MEDPAC | Medicare Payment Advisory Commission

TESTIMONY

Ensuring Medicare beneficiaries' access to care and reducing burden for providers

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Chair Rodgers, Chair Guthrie, Ranking Member Pallone, Ranking Member Eshoo, and distinguished Committee members, my name is Paul Masi, and I am the Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be with you today to discuss ensuring patient access to care and reducing burden for providers.

MedPAC is a small congressional support body established by the Balanced Budget Act of 1997 (P.L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. Three principles guide the Commission's work: (1) payments should be sufficient to support beneficiary access to high-quality health care in an appropriate clinical setting; (2) payments should reflect efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary; and (3) payments should give providers incentives to supply appropriate and equitable care. In all our efforts, the Commission follows a deliberative, analytic process to provide the Congress with thoughtful, empirically based information and advice on Medicare.

A core part of MedPAC's statutory mission is to assess whether payments in traditional fee-for-service (FFS) Medicare are adequate to achieve access to high-quality care for Medicare beneficiaries and advise the Congress on what steps to take if payments are too low or too high. Every year, the Commission makes recommendations to the Congress about how Medicare payment rates should be updated in the coming year based on that assessment. Our analysis takes into account evidence on beneficiaries' access to care, the quality of care that providers deliver, and the costs providers incur in delivering that care. We also evaluate the need for targeted policies addressing specific problems that could compromise Medicare beneficiaries' access to needed care. Where evidence exists of such a problem, policy solutions targeted to the specific problem ensure that Medicare's resources are used efficiently. This principle guided the Commission's March 2023 recommendation to establish an add-on payment to target resources for providers who treat low-income Medicare patients in order to support access to care for patients who face relatively more barriers to care and are more expensive to treat.

MedPAC does not take positions on proposed legislation but seeks to provide information about relevant Commission work that may be helpful as the Committee works to ensure Medicare patients have access to care, and to reduce provider burden. In this testimony, I will provide an overview of Medicare's payments for clinician services, including historical context for how payments have been updated each year. I will then discuss how the Commission assesses the adequacy of Medicare's payments and explain our findings. Next, I will describe MedPAC's recommendations for how to update payments to clinicians, target resources to where they are needed to support clinicians who care for beneficiaries with low incomes, improve the accuracy of relative prices under Medicare's fee schedule, and reduce administrative burden for clinicians.

Payments to clinicians in traditional fee-for-service Medicare

Since the Medicare program was created in the mid-1960s, policymakers have wrestled with how to set prices for services furnished by physicians and other clinicians and how to update those prices over time. The methods Medicare has used to determine and update prices for clinician services have evolved markedly. In the early years of the

program, Medicare's payment rates for clinician services largely reflected the amounts charged by clinicians themselves. Today, there is a complex system in place that sets prices based on the relative value of the clinician's work, practice expense (including nonclinician labor), and professional liability insurance needed to furnish the roughly 8,000 separate items and services—including visits, imaging, tests, and procedures—paid for under Medicare's physician fee schedule (PFS). The relative values for each item or service are intended to reflect the resources needed on average to provide the service; the sum of the relative value units is multiplied by a dollar amount (the "conversion factor") to produce the total payment amount for each item or service. Thus, the total amount of Medicare payments a clinician receives in a given year is a function of the number and type of services the clinician provides and the payment rate for each of those services.

My testimony today focuses on clinician services covered under fee-for-service Medicare, but beneficiaries enrolled in Medicare Advantage (MA) plans also receive clinician services. Payment rates for those services are established in private contracts between MA plans and providers. As required by law, the Commission provides a status report on MA in its annual March report to the Congress. The Commission has made recommendations about how to improve the quality of data on MA beneficiaries' use of clinician services; improved data would allow for greater monitoring on the quality of and access to clinician care for those beneficiaries.

Updating payments for clinician services

For the first roughly 20 years of the program, Medicare's payment rates for clinician services were largely determined by the amounts charged by clinicians themselves. As charges increased, so did Medicare's payment rates. This changed in the early 1990s, when Medicare began determining payment rates empirically, based on the relative value of resources and costs needed to furnish each service rather than what clinicians charged for those services.

While CMS now largely determines the relative prices for clinician services, the Congress specifies the methods and policies used to update those prices each year. Three approaches to updating payment rates for clinician services have been used: the volume performance standard, the sustainable growth rate, and the updates specified by MACRA. Under all three of these approaches, payment rates are updated each year by adjusting the fee schedule's conversion factor; increasing the conversion factor by 1 percent, for example, results in a 1 percent increase to payment rates, all else equal. Each year, the update to the conversion factor reflects two effects: (1) a percentage specified in law, and (2) an adjustment to ensure that any changes CMS has made to particular services' relative values do not, in and of themselves, increase or decrease total physician fee schedule spending by more than $20 million (referred to as CMS's budget-neutrality adjustment).

Congress historically has put into place different approaches to moderate growth in Medicare's spending under the fee schedule. Moderating Medicare spending growth also slows the rise in beneficiary premiums and cost sharing, and in taxpayer dollars used to fund the program.

Below, we outline the three approaches that have been used to update payments for clinician services over the past 30 years. Over this period, several lessons have been learned:

- Payment adjustments intended to incentivize individual clinicians to furnish care more efficiently are likely to be ineffective if applied at the national level;

- Use of spending targets to limit expenditure growth can lead to highly variable and unpredictable annual payment updates;

- Specifying fixed updates means payment rates cannot respond automatically to changing economic conditions, such as inflation;

- Despite updates that have been lower than inflation for the past two decades, Medicare beneficiaries continue to have access to care that is comparable to or better than that of higher-paying privately insured individuals.

The volume performance standard

From 1992 to 1997, the volume performance standard (VPS) was used to annually update Medicare's conversion factor for physician services. The VPS approach aimed to: (1) link updates in payment rates to growth in input costs and (2) restrain the growth of overall spending caused by increases in the volume and intensity of physician services delivered. Under the VPS approach, three separate conversion factors were updated: one for surgical services, one for primary care services, and one for nonsurgical, non–primary care services. The VPS used the Medicare Economic Index (MEI), a measure of the change in clinician input prices, as the default growth rate for annual updates of the conversion factors but also required the calculation of a spending target growth rate against which the actual growth of physician spending would be compared. By law, the three conversion factors were to be updated by MEI minus the difference between the VPS spending target growth rate and actual spending. For example, if the VPS target growth rate were 7 percent and spending grew by 8 percent, the formula would call for the coming year's update to be MEI minus 1 percentage point (i.e., the percentage difference between target growth and actual spending growth).

As time went on, clinicians and policymakers grew increasingly dissatisfied with the way VPS operated. The VPS was intended to create pressure to reduce the growth in the volume and intensity of the services provided. However, since the spending targets were determined at the national level, individual clinicians had very weak incentives to control the volume and intensity of services they provided. In addition, the spending targets for the three conversion factors diverged over time, such that the conversion factor for surgical services was 9 percent higher than that for primary care services, and 14 percent higher than the nonsurgical, non–primary care conversion factor (American Medical Association 2023a).

The sustainable growth rate

In 1997, the Congress replaced VPS with the sustainable growth rate (SGR) method of annually updating payment rates in the physician fee schedule. Though the SGR method eliminated the three conversion factors in favor of a single conversion factor, the SGR was largely a refinement of the VPS formula rather than a fundamental change in approach. The spending target formula for the SGR was similar to the one used for the VPS, with the major difference being that the SGR's allowed growth for volume and intensity was based on growth in real national per capita gross domestic product (GDP) rather than historical volume and intensity growth minus a discount factor. Using GDP in the SGR formula was meant to tie allowed growth in volume and intensity to an exogenous measure of economic growth rather than an endogenous measure of volume and intensity growth among physician services.

Perhaps the most important difference between the two methods was that the SGR's spending targets were cumulative over time, while the VPS's spending targets were not. To determine fee schedule updates under the SGR, CMS was required to annually compare actual cumulative Medicare spending on fee schedule services with the target spending amount over the same period. If cumulative expenditures equaled the cumulative targets, the SGR formula set physician fee updates equal to the MEI. However, if cumulative expenditures exceeded cumulative targets, the update for the subsequent year would be reduced, with the goal of bringing cumulative spending back in line with the target. Likewise, if cumulative expenditures were less than the cumulative target amount, the subsequent year's update would be higher than MEI.

The SGR formula contained two guardrails against overly large increases or decreases in updates. Regardless of how much the spending target exceeded actual spending or vice versa, the update in a given year could not be less than MEI minus 7 percentage points, and no greater than MEI plus 3 percentage points.

In the first years of the SGR system, actual expenditures did not exceed spending targets because volume did not grow faster than GDP. Therefore, updates to the physician fee schedule in the early years of the SGR system were at or above the MEI. However, beginning in 2001, actual cumulative expenditures exceeded allowed targets and the discrepancy continued to grow each year, resulting in a series of prescribed multiyear cuts under the formula in order to recoup the difference. The SGR's prescribed cuts were implemented in 2002; after that, the Congress passed a series of bills to override the SGR-specified fee schedule reductions, which pushed the required reductions several years into the future in order to achieve the required spending reduction while staying within the formula's annual rate reduction guardrails. Over time, these delayed reductions added up, with looming reductions in payment rates growing to more than 20 percent (Boards of Trustees 2015).

In a 2011 report to the Congress, MedPAC identified a series of flaws with the SGR approach. As with the VPS, the SGR's primary flaw was that the policy imposed incentives to reduce volume and intensity growth at the national level; individual practitioners had almost no incentive to practice efficiently or look for ways to reduce the volume or intensity of services they deliver when treating Medicare beneficiaries (Medicare Payment Advisory Commission 2011b). The formula neither rewarded

individual clinicians who restrained unnecessary volume growth nor penalized those who contributed most to inappropriate volume increases.

Many stakeholder groups faulted the SGR formula for limiting volume and intensity growth to GDP, which they said was too low and lacked flexibility to account for increases in medical spending due to factors outside of physicians' control (Government Accountability Office 2004). In addition, the underlying SGR formula itself, coupled with legislative action to override prescribed annual cuts with a series of deeper and longer reductions, led many to conclude that the required updates were unrealistic and untenable (Medicare Payment Advisory Commission 2011b).

In an October 2011 letter to the Congress, the Commission recommended that the Congress repeal the SGR system and replace it with a 10-year path of specified fee schedule updates (Medicare Payment Advisory Commission 2011a). The Commission also recommended that CMS take steps to improve the accuracy of prices for clinician services by collecting better data and identifying and reducing rates for overpriced services; we also recommended increasing incentives for physicians and other clinicians to join accountable care organizations with two-sided risk.

Medicare Access and CHIP Reauthorization Act framework

In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Congress replaced the SGR formula with a schedule of fixed annual updates to the physician fee schedule's payment rates. Under MACRA's original framework, payment rates were to be updated by zero percent from 2020 to 2025 and, starting in 2026, by 0.75 percent for clinicians participating in advanced alternative payment models (A–APMs) and by 0.25 percent for all other clinicians. MACRA also incentivized participation in A–APMs by establishing temporary bonus payments, and it created a pay-for-performance program for clinicians not in A–APMs that can increase or decrease their payment rates, called the Merit-based Incentive Payment System (MIPS).

In some ways, MACRA has achieved two of its policy goals of stabilizing updates to the physician fee schedule and providing meaningful incentives for clinicians to participate in alternative payment models. However, though MACRA initially was supported by physician groups, who saw it as an acceptable way of avoiding the deep rate cuts called for by the SGR formula, they and others have increasingly voiced concern that the law's framework of fixed updates does not account for inflation (Boards of Trustees 2023, O'Reilly 2023).

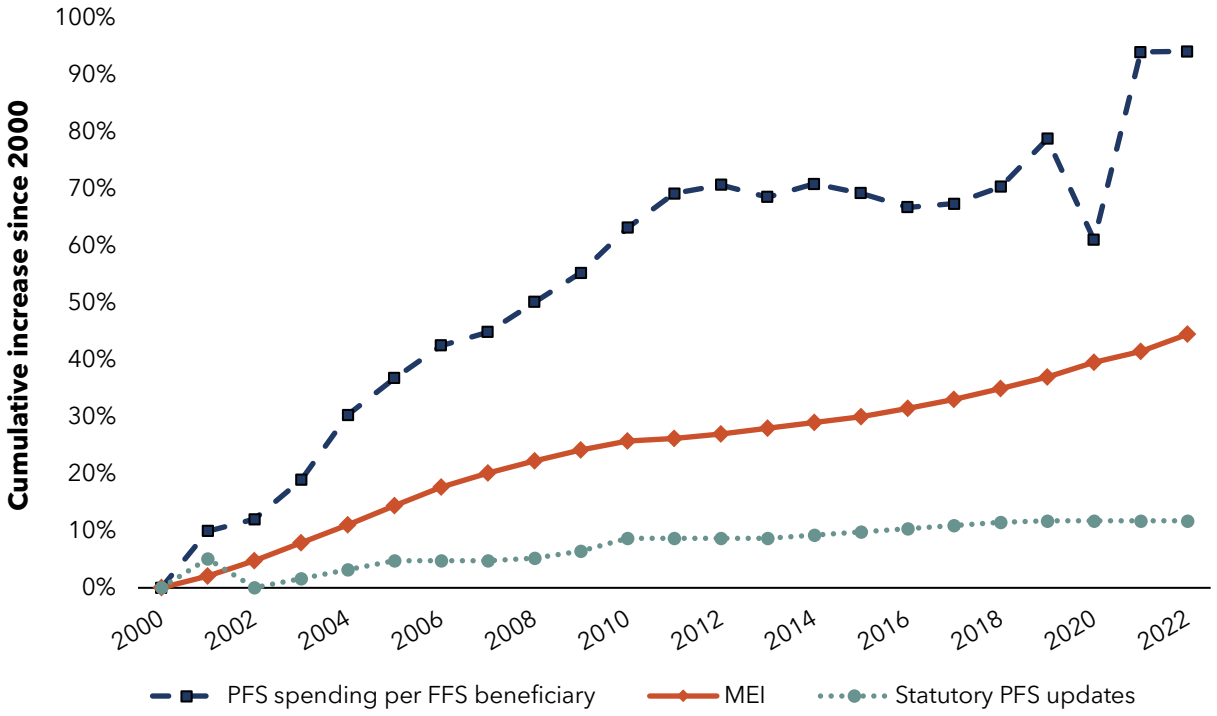
Over the last two decades, Medicare's physician fee schedule payments per FFS beneficiary have grown twice as much as clinicians' costs

As shown in Figure 1, over more than two decades, growth in the Medicare Economic Index (MEI), a measure of the change in clinicians' input costs, has consistently exceeded statutory updates to the fee schedule's payment rates. From 2000 to 2022, statutory updates to the fee schedule's rates totaled 12 percent, while the MEI grew by 45 percent. But Medicare's spending per FFS beneficiary on clinician services has increased twice as fast as MEI growth over the last two decades (94 percent vs. 45 percent), suggesting

continued growth in clinicians' Medicare revenues. These data indicate that, even after adjusting for inflation, Medicare had higher spending under the fee schedule for each Medicare beneficiary in 2022 than in 2000.

Multiple factors have driven the large increase in spending over this time. Two of the largest factors are increases in the number of services received per beneficiary and increases in the intensity of those services. As each beneficiary receives more services (e.g., more procedures) or more intense services (e.g., higher-level office visits), Medicare's payments for clinician services increase.

Figure 1 | Physician fee schedule spending per FFS beneficiary grew substantially faster than MEI or statutory payment updates, 2000-2022



Note: A-APM (advanced alternative payment model), MEI (Medicare Economic Index), MIPS (Merit-based Incentive Payment System), PFS (physician fee schedule). The MEI values used in the figure reflect the market basket increase published in the fee schedule final rule each year. MIPS adjustments, A-APM participation bonuses, and payment increases of 3.75 percent in 2021 and 3.0 percent in 2022 are not included in the figure since they are one-time payments not built into subsequent years' payment rates.

Source: MedPAC analysis of Medicare regulations and Trustees reports.

Since 2000, the volume and intensity of services clinicians provide to beneficiaries have increased substantially. From 2000 to 2017, the cumulative growth per beneficiary in volume and intensity of imaging services was 75 percent, and the growth for tests and nonmajor procedures was higher (Medicare Payment Advisory Commission 2019). The volume and intensity growth of E&M services and major procedures over the period was somewhat lower but still considerable (47 percent and 45 percent, respectively).

The unit of payment in the physician fee schedule is highly disaggregated, and Medicare makes a separate payment for each of the more than 8,000 separate items and services covered under the fee schedule. This provides little incentive for clinicians to limit the volume of services they provide. A larger unit of payment generally puts providers at greater financial risk for the services provided and thus creates an incentive to furnish services more judiciously. For example, in Medicare's hospital inpatient prospective payment system, Medicare generally pays a fixed rate (based on the beneficiary's principal diagnoses, the procedure being performed, and comorbidities, among other factors) for all of the services an acute care hospital provides during a beneficiary's inpatient stay; Medicare's payment generally does not increase if patients stay in the hospital longer or receive more services while in the hospital.

The physician fee schedule does include some larger payment bundles, such as global payments for surgical services plus preoperative and follow-up visits. However, evidence suggests there is a mismatch between the number of visits that CMS pays for in its global payments and the number that physicians actually provide. As a result, Medicare pays too much for these bundles. This finding underscores the need for CMS to collect empirical data when setting payment rates for particular services and to regularly identify and revalue overvalued services.

For the last two decades, MedPAC has found that FFS Medicare's payments generally have been adequate to support beneficiary access to clinician services

During most of the last two decades, the Commission has determined that payment rates under Medicare's physician fee schedule have been adequate to support Medicare beneficiaries' access to clinician services. The Commission has based this conclusion on several important findings about access to care: survey data suggest that beneficiary access to clinician care is comparable to or better than access for privately insured individuals; most beneficiaries report good access to clinician services in our annual focus groups with beneficiaries and clinicians; the share of clinicians who accept Medicare is comparable to the share who accept private health insurance; the number of encounters beneficiaries have with clinicians, an indirect measure for access to care, has continued to grow; and longer-term measures of access to clinician care also remain positive, with physician income keeping pace with (or exceeding) inflation, and interest in becoming a physician remaining high.

Survey data suggest Medicare beneficiaries' access to care is comparable to or better than access for privately insured individuals

Since 2004, the Commission has sponsored an annual survey of Medicare beneficiaries ages 65 and over and individuals ages 50 to 64 with private insurance. Respondents answer questions about how often they have to wait to get a doctor's appointment, whether they have had problems finding a new primary care clinician or specialist, and whether they have had any health problems about which they think they should have seen a clinician but did not. Over nearly two decades, Medicare beneficiaries have reported access to care that is comparable to or better than access for privately insured

individuals, despite the fact that we find that commercial insurance rates are about 34 percent higher than what Medicare pays (Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2023). This finding suggests that increasing Medicare's overall payment rates may not meaningfully change access for Medicare beneficiaries.

In addition to analyzing data from our own survey, the Commission analyzes data from other surveys and reviews research from others who track how easily Medicare beneficiaries can access clinician services. These surveys also tend to conclude that Medicare beneficiaries have good access to care. For example:

- The Behavioral Risk Factor Surveillance System survey has found that, compared with people with employer-sponsored or individually purchased health insurance, Medicare beneficiaries are more likely to have a personal physician, less likely to have medical debt, and more likely to be very satisfied with their care (Wray et al. 2021).
- The Commission's most recent analysis of CMS's 2020 Medicare Current Beneficiary Survey (MCBS) found that a relatively small share of beneficiaries (8 percent) reported experiencing trouble getting health care in the past year—primarily due to the cost of care rather than clinicians not accepting Medicare (Medicare Payment Advisory Commission 2023) .
- The Medical Expenditure Panel Survey has found that around age 65, when most people gain eligibility for Medicare, there is a reduction in reports of being unable to get necessary care and being unable to get needed care because of cost (Jacobs 2021).
- The National Health Interview Survey has found that delaying or forgoing needed care due to cost was more common among adults under the age of 65 than adults over the age of 65 (National Center for Health Statistics 2021).

In addition to our survey of beneficiaries, we conduct focus groups each year with beneficiaries and clinicians in different parts of the country to provide more qualitative descriptions of beneficiary and clinician experiences with the Medicare program. During these discussions, we hear from beneficiaries and providers about variation in experiences accessing care. In the summer of 2022, we conducted focus groups in three different urban markets with Medicare beneficiaries, privately insured individuals ages 55 to 64 years old, and clinicians. In addition, we conducted virtual focus groups with beneficiaries residing in rural areas. Most of the Medicare beneficiaries participating in our focus groups in both urban and rural areas described having timely access to primary care, especially when they had an acute care issue (Medicare Payment Advisory Commission 2023). Nearly all beneficiaries reported having a usual source of primary care. Several beneficiaries had sought a new source of primary care in recent years, and their experiences varied in terms of the ease of identifying a new clinician. Some privately insured individuals in our focus groups also reported challenges finding a new primary care provider and long wait times to schedule a first appointment. Across clinicians in our focus groups, most were accepting new patients, including Medicare patients.

The share of clinicians who accept Medicare is comparable to the share that accept private insurance

Although Medicare payment rates for clinician services are generally lower than commercial rates, the share of clinicians who accept Medicare is comparable to the share who accept private health insurance. From 2014 to 2019, the share of nonpediatric office-based physicians who accepted Medicare was only 0 to 2 percentage points lower than the share who accepted private health insurance, according to the CDC's National Electronic Health Records Survey (Ochieng et al. 2022). Meanwhile, the 2020 National Ambulatory Medical Care Survey found that among nonpediatric office-based physicians who reported accepting new patients, 86 percent said they accepted new Medicare patients, while 84 percent said they accepted new privately insured patients (Myrick and Schappert 2022). And in the Commission's 2022 survey of patients, only 1 percent of Medicare beneficiaries encountered a primary care provider or a specialist's office that did not accept Medicare, while 2 percent of privately insured people encountered a primary care provider's office that did not accept their insurance and 4 percent encountered a specialist's office that did not accept their insurance (Medicare Payment Advisory Commission 2023). There are other reasons why Medicare may be a relatively appealing payer, including a statutory requirement for prompt payment (by law, Medicare must pay clean claims within a specified period or pay the provider interest on the claim), and the lack of utilization management that some commercial payers implement.

The number of encounters beneficiaries have with clinicians has grown

As another way to measure access to care, the Commission also calculates the number of encounters Medicare beneficiaries have with clinicians under the physician fee schedule. Encounters measure the number of times a beneficiary received any service(s) covered under the fee schedule during a visit rather than a count of the number of discrete services provided. Because of the way this measure is calculated, it tends to grow more slowly than measures that include the effects of the increasing volume and intensity of services delivered by clinicians. However, even with this more conservative measure, utilization has continued to increase. From 2013 to 2021, the number of encounters per beneficiary grew from 20.8 to 21.6, an average increase of 0.5 percent per year. This growth rate was affected by the COVID-19 pandemic.

Clinician incomes have kept pace with or exceeded inflation, the number of clinicians billing Medicare continues to grow, and interest in becoming a physician remains high

In the long term, access also depends on the supply of clinicians. While less directly related to Medicare's FFS physician fee schedule payment rates than our short-term measures of access, we review evidence on three measures of clinician supply—clinician incomes, the number of clinicians who billed the fee schedule, and the number of applicants to medical school.

- *Clinicians' incomes increased faster than inflation*: Precise information on physician income has historically been difficult to obtain. Researchers (and the Commission)

mostly rely on survey data, with one recent research paper using federal tax data. The study that determined physicians' incomes using federal tax data found that, from 2005 to 2017, after accounting for inflation, physician incomes grew by about 1 percent per year (Gottlieb et al. 2023). More recent survey data suggest that physician incomes continue to grow. For example, from 2015 to 2022, one survey of physicians found that primary care physician incomes increased 33 percent and specialist physician incomes grew about 30 percent, which outpaced measures of inflation growth over that period (Kelly 2022). The incomes of nurse practitioners and physician assistants—who are increasingly important when considering the sufficiency of the supply of clinicians—also continue to grow at rates at or above inflation (Auerbach et al. 2020, Berenson et al. 2022, National Commission on Certification of Physician Assistants 2014).

- *The number of clinicians billing the physician fee schedule has increased*: The number of clinicians billing the fee schedule has increased substantially over time, and the number of clinicians who opt out of Medicare remains very low (Ochieng and Clerveau 2023). From 2009 to 2021, patterns in the growth in the number of clinicians who bill the fee schedule varied by clinician type. Over that period, the number of advanced practice registered nurses (APRNs) and PAs who billed the fee schedule increased nearly 9 percent per year while the number of physicians billing the fee schedule grew by just over 1 percent per year (Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2023).

- *The number of applicants to medical schools increased*: Interest in becoming a physician has increased over the last two decades. The Association of American Medical Colleges reports that, from the 2000–2001 academic year to the 2022–2023 academic year, the number of applicants climbed from 37,088 to 55,188, an increase of 49 percent (Association of American Medical Colleges 2022).

MedPAC's 2023 assessment of payment adequacy and recommended update to payment rates

In March 2023, MedPAC submitted to the Congress its annual assessment of the adequacy of Medicare's payments for clinician services and recommended an update for 2024. Overall, based on the indicators discussed above, MedPAC found that Medicare beneficiaries continued to have stable access to clinician services that was comparable to or better than that of privately insured individuals. However, the costs of running a physician practice grew faster in 2021 than in previous years and were projected to continue rising. The Commission expressed concern that clinicians may not be able to absorb these cost increases and voted to recommend that payment rates under the fee schedule for 2024 increase by one half of the projected increase in MEI. The Commission also voted to recommend additional financial support to clinicians who furnish care to low-income beneficiaries. A discussion of that policy follows in the next section.

Although recent projections indicate that the annual rate of MEI growth peaked in 2022 and the growth rate will slow in 2023 and 2024, some stakeholders continue to worry about whether clinician payments will remain adequate in the future (Centers for Medicare & Medicaid Services 2023). Under MACRA, clinician payment rates will not be

increased in 2025, and relatively low annual updates are scheduled for 2026 and beyond. At its October 2023 public meeting, the Commission began to consider whether changes to MACRA's scheduled updates are needed. As we do every year, the Commission will reassess the adequacy of Medicare's payments for clinician services with updated information during our December and January public meetings.

Supporting clinicians who treat beneficiaries with low incomes

The Commission has found that certain clinicians (referred to as "safety-net clinicians") treat a large share of low-income beneficiaries. In 2019, 9 percent of primary care clinicians and 8 percent of non–primary care clinicians who billed the physician fee schedule had more than 80 percent of their claims associated with beneficiaries who receive Medicare's Part D low-income subsidy (LIS) (Medicare Payment Advisory Commission 2023). (Beneficiaries qualify for the LIS if they have limited assets and income below 150 percent of the federal poverty level, and most who qualify for the subsidy also receive full or partial Medicaid benefits.) In contrast, the majority of clinicians had less than 40 percent of their claims associated with LIS beneficiaries.

Treating beneficiaries with low income often generates less revenue for clinicians. For most services, the Medicare program pays 80 percent of the fee schedule rate, and the beneficiary (or their supplemental insurer) is responsible for the remaining 20 percent. However, due to state prohibitions on collecting cost-sharing payments from most Medicaid beneficiaries and widespread adoption of policies that reduce or eliminate state payment of cost sharing for those beneficiaries, clinicians who care for low-income beneficiaries are often paid effective rates that are 20 percent below Medicare's standard physician fee schedule rates. The Commission estimates that in 2019, that forgone cost sharing amounted to about $3.6 billion (Medicare Payment Advisory Commission 2023). In addition, some beneficiaries who are not eligible for Medicaid coverage of cost sharing may have difficulty meeting their cost-sharing requirements, so providers may be less likely to collect cost sharing from them. Medicare does not pay clinicians for bad debt associated with an inability to collect cost-sharing payments. Since clinicians do not submit annual cost reports to CMS, it is difficult to quantify the magnitude of bad debt for individual clinicians.

Though the Commission has consistently found that Medicare beneficiaries have good access to clinician care overall, our analysis of the Medicare Current Beneficiary Survey (MCBS) suggests that low-income beneficiaries face greater challenges accessing care than other beneficiaries (Medicare Payment Advisory Commission 2023). While many low-income beneficiaries are exempt from the financial burden of cost sharing, challenges in accessing care can arise from a variety of other factors. These could include difficulty finding an available provider, the cost of transportation, and difficulty taking time away from work or caring for family members. Among FFS beneficiaries in 2019, we found that beneficiaries with low incomes were three times more likely to not receive care for a health problem. Low-income beneficiaries also reported having more trouble getting needed health care.

Given that additional support is warranted for safety-net clinicians, the Commission has recommended instituting an add-on payment for clinicians who treat beneficiaries with low incomes. Specifically, clinicians would receive add-on payments based on a

percentage of allowed charges for physician fee schedule services furnished to such beneficiaries. As such, the policy would provide predictable financial support for safety-net clinicians whose revenues are reduced by payment policies for dually eligible beneficiaries and a straightforward financial incentive for clinicians to provide access to care for beneficiaries with lower incomes. For primary care clinicians (including nurse practitioners and physician assistants who practice as primary care providers), the Commission recommended an add-on equal to 15 percent of fee schedule allowed charges for beneficiaries with low incomes; the add-on for other clinicians (including nurse practitioners and physician assistants who do not practice as primary care providers) would equal 5 percent of allowed charges. This difference in add-on rates recognizes that all clinicians who furnish care to low-income beneficiaries are in need of additional financial support, but that primary care clinicians play a central role in the delivery and coordination of care while generally receiving less total compensation than specialists, so they have an even greater need for safety-net payments. Because the physician fee schedule does not have an existing program to provide financial support to safety-net clinicians, and clinician payments are subject to relatively low statutory annual updates in the near term, the Commission recommended that this add-on payment be funded with new spending and not offset by reductions in fee schedule payment rates.

The approach for including a clinician safety-net add-on payment in FFS Medicare offers several benefits. The add-on would be relatively easy for clinicians to understand and for CMS to administer. Total add-on payments received by a clinician would be a simple function of total fee schedule allowed charges for all services furnished to LIS beneficiaries multiplied by a fixed percentage. There are no cliffs, cutoffs, or complex exclusions that would affect add-on payments in unexpected ways. Clinicians who furnish care to more LIS beneficiaries would tend to receive higher total Medicare safety-net add-on payments than clinicians who see fewer LIS beneficiaries.

These add-on payments will not increase administrative burdens on clinicians; Medicare administrative contractors (the entities that process FFS claims) would calculate the add-on payments based on standard claims submissions and make payments to clinicians without the need for additional forms or paperwork. Add-on payments themselves would not be subject to beneficiary cost sharing and could be paid to clinicians on a periodic lump-sum basis rather than adjusting payments for each eligible claim. Quarterly payments would be consistent with the way clinician payments under the Health Professional Shortage Area (HPSA) program are administered. Lump-sum payments are likely to be less burdensome for CMS to administer, and easier for clinicians to understand, than adjustments made on a claim-by-claim basis. Because our add-on payment recommendation would provide higher adjustments for services furnished by primary care clinicians than non–primary care clinicians, it would be necessary for CMS to definitively classify clinicians for these purposes.

Using 2019 data, we estimated the high-level impact of our recommended add-on payments for all fee schedule services furnished to LIS beneficiaries enrolled in FFS Medicare. The estimate shows that a 15 percent add-on for primary care clinicians and a 5 percent add-on for non–primary care clinicians would have increased Medicare spending on clinician services paid under the fee schedule by about $1.7 billion that year, about 40 percent of which would have gone to primary care clinicians and 60 percent to

other clinicians. On a per clinician basis, primary care providers would have received an average safety-net payment of $2,870 per year and other clinicians would have received an average of $990 per year. Primary care clinicians who treated the highest number of LIS beneficiaries would have received an estimated average add-on payment of $10,467.

Correcting misvaluation in the physician fee schedule

Having accurately valued billing codes in the physician fee schedule is essential to a well-performing program. But the Commission has long expressed concerns that many codes in the fee schedule are misvalued, with some codes being relatively overvalued and others relatively undervalued. As a result, payments for some services are too high, while others are too low. Misvaluation of certain services can have several adverse effects. First, when codes are overvalued, Medicare pays more than it should for them, as do beneficiaries via cost sharing. Second, overvaluation creates incentives for clinicians to provide more of the overvalued services and less of others, potentially affecting the amount and type of care that patients receive. Finally, because changes to relative values in the fee schedule are budget neutral, the overvaluation of some codes results in the undervaluation of others. When Medicare pays relatively too much for some services, it pays relatively too little for others.

The Commission has made recommendations to improve the processes and data used to set values for fee schedule billing codes. In 2006, the Commission recommended that CMS establish a standing panel of experts to help the agency identify overvalued services and review the billing code values recommended by the American Medical Association/Specialty Society Relative Value Scale Update Committee (the RUC), which is the main body that recommends relative values for fee schedule services to CMS (Medicare Payment Advisory Commission 2006). And in 2011, MedPAC recommended that CMS collect data on clinician work time, service volume, and practice expenses from a cohort of efficient practices, and use the data to establish more accurate values for fee schedule services (Medicare Payment Advisory Commission 2011a).

How codes become misvalued

Each billing code in the physician fee schedule is assigned a certain number of relative value units (RVUs), which account for the amount of clinician work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. Billing codes for services are first assigned a value (i.e., a certain number of relative value units, or RVUs) when a technique or technology is relatively new to medicine. (The RVUs assigned to a service are a key determinant of the payment rate for that service, since payment rates are calculated by multiplying a service's RVUs by the fee schedule's conversion factor—a fixed dollar amount that is updated each year.) As clinicians gain more experience performing a given service and become able to deliver it in less time, the RVUs for the service are supposed to be reassessed and reduced. This reassessment is typically done by the RUC, and its recommended code values are then submitted to CMS for consideration (and, usually, adoption).[1] Despite the fact that the RUC is supposed to

[1] According to the RUC, CMS accepts more than 90 percent of the RUC's recommendations each year (American Medical Association 2022).

regularly reassess existing values and reduce RVUs for overpriced codes, this tends not to happen. As of 2016, a third of the fee schedule's codes had never been revalued, and among the codes that had been reassessed, only half were revalued to have lower values (Medicare Payment Advisory Commission 2018a). A more recent self-assessment by the RUC found that it has recommended lowering RVUs for only 40 percent of the codes it has reassessed as part of its Potentially Misvalued Services Project (American Medical Association 2023b).

Billing codes can also be misvalued when they are first created, since the data the RUC uses to determine how many RVUs to assign to a service are usually survey responses from a small number of physicians (sometimes as few as 30 respondents) who have a financial incentive to offer inflated estimates of how much time a given service takes to perform (Berenson et al. 2022, Government Accountability Office 2015, Medicare Payment Advisory Commission 2018a).

As a result of innacurate initial code valuations or failures to reduce code values over time, many fee schedule codes assume more resources are being used to deliver services than is actually the case. For example, a study that compared "fee schedule time" (the amount of minutes assumed in the fee schedule for the particular billing codes used by a clinician) to "actual time worked" (the amount of minutes a clinician actually spent delivering these services) found that the billing codes used by radiologists and cardiologists assumed twice as many minutes were needed to deliver these clinicians' services than was actually the case (Merrell et al. 2014). Another study found large discrepancies between fee schedule time and actual time worked for imaging and for the interpretation of certain tests (Zuckerman et al. 2016). And a survey of cardiologists, family medicine physicians, radiologists, ophthalmologists, and orthopedic surgeons found that for 20 of 26 services, the amount of time assumed in the fee schedule was higher than the amount of time clinicians reported needing to actually deliver these services; radiologists were particularly likely to report this (Merrell et al. 2014).

Strong evidence of the overvaluation of certain surgical services

There is particularly strong evidence of overvaluation of surgical services. A 2022 analysis of the 1,349 procedures that involve the use of anesthesia found that, according to time-based anesthesia claims, these procedures took 27 percent less time to conduct, on average, than the billing codes in Medicare's physician fee schedule assumed (Crespin et al. 2022).[2] Studies have also found that clinicians often do not provide all of the postoperative visits that are assumed in the payment rates for 10- and 90-day global surgical codes.[3] According to a recent analysis of data submitted to CMS by clinicians in nine states, clinicians provided only 4 percent of the postoperative visits that are assumed in 10-day global codes, and only 38 percent of the postoperative visits assumed in 90-day global codes (Crespin et al. 2021). Before this empirical data was collected, the RUC had reassessed some of these global surgical codes (a third of the codes that had

[2] Prior studies have also found that fee schedule time exceeds the actual amount of time clinicians spend performing surgical procedures (McCall et al. 2006, Urwin et al. 2019).
[3] Global surgical codes are billed by a clinician who performs a surgical procedure and are intended to pay for the procedure plus pre- and postoperative care provided by this clinician on the day of the procedure (0-day global codes), the day of the procedure plus 10 days afterward (10-day global codes), or the day of the procedure plus 1 day prior and 90 days afterward (90-day global codes).

been previously flagged by HHS's Office of Inspector General), but it recommended reducing the number of postoperative visits assumed in only half of these codes (American Medical Association 2015).

One option to correct the misvaluation of these types of codes would be to convert 10- and 90-day global surgical codes to 0-day global codes, which would pay for surgical procedures plus pre- and postoperative care on the day of a procedure and allow clinicians to bill separately, on a fee-for-service basis, for pre- or postoperative visits furnished on the day before a procedure or in the days following a procedure. As we have noted in a prior comment letter to CMS, values for these new 0-day global codes could be calculated by simply subtracting the RVUs for the pre- and postoperative visits that are currently assumed in these codes' values (Medicare Payment Advisory Commission 2014). For codes that lack assumptions about the number and type of visits during the global period, CMS could extrapolate from similar codes that do have assumptions about pre- and postoperative visits to identify the average percent reduction for these other codes and then apply it to the code that lacks pre- and postoperative visit assumptions. Converting 10- and 90-day global surgical codes to 0-day codes would improve the accuracy of Medicare's payments for many surgical services. Policymakers could use the savings to reduce program spending (and beneficiary premiums and cost sharing), to increase payment rates to other codes, or some combination of the two.

Reducing administrative burden for clinicians

As noted above, MACRA created a pay-for-performance program called MIPS, which is intended to measure the performance of clinicians who do not participate in A–APMs. However, in March 2018, after closely considering the design of MIPS, the Commission recommended that the Congress eliminate it based on the conclusion that MIPS was burdensome for providers, would not provide beneficiaries with meaningful information about quality when choosing a clinician, would not help clinicians change practice patterns to improve the value of the care they provide, and would not help the Medicare program appropriately reward clinicians based on performance (Medicare Payment Advisory Commission 2018b).

MIPS is complex, burdensome, and inequitable, with different rules for clinicians based on location, practice size, and other factors. Many clinicians are not evaluated at all because, as individuals, they do not have a sufficient number of cases for statistically reliable scores to be calculated. For clinicians who must participate, MIPS scores reflect a mix of different, self-chosen measures. As a result, MIPS-based payment adjustments are arbitrary. In addition, MIPS imposes substantial burden for clinicians in the form of staff time spent learning the latest MIPS rules, collecting and reporting performance measure data to CMS, and working with staff to try to improve performance on measures. MIPS creates administrative burden for CMS as well. Eliminating MIPS would reduce administrative burden for providers and allow them to spend more time focusing on patient care.

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