MEDPAC

Advising the Congress on Medicare issues

Considering approaches for updating the Medicare physician fee schedule

Brian O'Donnell, Geoff Gerhardt, Rachel Burton

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Presentation roadmap

1. Background
2. Concerns with current fee schedule updates
3. Policy approaches
4. Commissioner discussion and feedback

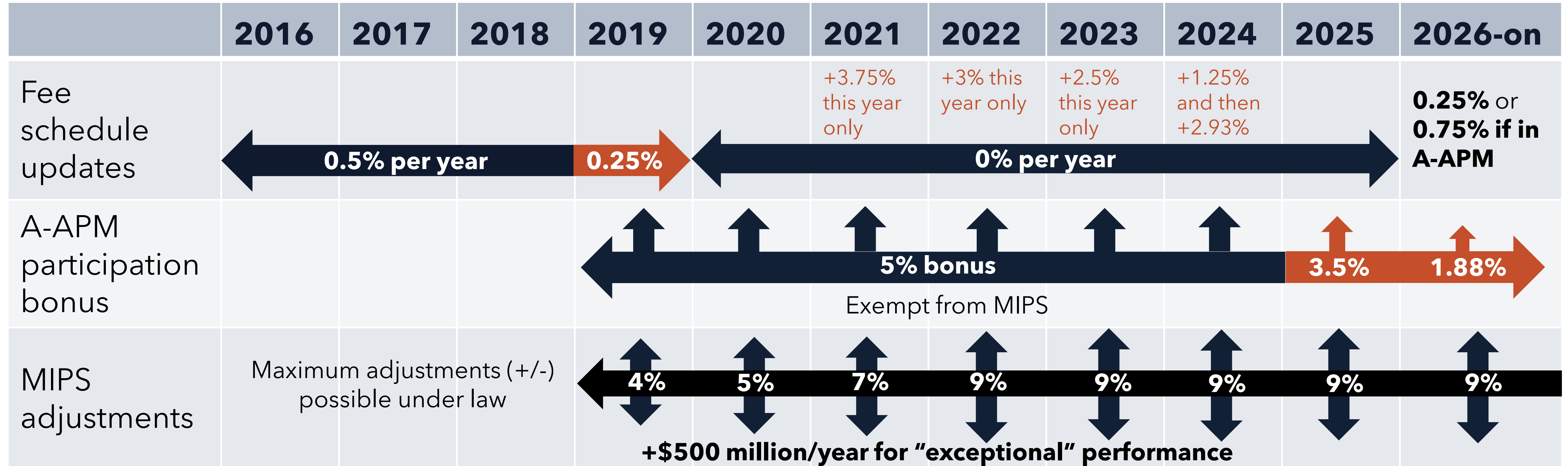
Background

Physician fee schedule background

- Payment rates for fee schedule services are determined based on RVUs, the conversion factor, and other adjustments
- RVUs are broken down into three components
  - Work (e.g., time, effort, and skill of clinician)
  - Practice expenses (e.g., staff wages, rent, equipment, supplies)
  - Professional liability insurance
- Fee schedule services vary substantially in terms of the share of RVUs associated with work, practice expense, and professional liability insurance
- RVUs are multiplied by a conversion factor to calculate a payment amount
- Medicare has updated the conversion factor differently over time
  - Commission's discussion today focuses on approaches to change updates over time
  - Current updates are largely based on MACRA

Note: RVU (relative value unit), A-APM (advanced alternative payment model), MACRA (Medicare Access and CHIP Reauthorization Act of 2015).

MACRA provides specified updates to payment rates, payment adjustments, and A-APM bonuses



Note: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System). Changes to MACRA's original provisions are shown in orange. In 2024, rates were updated by 1.25% through March 8, 2024, and then are instead updated by 2.93% from March 9, 2024, through December 31, 2024. MIPS adjustments to payment rates can be positive, neutral, or negative. The highest MIPS adjustment actually paid out so far has been lower than the maximum possible under law (+1.8% in 2021, +1.9% in 2022, and +2.3% in 2023). The A-APM participation bonus is not available after 2026. MIPS adjustments and the A-APM participation bonus apply for only one year at a time and are not built into subsequent years' payment rates. Since the fee schedule updates for 2021 through 2024 shown in orange apply for one year only and in most years decline in size from one year to the next, they have generally had the effect of slowly lowering the fee schedule's conversion factor. The conversion factor needed to be lowered to offset a large increase to the payment rates for a widely used set of billing codes used for office/outpatient evaluation and management visits that took effect in 2021.

Source: MedPAC analysis of MACRA and subsequent legislation.

Commission principles for assessing the adequacy of physician fee schedule rates

- Commission principles for assessing payment adequacy:
  - Ensuring beneficiary access to care
  - Promoting high quality of care
  - Ensuring payments are adequate to meet the costs of relatively efficient providers
- Commission's goal is to identify rates that will ensure both beneficiary access and good stewardship of taxpayer resources
- After the SGR repeal, the Commission has largely recommended implementing current law updates
- In 2023 and 2024, the Commission recommended updates of current law plus:
  - 50 percent of MEI growth
  - Safety-net add-on payments for treating low-income beneficiaries

Note: SGR (sustainable growth rate), MEI (Medicare Economic Index).
Source: MedPAC annual March reports to the Congress.

Access to care and provider acceptance of Medicare have 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

Despite positive historical access, the Commission has concerns about future access to care

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.

Concerns

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 2033, the average annual difference between projected MEI growth and current law fee schedule updates is larger:
  - 1.7% for clinicians in A-APMs
  - 2.1% for clinicians not in A-APMs
- While full MEI updates have not been necessary in the past to ensure beneficiaries maintain access to care that is comparable to the privately insured, the concern is that a larger gap between MEI growth and updates could negatively affect beneficiary access in the future

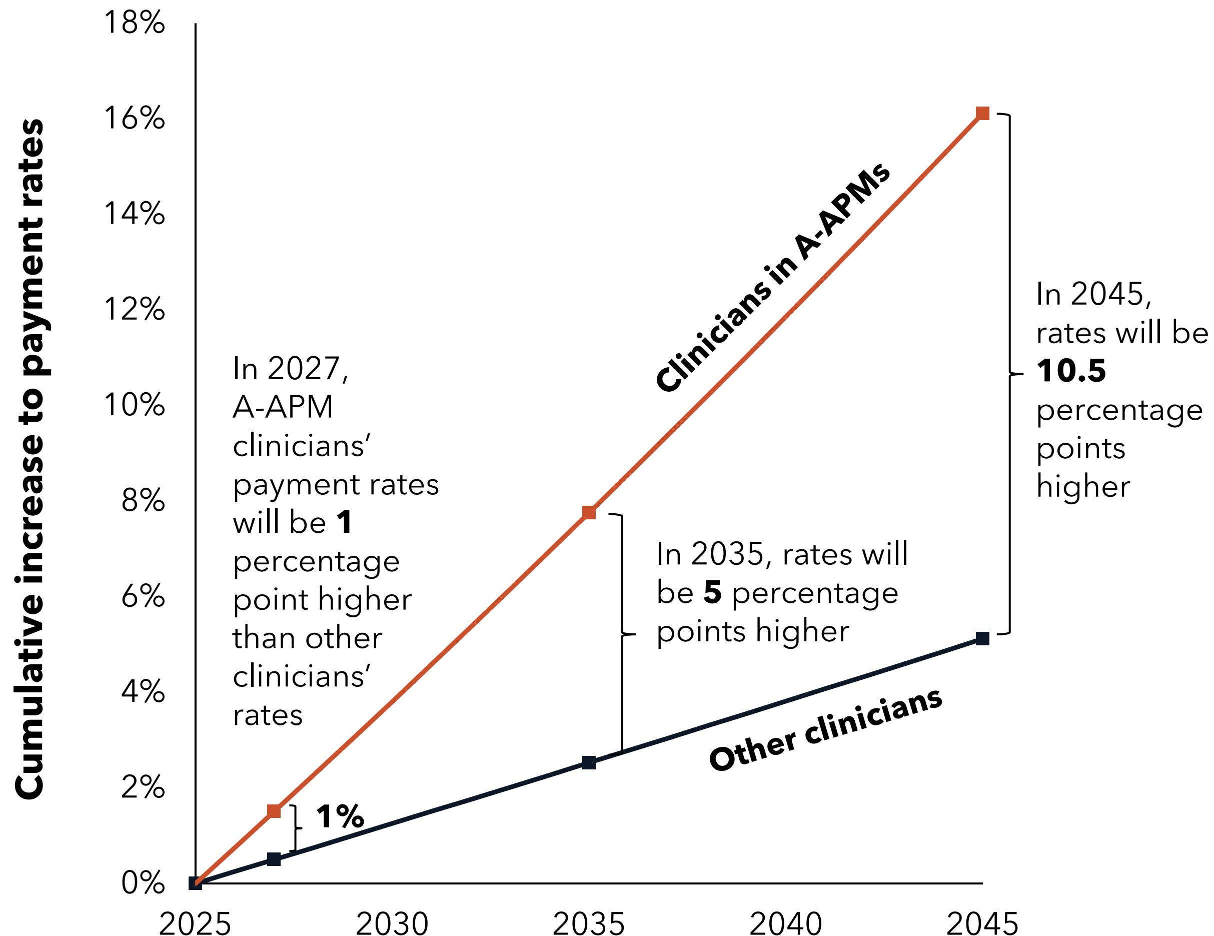
Note: MEI (Medicare Economic Index), A-APM (advanced alternative payment model).

Concern 2: Site-of-service payment differentials

- Medicare generally pays more for the same service when it is performed in the HOPD versus a freestanding clinician office
- Payments for clinician work are similar across sites of service, but payment differences for practice expenses can be large
- Medicare updates contribute to growing site-of-service differentials
  - Physician fee schedule: updates specified in law (e.g., 0.25% per year)
  - OPPS: hospital market basket (minus a productivity adjustment)
- Site-of-service differentials is one factor that encourages vertical consolidation, although the effect might be modest

Note: HOPD (hospital outpatient department), OPPS (outpatient prospective payment system).

Concern 3: Current law's differential updates will provide a weak incentive to participate in A-APMs in late 2020s



- A-APM participation bonus will no longer be available after 2026
- 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: Weak incentive
  - 2040s: Potentially untenably large incentive
- MIPS payment adjustments are allowed to reach as high as +9%

Note: A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System). Graph does not show expiration of 2% sequester in 2032.

Source: MedPAC analysis of MACRA.

Policy approaches

Approach 1: Update practice expenses by the hospital market basket minus productivity

- Update the practice expense (PE) portion of fee schedule payment rates by the hospital market basket index, minus productivity
  - Would require two conversion factors:
    - **PE conversion factor** would be automatically updated each year
    - **Work & PLI conversion factor** would not be automatically updated
- Rationale
  - Disparities in updates for PE costs between the physician fee schedule and hospital OPPS may incentivize vertical consolidation
  - Measures of clinician supply and beneficiary access could be interpreted to mean that payments for work are currently sufficient

Note: PLI (professional liability insurance), OPPS (outpatient prospective payment system).

Approach 1: Impacts would vary across services and clinicians

- Services where PE is high share of total payment rate would receive larger aggregate updates compared to services where PE is smaller share of total
- Impacts on clinician payments would vary across clinicians, depending on mix of services and site of service
  - **Largest increases:** Clinicians who perform high-PE services in freestanding office settings
  - **Smallest increases:** Clinicians who perform low-PE services and services in facility settings

Note: PE (practice expense).

Approach 1: Payment rates would increase more for some specialties than others

- Projected average cumulative updates from 2024 to 2033:
  - All clinicians: 11.4%
  - Clinicians specializing in internal medicine: 10.8%

Clinician specialties with largest increases in payments	Projected average cumulative update 2024 to 2033	Clinician specialties with smallest increases in payments	Projected average cumulative update 2024 to 2033
Allergy/immunology	16.8%	Critical care	7.1%
Radiation oncology	16.8%	Hospital medicine	7.1%
Vascular surgery	16.3%	Clinical psychologist	5.5%
Interventional radiology	15.9%	Emergency medicine	4.9%
Dermatology	15.5%	Licensed clinical social worker	4.9%

Note: Estimates assume that the relative value units for each service remain constant over the period. Does not include the effects of the expiration of the 2 percent sequester that applies through September 2032.

Source: MedPAC calculations based on 2022 claims data, 2022 physician fee schedule payment rates from CMS, and OACT projections of hospital market basket index and productivity.

Approach 1: Pros and cons

- Pros:
  - Would help payments for PE costs keep pace with inflation
  - May reduce incentives for vertical consolidation
  - Policymakers would be able to increase work at different rate than PE
- Cons:
  - Relatively small increases for primary care and behavioral health could create or exacerbate supply and access problems with those specialties
  - Payment rates would become increasing disconnected from RVUs for each service
  - Not increasing work costs may not be sustainable over time and could require additional update policies or one-time adjustments
  - Could incentivize clinicians to increase provision of high-PE services

Note: PE (practice expense), HOPD (hospital outpatient department), RVU (relative value unit).

Approach 1: Potential additional policies

- Ensuring accuracy of RVUs is important for any PFS reform approach, but especially if PE and work RVUs were updated at different rates
- Reform 10- and 90-day global surgical codes
  - Evidence that work RVUs for these codes are overvalued
  - Reducing spending on these codes could be redirected to increasing payments for other codes
- Commission could pursue other policies for improving the accuracy and timeliness of data used to determine RVUs

Note: RVU (relative value unit), PFS (physician fee schedule), PE (practice expense).

Approach 2: Update payment rates by Medicare Economic Index minus 1 percentage point

- Update single conversion factor by the Medicare Economic Index (MEI) minus 1 percentage point
  - Put a floor on annual updates equal to half of MEI
- Rationale
  - Presumes both PE and work costs increase over time
  - MEI is designed to track weighted cost trends of clinician practices, including both work and PE
  - In two decades prior to pandemic, PFS updates have averaged about MEI minus 1 percentage point
    - Clinician participation has generally been stable and beneficiary access similar to privately insured
  - Likely to be more predictable and stable than past update approaches

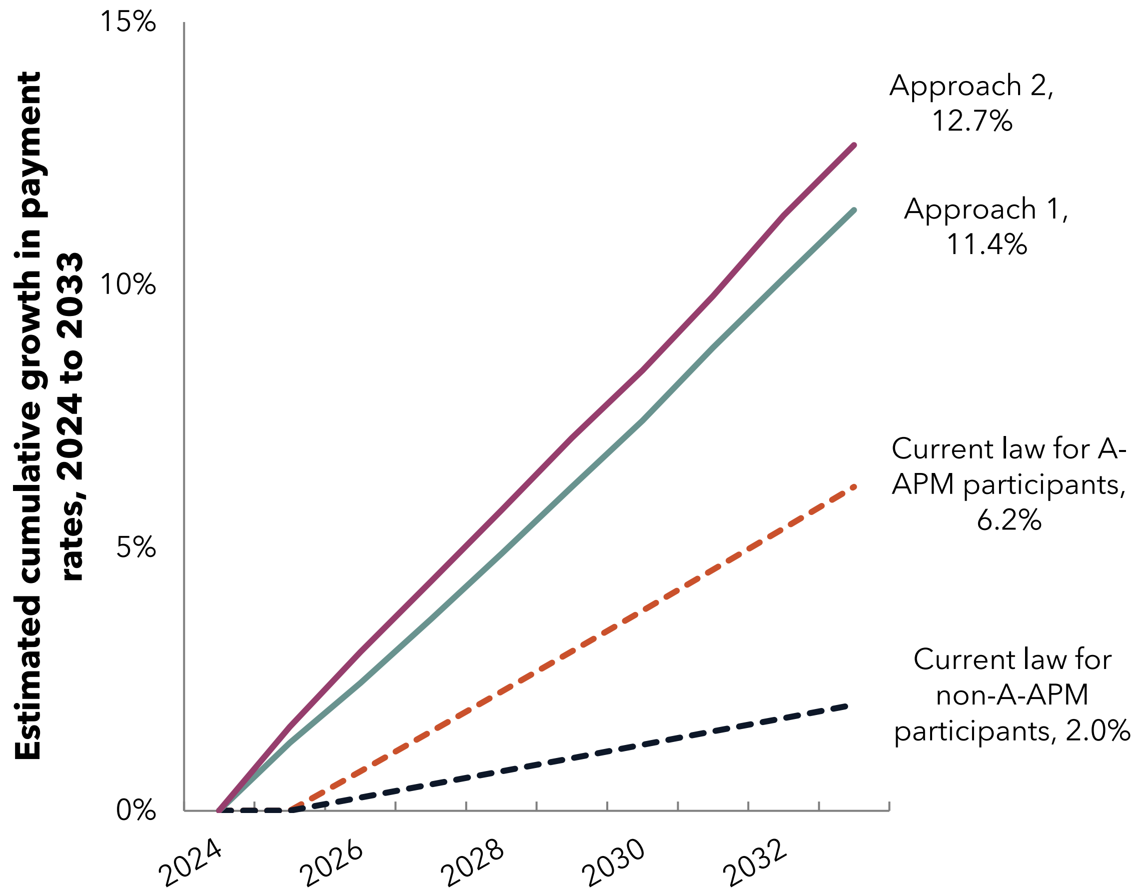
Note: PE (practice expense), PFS (physician fee schedule).

Approach 2: Pros and cons

- Pros:
  - Preserves “relative value” concept of fee schedule
  - Effects from update would be evenly distributed
  - Would not exacerbate differences in payments across specialties
  - Reduces chances that growth in work costs would need to be addressed in the future
- Cons:
  - Measures of clinician supply and access to care suggest increase in work payments may not be needed at this time
  - Does not address site-of-service payment differences
  - Additional policies may be needed to address low PE payments for certain services

Note: PE (practice expense).

Comparison of cumulative updates under two approaches and current law



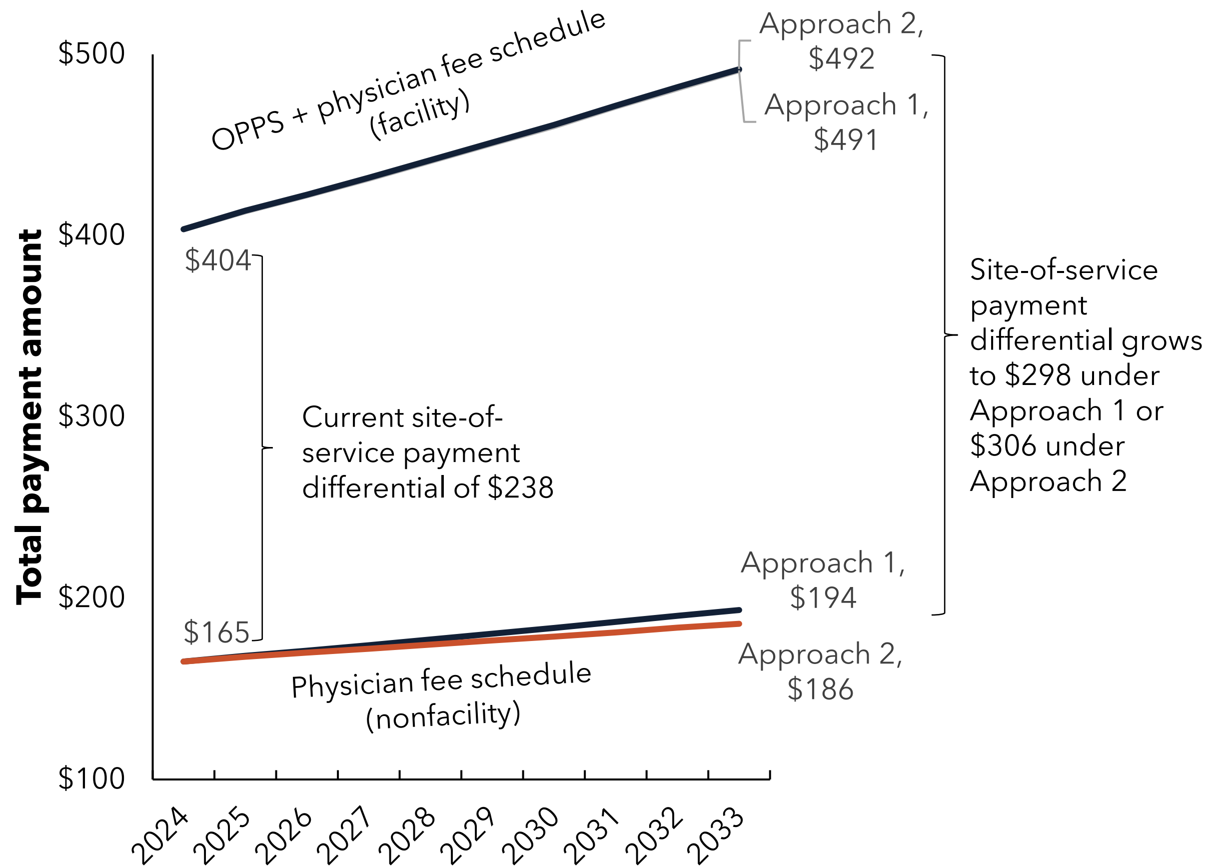
Approach 1: Update PE RVUs by hospital market basket, minus productivity
Approach 2: Update all RVUs by MEI minus 1 percentage point

- Average updates under both approaches are substantially larger than current law updates
- No variation in updates under approach 2
- Substantial variation in updates under approach 1 means updates for some clinicians could be less than the higher current law updates

Note: RVU (relative value unit), MEI (Medicare Economic Index), A-APM (advanced alternative payment model). Growth for approach 1 is a weighted average and assumes that RVUs for each service remain constant. Graph does not show effects of the expiration of the 2 percent sequester that applies through September 2032.

Source: MedPAC calculations based on OACT projections of hospital market basket, productivity, and MEI.

Payment differences between freestanding office and HOPD would remain



Approach 1: Update PE RVUs by hospital market basket, minus productivity
Approach 2: Update all RVUs by MEI minus 1 percentage point

- Compares total payments in freestanding office and HOPD for high-PE service (removal of skin lesions)
- Payment differential is similar under both approaches
- Neither approach may have substantial impact on incentivizes for vertical consolidation
- MedPAC's recommendations for site-neutral payments for select services could be more effective in addressing vertical consolidation

Note: HOPD (hospital outpatient department), OPPS (outpatient prospective payment system). Assumes that physician fee schedule relative value units and hospital OPPS payment weights are constant throughout the period.

Source: CMS 2017-2024 payment files for OPPS and physician fee schedule. MedPAC calculations of future payment rates based on OACT projections of hospital market basket, productivity, and MEI.

Approach 2: Potential additional policies

- Could be paired with policies to address issues with practice expense RVUs that contribute to vertical consolidation
- Rescale RVUs to reflect updated MEI data
  - Aggregate RVUs normally reflect MEI's distribution of PE and work costs associated with furnishing clinician services
  - CMS has not rescaled RVUs to reflect updated MEI cost data
  - Rescaling would increase PE RVUs and could help address vertical consolidation
- Commission could pursue other policies to improve accurate and timely valuation of PE RVUs

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

Approach 3: Extend the A-APM participation bonus for a few years

- Approaches 1 and 2 would replace current law's differential updates
- To incentivize participation in A-APMs over MIPS, could:
  - Repeal MIPS (per our 2018 recommendation)
  - Extend the A-APM participation bonus for 2 or 3 years (through 2028 or 2029)
- If MIPS is continued, an extended A-APM participation bonus could help maintain clinician participation in A-APMs in the late 2020s, given uncertainty about whether MIPS will become a more generous program
- Once MIPS's future direction becomes clearer, could reassess the need for the A-APM participation bonus
- If bonus is temporarily extended: What size to make it? Freeze payment & patient participation thresholds? Restructure bonus?

Note: A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System).

Approach 3: How large to make the bonus?

- Historically, A-APM participation bonuses have always been larger than the highest MIPS adjustments (which have been low)
- MIPS adjustments may become larger than A-APM bonuses in the future
- Ideally, the extended A-APM participation bonus plus payments through an A-APM (e.g., shared savings) would exceed the highest MIPS adjustment

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Actual highest MIPS adjustment	1.9%	1.7%	1.8%	1.9%	2.3%	6.6% (projection*)	6.1% (projection*)	3% (projection)	TBD up to 9%	TBD up to 9%	TBD up to 9%
A-APM participation bonus	5%	5%	5%	5%	5%	5%	3.5%	1.9%	0%	0%	0%
A-APM payments (e.g., shared savings)	Varies depending on the A-APM and the clinician's performance on measures of quality, cost, utilization										

Note: A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System). Years shown are payment years. MIPS adjustments shown for 2019-2023 are the actual highest adjustments actually paid; MIPS adjustments for 2024-2026 are CMS's projections of what the highest MIPS adjustment will be in those years; MIPS adjustments for 2027-2029 are the maximum MIPS adjustments available under law.
*CMS has warned that these two projections may be overestimates since CMS used data from the pandemic to model clinician behavior in these years.

Source: MACRA; MIPS performance results posted publicly; CMS's final rules for the physician fee schedule.

Approach 3: Pros and cons of extending the bonus

- Pros:
  - Could prompt some clinicians to choose to participate in A-APMs over MIPS
- Cons:
  - Might not prompt clinicians to prefer A-APMs over MIPS, if bonus is too small
    - i.e., if the A-APM participation bonus plus A-APM model payments (e.g., shared savings) are lower than the highest MIPS adjustment
  - Could be viewed as inequitable by clinicians who are unable to participate in A-APMs (due to a lack of A-APMs in their geographic area, medical specialty, or other circumstances)

Note: A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System).

Freeze the current payment and patient thresholds used to qualify for A-APM bonus?

- Clinicians must exceed one of two thresholds to qualify for the bonus
- The share of *payments* that must be in A-APMs to qualify for the bonus will increase from 50% to 75% in 2027
- The share of *patients* that must be in A-APMs is allowed to increase from 35% to some higher percentage chosen by CMS in 2026
- If the current thresholds were frozen (at 50% and 35%), many clinicians would continue to qualify for the bonus who would otherwise stop receiving it

Note: A-APM (advanced alternative payment model).

Pros and cons of freezing the current thresholds used to qualify for A-APM bonus

- Pros:
  - Would result in many clinicians continuing to qualify for the bonus who would otherwise no longer receive it
    - Could increase A-APMs' chances of attracting top-performing clinicians and generating net savings for Medicare
- Cons:
  - Clinicians who already exceed the thresholds would not have an incentive to increase the share of their payments/patients in A-APMs

Note: A-APM (advanced alternative payment model).

Restructure the A-APM participation bonus?

- Currently calculated as a percentage of a clinician's Medicare payments for fee schedule services
  - Incentivizes clinicians to increase the amount of FFS Medicare spending they generate (counter to A-APMs' goal of delivering care more efficiently)
- Could instead be based on the number of FFS Medicare A-APM beneficiaries attributed to a clinician
  - Would incentivize clinicians to increase the number of FFS Medicare A-APM beneficiaries they treat
  - CMS would need to develop a new algorithm/formula for calculating bonuses
    - Bonus would need to be risk-adjusted

Note: A-APM (advanced alternative payment model), FFS (fee-for-service).

Pros and cons of restructuring the A-APM participation bonus

- Pros:
  - Bonus would no longer incentivize clinicians to increase spending
  - Could increase clinicians' incentives to accept Medicare patients
- Cons:
  - Many specialists would lose access to the bonus
    - Patients in A-APMs tend to be attributed to their primary care provider
  - Would be harder for clinicians to compare their expected bonus to their expected MIPS adjustment
    - Currently, both are a % of a clinician's Medicare payments for fee schedule services

Note: A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System).

Discussion

Discussion

- Staff seek your feedback
  - Approach 1: Update PE RVUs by the hospital market basket minus productivity
  - Approach 2: Update all RVUs by MEI minus 1 percentage point, with a floor of half-of-MEI
  - Approach 3: Extend the A-APM participation bonus for a few years
    - Size of bonus?
    - Freeze the two participation thresholds?
    - Restructure the bonus?

Note: PE (practice expense), RVU (relative value unit), MEI (Medicare Economic Index), A-APM (advanced alternative payment model).

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meetingcomments@medpac.gov

www.medpac.gov

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