses	✓	✓
Direct expenses		✓
Malpractice insurance	✓	

- When service is furnished in facility, indirect PE is paid to both the clinician and the facility
- Paying both clinicians and facilities for indirect PE:
  - Could result in overpayment for total indirect PE costs
  - May encourage vertical consolidation
- Policymakers could revalue fee schedule's facility indirect PE payment in certain circumstances

Note: PFS (physician fee schedule), OPPS (outpatient prospective payment system), PE (practice expense), HOPD (hospital outpatient department). Direct PE is also included in fee schedule payments for certain facility services, such as global surgical codes.

Draft recommendation 2

The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflects the costs of delivering care.

Implications

Spending

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

Beneficiary and provider

- Could improve care for beneficiaries by reducing incentives for clinicians to overprovide or underprovide certain services
- Could have redistributive effects on payments to providers

Draft recommendations

Draft recommendation 1

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Draft recommendation 2

- The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflects the costs of delivering care.

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