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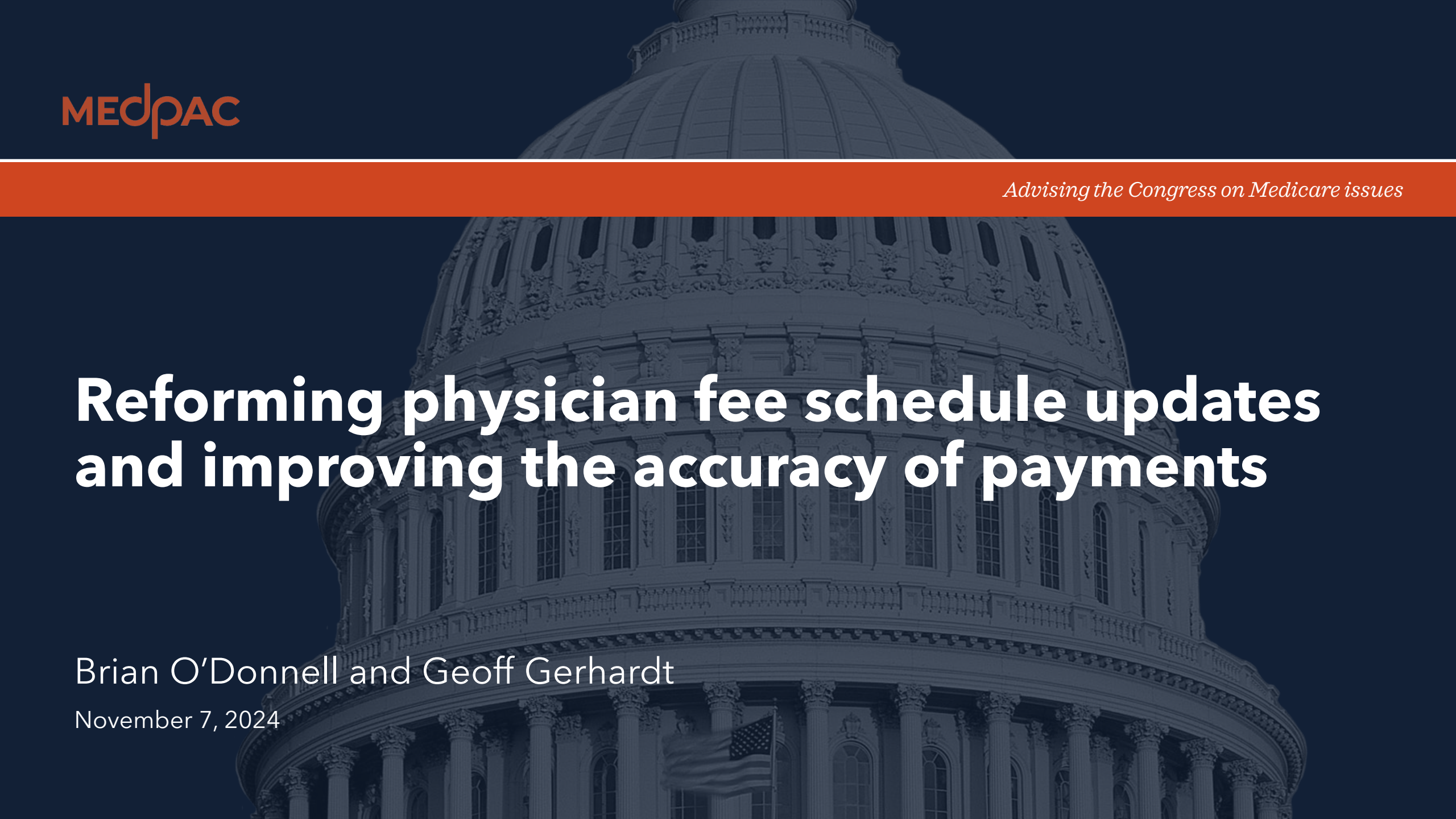

Reforming physician fee schedule updates and improving the accuracy of payments

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Presentation roadmap

1. Background
2. Concerns with current fee schedule updates
3. Policy option to reform fee schedule updates
4. Concerns with the accuracy of fee schedule payments
5. Commissioner discussion and feedback

Background

Physician fee schedule

- Pays for about 9,000 different clinician services
  - Services performed in a wide variety of settings (e.g., offices, hospitals)
  - Services can be discrete or a bundle of services (e.g., surgery and post operative 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 performed, and are broken down into three components
  - Work
  - Practice expenses (PE)—direct and indirect
  - Professional liability insurance (PLI)
- RVUs are multiplied by a conversion factor to calculate a payment amount

Note: RVU (relative value unit).

MACRA provides specified updates to PFS payment rates

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026-on
Fee schedule updates	**0.5% per year**			**0.25%**	**0% per year**	**+3.75% this year only**	**+3% this year only**	**+2.5% this year only**	**+1.25% and then +2.93%**		**0.25%** or **0.75% if in A-APM**

Notes: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), PFS (physician fee schedule), A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System). Fee schedule updates for 2021 through 2024 (written in orange) 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 percent through March 8, 2024, and then are instead updated by 2.93 percent 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 ensure beneficiary access and reflect good stewardship of taxpayer resources
- Since MACRA, the Commission has largely recommended implementing current law updates
- In 2023 and 2024, the Commission recommended updates of current law plus:
  - Half of the growth in MEI (which is 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 similar rates as commercial insurance despite lower payment rates
- Volume and intensity of care per beneficiary has increased

Longer-term indicators of access

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

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. July.

Commission's June 2024 report to the Congress

- Explored alternatives to current law updates of PFS payment rates
- Considered updating PFS payment rates by a portion of MEI growth, such as MEI minus 1 percentage point
- Expressed multiple concerns about the accuracy of PFS payment rates

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

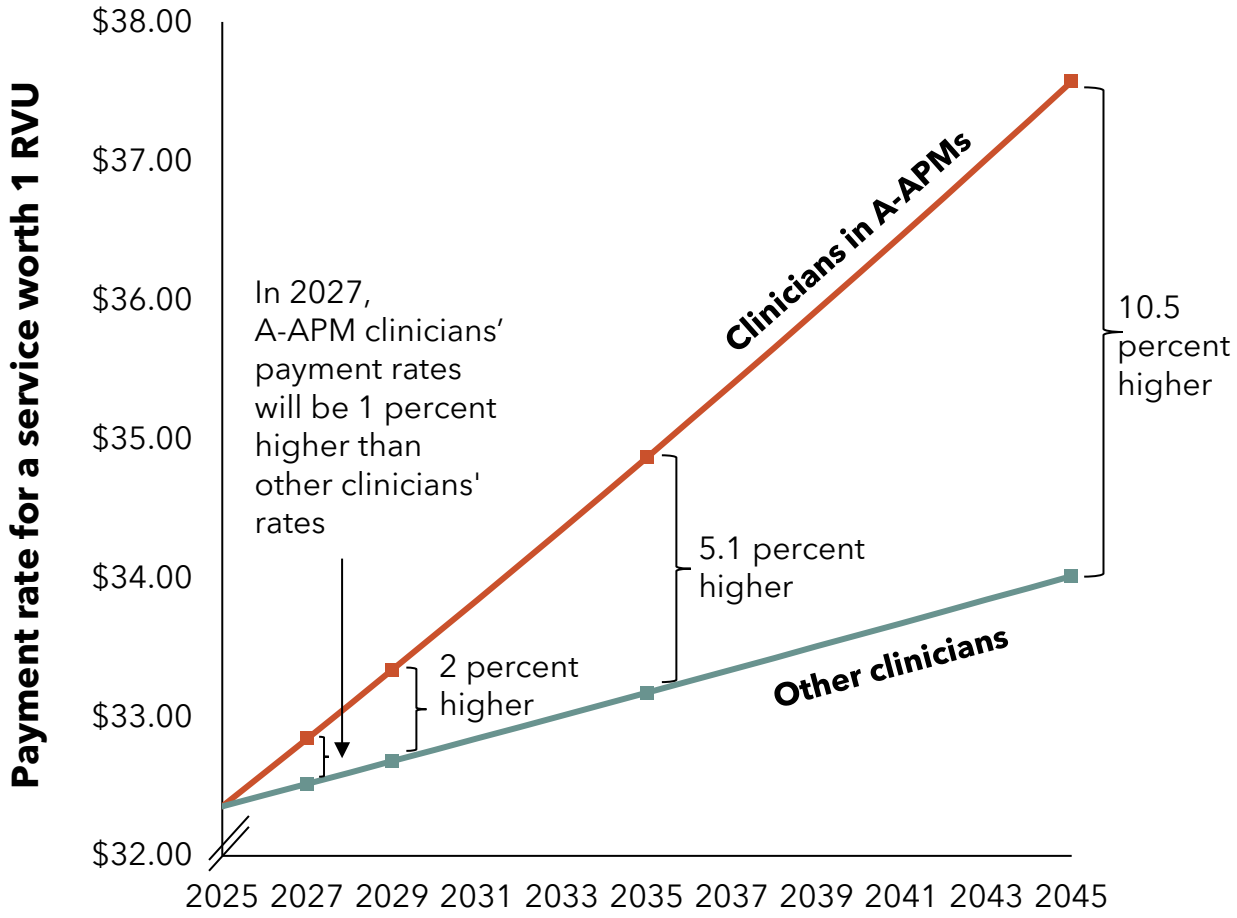
Concerns with current physician fee schedule updates

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
- From 2025 to 2034, the average annual difference between projected MEI growth and current law fee schedule updates is larger:
  - 1.5% for clinicians in A-APMs
  - 2.0% for clinicians not in A-APMs
- Historically, the Commission has found that Medicare beneficiaries had similar access to care relative to the privately insured, but the larger gap between MEI growth and PFS updates could negatively affect beneficiary access in the future

Note: MEI (Medicare Economic Index), 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.

Policy option to reform PFS updates

Policy option: Update PFS rates annually by a portion of MEI growth

- Replace the dual PFS updates based on A-APM participation with a single update based on a portion of MEI growth
- The Commission considered this approach in its June 2024 report
- 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 is not 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

- Policy option is intended to ensure continued beneficiary access to care without incurring unnecessary increases in Medicare spending
- Updates based on a portion of MEI growth (e.g., MEI minus 1 percentage point) have multiple benefits:
  - Simple to administer
  - Automatically adjust to changes in inflation
  - Improve predictability
  - Achieve good value
- The Commission would continue to monitor access to care and, to the extent needed, recommend higher or lower updates in the future

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

Concerns with the accuracy of fee schedule payment rates

Prior MedPAC work on accuracy of fee schedule RVUs

- The Commission has previously expressed concerns about the way RVUs are calculated and updated
- Accuracy of RVUs is important because rates affect distribution of payments, incentives to provide services, and beneficiary cost-sharing
- Recommendations in 2006 and 2011
  - Expert panel to help CMS review RVU recommendations from RUC
  - CMS and expert panel should regularly review RVUs of existing codes that have experienced large changes in utilization, which may indicate revaluation is needed
  - RUC should review codes where reductions in value are likely
  - CMS should collect data from cohort of efficient physician practices to inform valuation process

Note: RVUs (relative value units), Relative Value Update Committee (RUC).

Additional concerns with accuracy of fee schedule payment rates

- Timeliness and accuracy of data used to determine practice costs
- May not accurately reflect current practice patterns
- Doesn't account for possible financial relationship between clinicians and facilities

Three illustrative examples of policies that could address concerns about payment rates

- Updating allocation of work, practice expense, and professional liability insurance RVUs
- Improving the accuracy of global surgical bundles
- Improving the accuracy of payments for indirect practice expense

Note: RVUs (relative value units).

Example 1: Updating allocation of RVUs

- On aggregate basis, allocation of work, PE, and PLI RVUs should reflect distribution of practice costs across physician practices
- MEI cost shares are used as the basis for allocation of RVUs
  - Data used to calculate MEI comes from several sources, including AMA survey of specialty-level costs
- Most recent MEI uses 2017 data, but CMS continues to use MEI based on 2006 data to allocate RVUs
  - CMS waiting for AMA to collect new data

Note: RVUs (relative value units), PE (practice expense), PLI (professional liability insurance), MEI (Medicare Economic Index), AMA (American Medical Association).

Comparing share of total practice costs based on most recent versions of the Medicare Economic Index

Type of cost	Share of total costs		Percentage change in share
	2006 data	2017 data	
Work	50.9%	47.5%	-6.7%
Practice Expense	44.8	51.1	14.1
Professional liability insurance	4.3	1.3	-69.8

- Changes shown in table do **not** represent changes in absolute costs – they show changes in expenses as share of total costs across physician practices

Note: RVUs (relative value units). Share of total costs might not sum to 100 percent due to rounding.

Impacts of reallocating RVUs using updated MEI

Setting	**Difference in total RVUs** (not including budget neutrality adjustment)	**Difference in simulated spending** (including budget neutrality adjustment)
Nonfacility	9.2%	3.3%
Facility	-0.03	-5.5
All settings	5.8	0.0

- 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 MEI is updated
- Future updates to MEI could have different impacts, depending on how practice costs change

Note: RVU (relative value unit), MEI (Medicare Economic Index). Differences in simulated spending shows how changing total RVUs would affect spending with volume held constant for each billing code.
Source: MedPAC summary of Actuarial Research Corporation analysis.

Example 2: Improving the accuracy of global surgical bundles

- Roughly 4,000 billing codes are 10- or 90-day surgical bundles
  - About 10% of total fee schedule spending
- Intended to pay for all care provided on day of procedure and postoperative visits with performing physician over global period
  - 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
- Studies have shown that for most global codes, performing clinicians furnish fewer postoperative visits than are assumed

Note: RVUs (relative value units).
Source: HHS Office of the Inspector General, *Musculoskeletal global surgery fees often did not reflect the number of evaluation and management services provided*, 2012. Crespin, et al., *Claims-based reporting of post-operative visits for procedures with 10- or 90-day global periods: Updated results using 2019 data*, 2021.

Illustrative approach A: Convert 10- and 90-day global codes to 0-day codes

- Remove portion of global RVUs attributed to postoperative visits
- Procedure codes would cover just the costs for care on day of procedure
- Each postoperative visit would be paid separately
- Policy would reduce beneficiary liability for procedure itself, but could discourage postoperative care by imposing cost sharing for each of those visits
- If budget neutrality were applied, rates for all other codes would increase

Note: RVUs (relative value units).

Illustrative approach B: Revalue global codes

- Retain 10- and 90-day global codes, but base RVUs on more accurate data about postoperative visits
- Studies suggest this would reduce global RVUs by average of 28%
  - If budget neutrality were applied, rates for all other codes would increase by 2.6%
- Cost sharing would go down for most global codes and beneficiaries would not face cost sharing for postoperative visits
- Revaluation would take more time and data than converting all globals to 0-day codes

Note: RVUs (relative value units).
Source: Mulcahy, et al., *Using claims-based estimates of post-operative visits to revalue procedures with 10- and 90-day global periods*, 2021.

Example 3: Improving the accuracy of payments for indirect practice expenses

Type of RVUs included in payment rates for fee schedule services, by setting (current)

Type of RVU	Setting	
	Nonfacility	Facility
Work	✓	✓
Indirect PE	✓	✓
Direct PE	✓	
PLI	✓	✓

- Two sets of RVUs:
  - Nonfacility RVU when service is performed in office setting
  - Facility RVU when service is performed in facility setting (e.g., HOPD or ASC)
- Two types of practice expense:
  - Indirect (overhead expenses)
  - Direct (supplies, equipment, clinical labor)
- Excluding indirect PE from facility RVUs may be appropriate when clinicians and facility have a direct financial relationship
  - Facility fee (e.g., OPPS) includes payment for indirect PE

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

Share of physicians who are financially affiliated with a hospital has increased

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
Wholly owed by hospital	14.7	20.1
Jointly owned by physician and hospital	6.0	6.7
Unknown, either wholly or partly owned	2.5	4.5
Other	10.9	12.5

Note: N/A (not available). "Other" ownership arrangements include managed care organizations, private equity, and nonprofit foundations. Components may not sum to 100 percent due to rounding.

Source: American Medical Association, *Research changes in physician practice arrangements: Shifts away from private practice towards large practice size continues through 2022*, https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf.

Impacts of reducing indirect PE for facility-based clinician services

- Decrease in payment rates for services furnished by clinicians who are financially connected to facility
- Increase in payment rates for all other services
  - Among services furnished in both settings, could increase incentives to provide those services in nonfacility settings
  - Could reduce incentives for independent practices to consolidate with hospitals
- For services that are predominately performed in hospitals (e.g. emergency room visits, surgical procedures), impact is less clear

Note: PE (practice expense).

Discussion

- Reforming update policy:
  - Do commissioners support reforming current law approach by having a single conversion factor and basing annual updates on a portion of MEI growth?
- Improving payment accuracy:
  - Do commissioners support taking additional steps to improve accuracy of fee schedule payment rates?
- Based on commissioner feedback, the Chair may present draft recommendations for consideration in the spring

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