Escaping from Medicare's Flawed Physician Payment System

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EXECUTIVE SUMMARY

What This Paper Covers

There have been many changes over the years to Medicare's reimbursement system for physicians and other clinicians. This paper summarizes these changes before and after the enactment of the Physician Fee Schedule, including policies for setting payment rates and controlling aggregate expenditures. It then discusses how current policy balances the goals of maintaining access to physician services for Medicare beneficiaries, containing costs for patients and the Medicare program overall, and minimizing distortions of the health care sector resulting from payment policy.

What We Found

Medicare policies enacted in recent decades have helped to contain costs by slowing the growth of payment rates. However, expenditures have continued to grow with the volume of physician services and with rapidly rising spending on other Part B services. Access to physician care seems to be stable or improving by several metrics, but it is important to maintain this trend in the long term. Physician payment in Medicare continues to rely on a fee-for-service approach that incentivizes quantity of care over quality and administrative pricing that misestimates the value of health care services.

Why It Matters

Balancing adequacy, containment, and accuracy of payments has important consequences. Inadequate payment levels could discourage doctors from participating in Medicare and thereby compromise access to care for seniors. On the other hand, excessive payments directly increase costs borne by patients and their families while also undermining the fiscal sustainability of the Medicare program for taxpayers and future beneficiaries. Administrative pricing and fee-for-service payment increases these risks in both directions because government agencies tend to misestimate the value of services, which are best determined by the aggregate preferences of consumers expressed through market prices.

Policy Suggestions

While maintaining patients' access to physician services is important, doing so by simply setting payment rates to an external measure of inflation such as the Medicare Economic Index is a flawed approach because it would increase costs and do nothing to ensure the accuracy of payment rates. Policymakers should tie increases to physician payment to other policy changes, such as:

- reducing overpayments on outpatient hospital services, Part B drugs, clinical laboratory services, and durable medical equipment in order to contain overall Part B spending;
- reforming the Physician Fee Schedule, including by incorporating market-based pricing and strengthening budget-neutrality requirements;
- eliminating or significantly reforming failed efforts to promote value-based care such as the Merit-Based Incentive Payment System and financial enticements to participate in advanced alternative payment models.

The most realistic prospect for a long-term transformation of Medicare that balances payment adequacy and efficiency while moving away from a government-driven approach to price-setting and quality improvement would be greater growth in Medicare Advantage.

INTRODUCTION

Medicare's method for reimbursing physicians has gone through many changes over the years. The last major reforms in 2015 were intended to simultaneously avoid massive cuts, control spending, and reform Medicare's payment methodology to encourage greater value. While these were worthy goals to pursue, success has been mixed. In recent years, Medicare participation by doctors has been high, but stagnating pay could reduce this in the long run and thereby compromise access to care for seniors. On the other hand, overpaying for physician services would inflate costs of care and worsen the program's already-strained finances, necessitating higher taxes or benefit cuts and potentially contributing to a fiscal crisis. Medicare's current government-driven payment policies make under-or overpayments more likely because they are not based on the economic value of services as dictated by consumers in a free market. This policy brief outlines the history of physician payment in Medicare, its current shortcomings, and potential options for reforming it.

BACKGROUND

The Evolution of Physician Payment Policy

Physicians and clinicians have consistently been the second highest source of Medicare expenditures behind hospitals, accounting for about 25 percent, or $222 billion, in 2021.[1] Given this scale, physician payment policy in Medicare Part B has attracted much attention — and many changes — over the years. At the start of Medicare, doctors had a great deal of leverage over pay. Reimbursement was based on "customary, prevailing, and reasonable" rates — similar to "usual, customary, and reasonable" private insurance rates at the time. Medicare paid for a service at the lowest of the physician's billed charges, the service's customary or median charge, or the service's "prevailing charge" in a location.[2] Providers could also charge more than the Medicare payment rate and balance bill patients for the remainder.[3]

This process encouraged doctors to raise their fees to obtain higher reimbursement. As a result, annual growth in clinician spending averaged 16 percent in the 1970s.[4] In response to

1 *Clinician* encompasses physicians as well as non-physician practitioners such as nurses, who are all paid under the Medicare Physician Fee Schedule. This paper uses the term *physician* by default unless there is reason to make a specific distinction, such as the term used in data and bibliographical sources. See Centers for Medicare and Medicaid Services, "Historical," https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.

2 Robert A. Berenson et al., "Fee Schedules for Physicians and Other Health Professionals," Urban Institute, April 2016, https://www.urban.org/sites/default/files/2016/05/03/01_fee_schedules_for_physicians.pdf.

3 Michael L. Millenson, "Medicare, Fair Pay, and the AMA: The Forgotten History," *Health Affairs*, September 10, 2015, https://www.healthaffairs.org/do/10.1377/forefront.20150910.050461/; Rick Mayes and Robert A. Berenson, *Medicare Prospective Payment and the Shaping of U.S. Health Care* (Baltimore, MD: Johns Hopkins University Press, 2006).

4 Joe Albanese, "MACRA: Medicare's Fitful Quest for Value-Based Care," Paragon Health Institute, May 2023, https://paragoninstitute.org/research-paper-joe-albanese-macra-medicare-value-based-care-page/.

this unsustainable trend, Congress froze Medicare fees from 1984 to 1986 and disallowed balance billing by participating providers.[5] However, physician spending still increased during this time due to increases in the volume of services and changing practice patterns by doctors.[6]

Over time, commercial insurers began to set their rates in fee schedules that established relative values for each service based on prevailing charges.[7] Congress in turn instructed the Department of Health and Human Services (HHS) to develop a fee schedule based on a resource-based relative value scale (RB-RVS). The RB-RVS weighs each service by the estimated resources needed for physician work, practice expenses, and liability insurance, with each adjusted by estimated geographic differences in costs such as wages, rent, and other input costs.[8] In 1989, Congress enacted the Physician Fee Schedule (PFS) based on these components. It also restricted balance billing of Medicare enrollees by non-participating practitioners to 15 percent of Medicare rates.[9]

The PFS sets payment rates for individual services by multiplying a dollar-value conversion factor by the services' relative values. For example, with the 2023 conversion factor of $33.8872, a particular service in a given location with a relative value that is 1 percent higher than the overall average receives a base payment rate (before other modifiers) of $33.8872 * 1.0100 = $34.2261. The Centers for Medicare and Medicaid Services (CMS) updates the PFS's components in annual rulemaking. CMS receives — and often accepts — recommendations from the American Medical Association's (AMA's) RB-RVS Update Committee (RUC) for updating the RB-RVS. Regulatory changes to the PFS must typically be budget neutral.[10] Figure 1 below summarizes the PFS's payment methodology.

Fiscal Constraints

Despite changing from a charge-based to a cost-based price-setting methodology with the PFS, Medicare's payments to doctors continue to be on a fee-for-service (FFS) basis. Doctors earn more when they provide more services, even if doing so is unhelpful or even harmful for

5 Janet B. Mitchell, Margo L. Rosenbach, and Jerry Cromwell, "To Sign or Not to Sign: Physician Participation in Medicare, 1984," *Health Care Finance Review* 10, no. 1 (Fall 1988): 17-26, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192908/.

6 Janet B. Mitchell, Gerard Wedig, and Jerry Cromwell, "The Medicare Physician Fee Freeze: What Really Happened?," *Health Affairs* 8, no. 1 (Spring 1989), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.8.1.21.

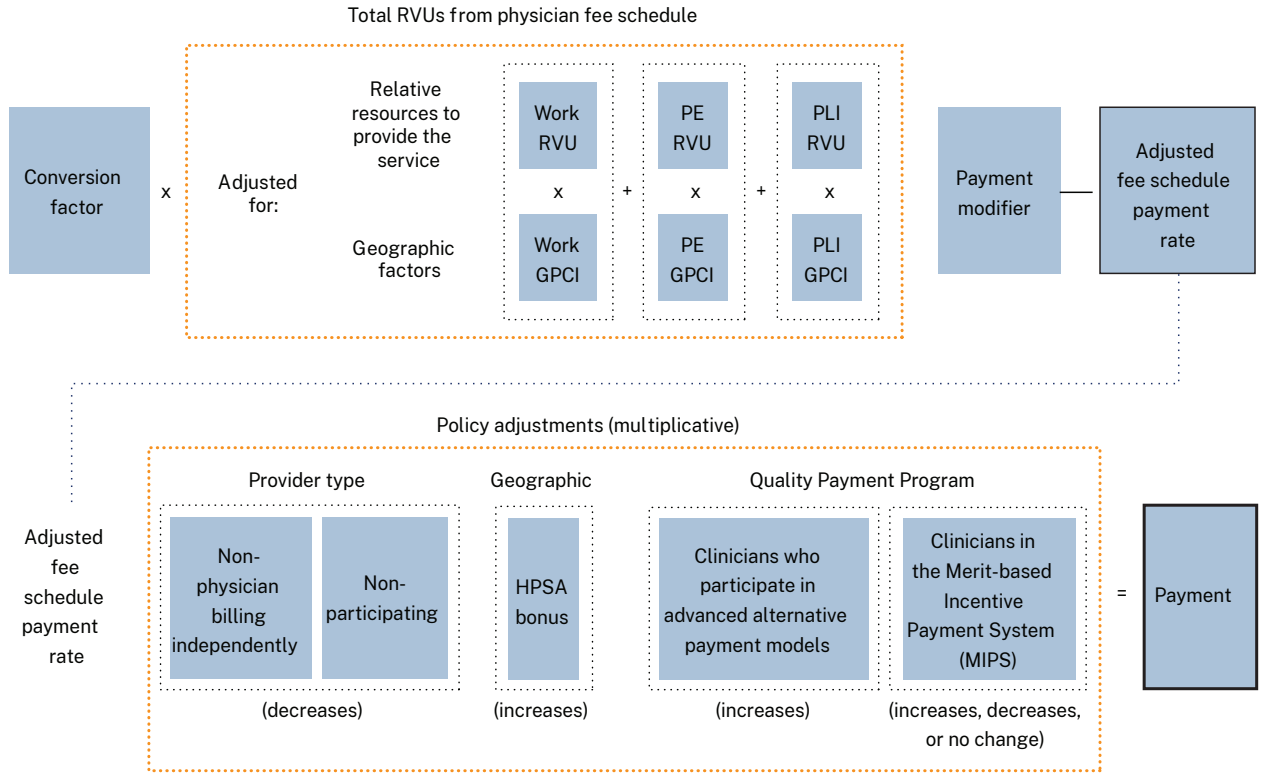
7 Berenson, "Fee Schedules for Physicians."

8 Jackson Hammond, "Primer: Geographic Adjustment of Medicare Rates," American Action Forum, September 8, 2021, https://www.americanactionforum.org/insight/geographic_adjustment/.

9 Congressional Budget Office (CBO), *CBO Study on Physician Payment Reform*, April 1990, https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/79xx/doc7952/90-cbo-049.pdf.

10 John O'Shea, Elise Amez-Droz, and Kofi Ampaabeng, "The Medicare Physician Fee Schedule: Overview, Influence on Healthcare Spending, and Policy Options to Fix the Current Payment System," Mercatus Center, May 24, 2023, https://www.mercatus.org/research/policy-briefs/medicare-physician-fee-schedule-overview-influence-healthcare-spending-and.

Figure 1: Physician and Other Health Professional Payment System, 2023



SOURCE: Medicare Payment Advisory Commission (MedPAC), Physician and Other Health Professional Payment System, revised October 2023, https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf.

patients. Therefore, policymakers have experimented with mechanisms to control overall expenditures.

In 1975, HHS created the Medicare Economic Index (MEI) at Congress's behest to track increases in physician practice costs and earning levels, using it to limit the growth of prevailing charges.[11] Still, expenditures continued to grow rapidly, and the initial conversion factor set under the PFS incorporated overpayments from the previous system.[12] Therefore, when Congress enacted the PFS in 1989, it also created the Volume Performance Standard (VPS). The VPS was a target growth rate for physician spending calculated from projected and historical changes to payment rates and the volume of services. Under the VPS, PFS payment updates were based on (1) the MEI and (2) expenditure growth relative to the VPS target. For example, if Medicare physician spending increased by 11.1 percent in Year 1 compared to a 9.1 percent target for that year, then PFS rates in Year 3 would update by the

11 Benson L. Dutton Jr. and Peter McMenamin, "The Medicare Economic Index: Its Background and Beginnings," *Health Care Finance Review* 3, no. 1 (September 1981): 137-140, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191233/.

12 Paul B. Ginsburg, Lauren B. LeRoy, and Glenn T. Hammons, "I. Legislation: Medicare Physician Payment Reform," *Health Affairs* 9, no. 1 (Spring 1990), https://www.healthaffairs.org/doi/10.1377/hlthaff.9.1.178.

percentage change in the MEI minus the 2 percent excess growth from Year 1 relative to the VPS, with a cap on downward adjustments. If actual growth was lower than the target rate, the difference would be added to the MEI.[13]

In 1997, Congress replaced the VPS with the Sustainable Growth Rate (SGR) formula due to the instability of annual PFS updates under the VPS, which ranged from 0.6 percent to 7.5 percent.[14] The SGR functioned similarly to the VPS, except that it also accounted for economic growth. Within a few years, continued growth in physician spending coupled with a recession led the SGR to mandate a 4.4 percent cut for 2003. The SGR restricted annual adjustments to be between -7 percent and +3 percent, but this reduction was unpopular, particularly as the cuts applied across the board regardless of how cost-effective individual physicians or practices were. As the SGR required more cuts, Congress began to override them with "doc fixes."[15] These doc fixes did not necessarily mean pay raises for physicians, though they did sometimes change the SGR itself. For example, the Tax Relief and Health Care Act of 2006 bumped the 2007 update from -5.0 percent to +0.0 percent and required CMS to update future PFS rates based on SGR adjustments despite Congress not letting them go into effect. This meant the SGR's impact accumulated over time. Although Medicare's spending increases eventually fell below the SGR's targets, the SGR formula, which accounted for years of excess cost growth, called for a 20 percent payment cut in 2015.[16] Figure 2 below shows increases to PFS rates over time, including the deviations between the updates required under the SGR and those enacted by Congress starting in 2003.

Frustration among lawmakers with the political pressure to mitigate SGR cuts and develop offsets led to the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA repealed the SGR, created a new Quality Payment Program with financial incentives for value-based care, and set a fixed schedule of PFS updates.[17] Annual payment updates ranged between -3.3 and +0.3 percent during 2016 to 2023, including with congressional intervention to prevent bigger cuts schedule for 2021 through 2024.[18]

13 CBO, *CBO Study on Physician Payment Reform*.

14 Douglas Holtz-Eakin, Director, CBO, "Medicare's Physician Fee Schedule," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, May 5, 2004, https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/54xx/doc5416/medicarephyspaymts.pdf.

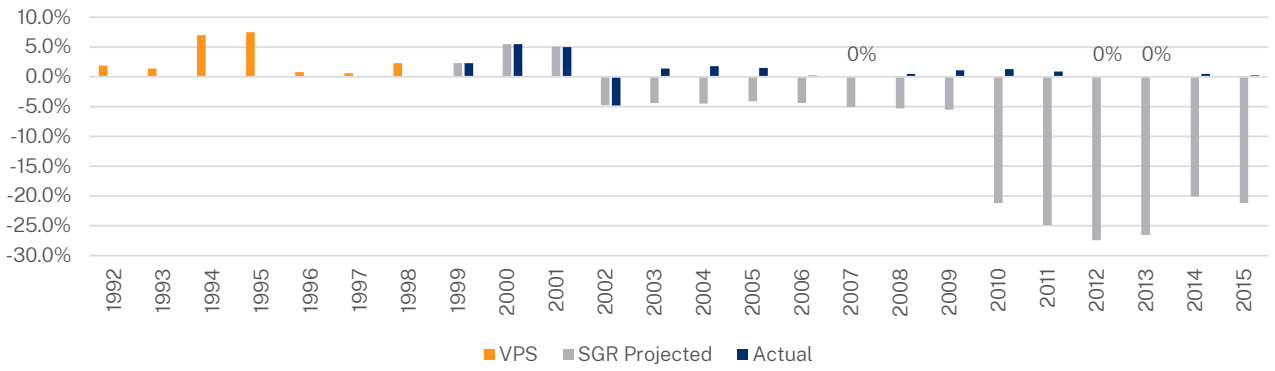
15 For a list of doc fix legislation before MACRA, see Jim Hahn, *The Sustainable Growth Rate (SGR) and Medicare Physician Payments: Frequently Asked Questions*, Congressional Research Service, updated March 16, 2015, https://crsreports.congress.gov/product/pdf/R/R43430.

16 Conor Ryan, "Explaining the Medicare Sustainable Growth Rate," American Action Forum, March 26, 2015, https://www.americanactionforum.org/insight/explaining-the-medicare-sustainable-growth-rate/.

17 Albanese, "MACRA: Medicare's Fitful Quest for Value-Based Care."

18 MACRA set updates to the PFS conversion factor at 0 percent for 2019-2025, but additional required adjustments, such as those for budget neutrality, resulted in net reductions.

Figure 2: VPS, SGR Projected, and Actual Updates to PFS (1992-2015)



SOURCE AMA, "History of Medicare Conversion Factors," https://www.ama-assn.org/system/files/2021-01/cf-history.pdf; CMS, "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2015," https://www.cms.gov/medicare/

PROBLEMS WITH PHYSICIAN REIMBURSEMENT IN MEDICARE

Medicare payment policy continues to be a source of contention, with competing concerns about the adequacy of PFS updates on one hand and Medicare's excessive costs on the other hand prompting lawmakers to consider further reforms to MACRA. Policy changes should safeguard both access to care and program finances, ideally while minimizing government distortions of the health care sector.

Payment Adequacy

Although Congress did not perfectly adhere to the SGR or MACRA statutory updates, they have arguably succeeded in containing physician costs in Medicare. The PFS conversion factor declined roughly 8 percent between 1998 and 2023 in nominal terms, and expenditures fell from 48 percent to 32 percent of FFS Part B spending, indicating that other services grew at a faster rate.[19] Although PFS per capita spending rose 128 percent in that time — versus 66 percent for gross domestic product (GDP), 88 percent for overall inflation, and 126 percent for medical inflation — this was due to growth in volume and intensity of those services.[20]

19 Committee for a Responsible Federal Budget, "Actually, the SGR Has Slowed Health Care Cost Growth," March 13, 2014, https://www.crfb.org/blogs/actually-sgr-has-slowed-health-care-cost-growth; AMA, "History of Medicare Conversion Factors;" Table IV.B7 of the 2008 Medicare trustees' report at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2008.pdf; and Table IV.B6 of the 2023 Medicare trustees' report at https://www.cms.gov/oact/tr/2023.

20 See CBO's June 2023 long-term economic projections data at https://www.cbo.gov/data/budget-economic-data#11 and Federal Reserve Bank of St. Louis, "Consumer Price Index for All Urban Consumers: Medical Care in U.S. City Average," https://fred.stlouisfed.org/series/CPIMEDSL.

Physician groups have argued that a continued decline in fees will compromise Medicare beneficiaries' access to care, as lower pay may attract fewer doctors to participate. Medicare's trustees and the Medicare Payment Advisory Commission (MedPAC) have cited these as long-term concerns as well, although MedPAC reports have often found that access to such services in Medicare is roughly equal to or better than the private insurance market, which offers higher rates.[21] Figures 3 and 4 also demonstrate this based on alternative metrics.

Budgetary Concerns

Containing per unit physician costs has been helpful but insufficient to put Medicare on a sustainable trajectory: expenditures are expected to rise by nearly $1 trillion between 2022 and 2033, from 3.0 percent to 4.5 percent of GDP.[22] Part B is the fastest growing part of the program.[23] Part B premium levels are based on overall program spending, and coinsurance is typically applied as a fixed percentage of costs, so Medicare cost growth directly raises beneficiary expenses. Because general revenues mostly fund it, Part B will also gradually crowd out other federal priorities or increase deficits, potentially contributing to a debt crisis with dire economic consequences.[24] As the number of Americans over age 65 grows, Medicare needs to be even more efficient to be sustainable. Policy changes that simply increase physician payments will leave the program in a more tenuous position.

One proposal would tie PFS updates to the percentage growth of the MEI. The Medicare trustees found that this and other payment changes, such as extending bonuses from MACRA, would increase spending as a share of GDP by 0.4 percentage points over ten years relative to current law ($97 billion) or 2.9 percentage points over 20 years (roughly $824 billion).[25] MedPAC found that updating PFS rates by half of the MEI would increase spending by up to $10 billion over five years (see Figure 5). If PFS conversion factor updates between 1998 and 2023 had been based on MEI, all else being equal, spending would have been over $500 billion higher during that time, as Figure 6 shows.

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21 Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2023 Annual Report*, https://www.cms.gov/oact/tr/2023; MedPAC, "Physician and Other Health Professional Services," in *Report to the Congress: Medicare Payment Policy*, March 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Ch4_Mar23_MedPAC_Report_To_Congress_SEC.pdf; Matthew Fiedler, Brookings Institution, testimony before Committee on Energy and Commerce, Subcommittee on Health, U.S. House of Representatives, October 19, 2023, https://d1dth6e84htgma.cloudfront.net/Matthew_Fiedler_Witness_Testimony_10_19_23_59ef13cc3b.pdf.

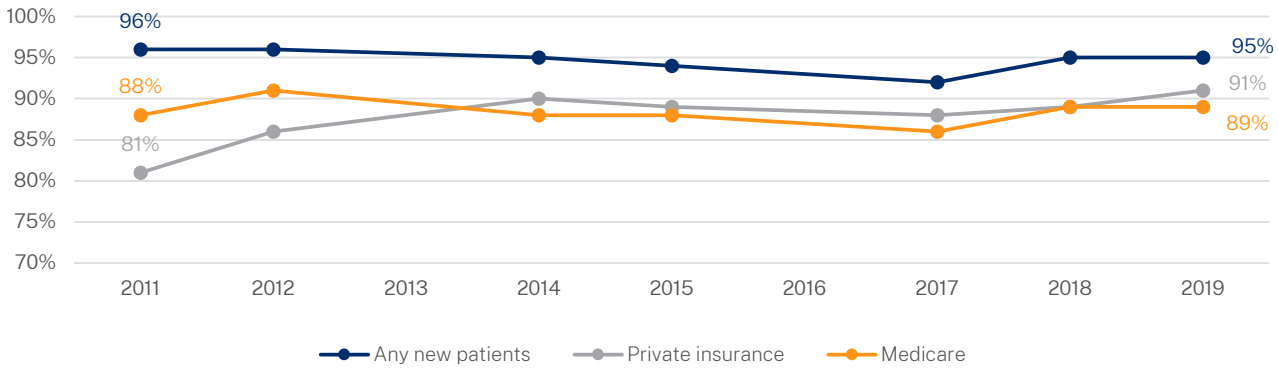
22 Tables S-4 and S-5 in Office of Management and Budget, *Budget of the U.S. Government: Fiscal Year 2024*, https://www.whitehouse.gov/wp-content/uploads/2023/03/budget_fy2024.pdf.

23 Table IV.B6 of the 2023 Medicare trustees' report.

24 Joe Albanese, "Reformers Should Look beyond Medicare's Trust Funds," *National Review*, April 14, 2023, https://www.nationalreview.com/2023/04/reformers-should-look-beyond-medicares-trust-funds/.

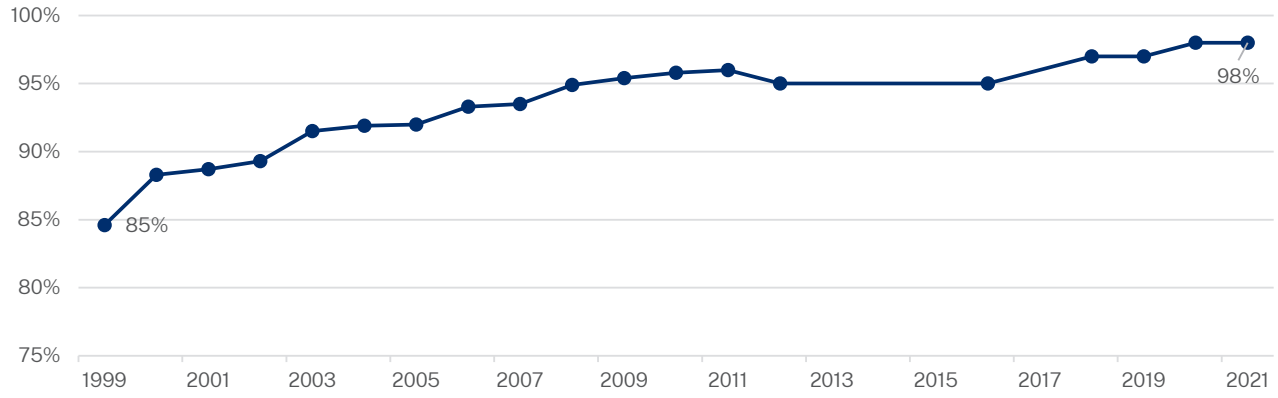
25 The specific parameters are (1) a transition from economy-wide to health-care-specific productivity adjustments for PFS payment updates, (2) updating PFS payment rates based on the MEI, and (3) indefinitely extending bonuses for clinicians participating in advanced APMs as well as a $500 million bonus pool for participants in MIPS. These projections assume a transition to (1) and (2) starting in 2028. See the 2023 Medicare trustees' report. The cost estimate for 2028-2047 is based on GDP estimates from CBO's June 2023 long-term economic projections at https://www.cbo.gov/data/budget-economic-data#11.

Figure 3: Most Physicians Accept New Medicare Patients, With Little Change Over Time



SOURCE Nancy Ochieng et al., "Most Office-Based Physicians Accept New Patients, Including Patients with Medicare and Private Insurance," KFF, May 12, 2022, https://www.kff.org/medicare/issue-brief/most-office-based-physicians-accept-new-patients-including-patients-with-medicare-and-private-insurance/.

Figure 4: Clinician Participation Rate in Medicare



SOURCE CMS data compendiums for 2002, 2003, and 2006-2011 at https://www.cms.gov/data-research/statistics-trends-and-reports/archives/data-compedium and MedPAC reports to Congress on Medicare payment policy for March 2016, 2017, and 2020-2023 at https://www.medpac.gov/document-type/report/.

Payment Distortions

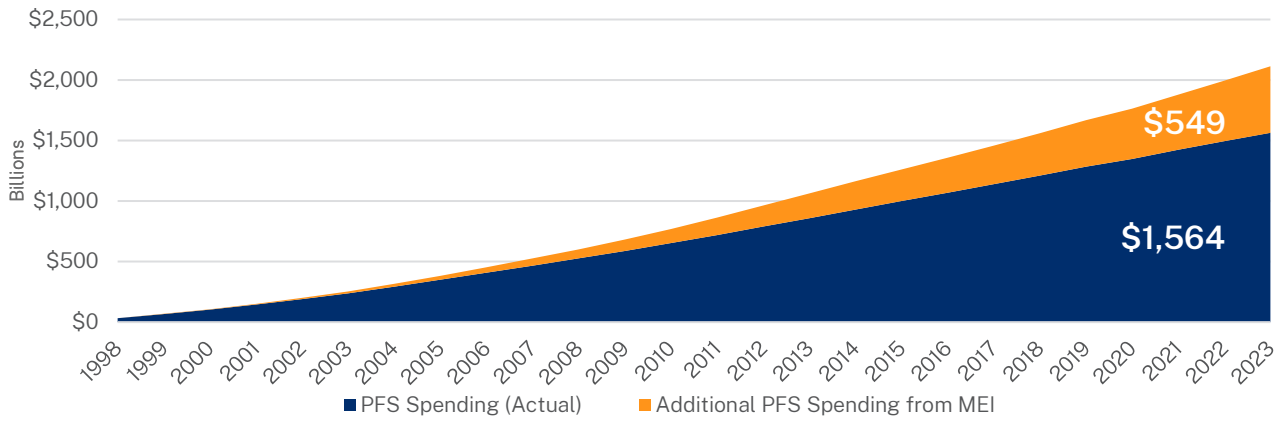
Reforming physician payment also offers an opportunity to remedy two major distortions in the Medicare program: FFS reimbursement and administrative price-setting. Medicare FFS incentivizes the provision of more health care services regardless of their necessity or effectiveness, leading to significant spending on wasteful or even harmful items and services.[26] Furthermore, the incentives faced by doctors uniquely impact overall health care costs with their prescriptions, referrals, and other recommendations. The "physician's pen"

26 Joe Albanese, "Roadblock to Progress: How Medicare Impedes Health Care Innovation," Paragon Health Institute, September 2023, https://paragoninstitute.org/wp-content/uploads/2023/09/Medicare_Roadblock-to-Progress_Albanese_FOR-RELEASE_V2.html.

Figure 5: Cumulative Spending Rises More Than $800 Billion Over 20 Years in Trustees' Alternative Projections

SOURCE MedPAC, "Physician and Other Health Professional Services;" and CBO's June 2023 long-term budget projections.

Figure 6: Cumulative Medicare Spending Would Be $500 Billion Higher If PFS Were Based on MEI



SOURCE AMA, "History of Medicare Conversion Factors;" the 2008 Medicare trustees' report; the 2023 Medicare trustees' report; and CMS's actual regulation market basket updates at https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data.

affects 80-85 cents of every health care dollar spent.[27] MACRA tried to move Medicare away from FFS toward "value-based care" by using a portion of physician payments to reward performance on quality metrics in the Merit-Based Incentive Payment System (MIPS) or participation in advanced alternative payment models (APMs).[28] This effort has generally

27 David Dranove and Lawton Robert Burns, *Big Med: Megaproviders and the High Cost of Health Care in America* (Chicago: University of Chicago Press, 2021), p. 4.

28 Advanced APMs are APMs that require participants to be meaningful users of certified electronic health record technology, provide payment based on quality metrics, and imposes "more than nominal" financial risk on participants.

failed to achieve its goals, and significant reforms are needed to align value with consumer preferences rather than the priorities of federal bureaucracies.[29]

The PFS also provides multiple avenues for government and special interests to directly influence the health care sector. In most markets, prices are based on economic value as determined by interactions between consumers and producers. Medicare payment systems, which influence or are directly adopted by the private insurance market, instead rely on calculation methodologies that give a veneer of technocratic sophistication. But no central planner can replicate the organic order that emerges from decentralized decisions of numerous individuals and firms.

There are also clear examples of purely political considerations influencing this process, especially in the PFS. Congress's frequent interventions over the past few decades — although motivated by a well-intentioned desire to balance access to care and fiscal responsibility — are a key example, as they do not account for the value of physician services to beneficiaries.

The predominant role of the AMA in setting RB-RVUs in the PFS is another instance of this, as federal officials usually defer to the RUC, allowing practitioners to decide specialties' pay relative to others. However, the RUC's estimated payment weights often do not comport with reality.[30] The Government Accountability Office has suggested that the RUC's results are flawed and has recommended that CMS better document its process of establishing relative values, including validating RUC recommendations and identifying potentially misvalued services.[31]

The accuracy of Medicare payments is not simply an academic question. Administrative price-setting by the government significantly risks shortages by underpaying for certain services or waste by overpaying for them. Analysts have argued, for example, that the PFS routinely

29 Albanese, "MACRA: Medicare's Fitful Quest for Value-Based Care;" Joe Albanese, "Another Overpowered Government Office Fails to Meet Expectations," *National Review*, October 4, 2023, https://www.nationalreview.com/2023/10/another-overpowered-government-office-fails-to-meet-expectations/.

30 Peter Whoriskey and Dan Keating, "How a Secretive Panel Uses Data That Distorts Doctors' Pay," *Washington Post*, July 20, 2013, https://www.washingtonpost.com/business/economy/how-a-secretive-panel-uses-data-that-distorts-doctors-pay/2013/07/20/ee134e3a-eda8-11e2-9008-61e94a7ea20d_story.html; Lane F. Burgette et al., "Estimating Surgical Procedure Times Using Anesthesia Billing Data and Operating Room Records," *Health Services Research* 52, no. 1 (February 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5264104/; and Andrew W. Mulcahy et al., "Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods," RAND Corporation, 2021, https://www.rand.org/pubs/research_reports/RR3035-1.html.

31 Government Accountability Office, *Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy*, May 21, 2015, https://www.gao.gov/products/gao-15-434; Geoff Gerhardt, Brian O'Donnell, and Rachel Burton, *Considering Current Law Updates to Medicare's Payment Rates for Clinicians*, MedPAC, October 5, 2023, https://www.medpac.gov/wp-content/uploads/2023/03/PFS-update-reform-MedPAC-Oct-2023-SEC.pdf.

overvalues specialist pay at the expense of primary care services, which has distorted the supply of practitioners.[32]

APPROACHES TO PAYMENT REFORM

Medicare payment policy should ensure access to high-quality physician services, contain costs for beneficiaries and taxpayers, and move away from FFS administrative pricing. The sections below discuss how potential policy options would measure up against these goals.

Incrementalism in the PFS

The simplest approach suggested by some policy experts has been to leave the PFS largely the same and replace MACRA's statutory payment updates with a measure of inflation such as the MEI, similar to how other Medicare payment systems use a wage or market basket index.[33] However, this would increase government spending and patient costs while continuing to rely on FFS administrative pricing. If policymakers overreact to the potential future risk of reduced provider participation in Medicare, the harms created by these additional costs may outweigh the benefits.

Some have suggested other incremental reforms to the PFS, such as providing more oversight of the RUC, rebalancing pay by specialty or geography, calculating provider costs similarly to other payment systems, or incorporating more empirical data to determine relative weights.[34] While certain individual policies to address identifiable shortcomings with the PFS are sensible, tweaking the PFS would retain a flawed approach that leads to mismeasurement of the value of services. Instead, lawmakers should couple any changes to physician payment that increase spending with more substantive reforms to the program and should not increase overall Medicare costs.

Reducing Part B Spending

One approach would be to offset new physician spending with changes elsewhere in Part B.

Part B overpayments are common for outpatient hospital services in particular. A major reason for this is site-of-service differentials, where Medicare pays hospitals twice as much on

32 O'Shea, Amez-Droz, and Ampaabeng, "The Medicare Physician Fee Schedule;" John O'Shea, Kofi Ampaabeng, and Elise Amez-Droz, "How Medicare Part B's Physician Fee Schedule Drives Up Spending and Influences the Provision of Care," Mercatus Center, June 13, 2023, https://www.mercatus.org/research/policy-briefs/medicare-part-b-physician-fee.

33 MedPAC, "Physician and Other Health Professional Services."

34 Maura Calsyn and Madeline Twomey, "Rethinking the RUC: Reforming How Medicare Pays for Doctors' Services," Center for American Progress, July 13, 2018, https://www.americanprogress.org/article/rethinking-the-ruc/; Government Accountability Office, *Medicare: Information on Geographic Adjustments to Physician Payments for Physicians' Time, Skills, and Effort*, February 4, 2022, https://www.gao.gov/products/gao-22-103876; Gerhardt, O'Donnell, and Burton, *Considering Current Law Updates*.

average for routine services that could be performed just as safely and effectively in a physician's office or ambulatory surgical center. Hospitals have a financial incentive to acquire independent physician practices and convert them to hospital outpatient departments in order to command higher outpatient hospital payment rates, which have grown faster than physician fees. Pursuing site-neutral payments for such services – that is, paying the same rate for the same service regardless of the setting – would be a straightforward way to reduce overpayments.[35]

Outpatient drug spending has also grown rapidly. Part B's price controls, which reimburse most drugs at 106 percent of their average sales prices, are a major driver of this overspending. Reducing these baked-in overpayments or enacting more comprehensive reforms to incorporate market-based pricing would be an improvement. For example, policymakers could move coverage of Part B drug benefits to Part D, where spending growth has been far below expectations because of competition among private plans.[36] Addressing federal programs that further distort the drug market, such as the 340B program, is also an option. Under 340B, hospitals acquire drugs at a sizable discount without having to pass savings along to patients. Medicare purchases these drugs at the same rate as non-discounted drugs. Lawmakers could authorize or require CMS to adjust payment for 340B drugs.[37]

Continuing to implement other market-based policies in Part B for clinical laboratories and durable medical equipment (DME) would reinforce previous reforms. Congress created a DME competitive bidding program starting 2008 and has conducted or re-conducted several rounds of bids since then. This program has driven down the cost of certain products, but CMS significantly narrowed the latest round of bids in 2021. Lack of guidance on the 2024 round has created uncertainty. Policymakers should require more timely guidance for future rounds of the competitive bidding program and consider expanding it, including to more DME items.

In 2018, Medicare updated its clinical laboratory fee schedule so that payment rates would be based on private payer data. Industry groups have raised concerns about the accuracy of these rates, and Congress has prevented them from going into effect since the start of the COVID-19 pandemic. Finding a sound way to implement these policies — even if that requires

35 Joe Albanese, "Reducing Overpayments in Medicare through Site-Neutral Reforms," Paragon Health Institute, June 7, 2023, https://paragoninstitute.org/policy-brief-site-neutral-payments-joe-albanese-20230607/.

36 Phillip L. Swagel, Director, CBO, letter to the Hon. Sheldon Whitehouse, March 17, 2023, https://www.cbo.gov/system/files/2023-03/58997-Whitehouse.pdf; Joel Zinberg, "The Arrival of Medicare Drug Price Controls: No Cause for Celebration," Paragon Health Institute, September 6, 2023, https://paragoninstitute.org/policy-brief-joel-zinberg-medicare-drug-price-controls-20230906/.

37 Brian Blase and Joe Albanese, "Turning the Tide on Red Ink: Commonsense Policies to Make Federal Health Programs More Sustainable," Paragon Health Institute, March 2023, https://paragoninstitute.org/wp-content/uploads/2023/03/Turning-the-Tide-on-Red-Ink_Brian-Blase_Joe-Alabanese_FINAL_202303072031.html.

updating the methodology for calculating rates — would improve the accuracy of Medicare payments for laboratory services.

Overhauling the PFS

Reducing other Part B spending would help overall program finances, but it would not control physician spending. Lawmakers could mitigate this risk by limiting pay raises, given that physician participation in Medicare is currently strong, and coupling them with other meaningful changes.

Adding guardrails to the PFS is one possibility. For example, CMS routinely creates new procedure codes through the rulemaking process and must predict the impact on future expenditures. Despite budget-neutrality requirements, utilization growth for new items and services can nonetheless drive spending up over time. Improving budget-neutrality requirements — including by adding retrospective adjustments of prior years' utilization estimates or requiring oversight of new codes — could help control spending.[38]

Another option is to incorporate more pricing information from the private market, such as rates paid by Medicare Advantage (MA) plans. Medicare payments can be set at these rates, or CMS can use MA rate data as an input for PFS rate calculations. Using private payer data for the RB-RVS could eliminate the need for an RUC and move the PFS away from administrative price-setting. MA rates tend to resemble traditional FFS Medicare rates more closely than commercial insurance rates, but MA plans tend to attain similar discounts as commercial plans do in areas where FFS overpays, such as clinical laboratory services and DME.[39]

In the near term, using private payment data may have a limited impact because private payers frequently negotiate based on percentages of Medicare rates. Over time, however, the market could adapt and incorporate a more accurate valuation of physician services, balancing cost reduction and access to care. CMS finalized a similar approach for inpatient hospital services in 2020 but reversed course in 2021 after the transition from the Trump administration to the Biden administration.[40]

38 Chris Pope, "Keeping Medicare Affordable: The Cost of Adding Services," Manhattan Institute, May 30, 2023, https://manhattan.institute/article/keeping-medicare-affordable-the-cost-of-adding-services.

39 Erin Trish et al., "Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance," *JAMA Intern Medicine* 177, no. 9 (2017): 1287-1295, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2643349.

40 See the CMS rule at 86 Fed. Reg. 44774 (Aug. 13, 2021), https://www.federalregister.gov/documents/2021/08/13/2021-16519/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.

Table 1: Advanced APM Performance

Model	Evaluation Period	Net Costs (Millions)	Quality Improvements	Notes
Bundled Payments for Care Improvement Advanced	2018-2021	+$179	Improved readmissions and mortality in Year 3, worse or neutral patient-reported measures in Year 4	
Comprehensive Care for Joint Replacement	2016-2019	+$95	Improved/maintained claims-based measures	Track 1 is advanced.
Comprehensive ESRD Care	2015-2019	+$46	Improved a number of model-specific measures and mortality	LDO and non-LDO two-sided risk are advanced.
Comprehensive Primary Care Plus	2017-2020	+$60	Less utilization and improved on some claims-based measures	Cost estimates for Tracks 1 and 2.
Maryland Total Cost of Care	2019-2021	-$781	Reduced hospital admissions and improved several measures	Care Redesign Program and Primary Care Program Track 3 (started 2023) are advanced.
Medicare Shared Savings Program	2017-2022	-$7,232	Higher average performance on measures required for shared savings	Basic Track E and Enhanced Track (started 2019) and Medicare ACOs Tracks 1+, 2, and 3 (2017-2021) are advanced.
Next Generation ACO	2016-2020	+$387	Not associated with changes on certain measures (Fourth Report)	
Oncology Care Model	2016-2020	+$377	No significant change in measures	Two-sided risk arrangement is advanced.
Vermont All-Payer ACO	2018-2021	-$125	Reduced state-level hospital utilization, ACO-level specialty E&M visits	Vermont Medicare ACO Initiative (started 2019).

SOURCE: For models where the latest evaluation was released by early 2022, see CMS, *Synthesis of Evaluation Results across 21 Medicare Models, 2012-2020*, https://www.cms.gov/priorities/innovation/data-and-reports/2022/wp-eval-synthesis-21models. For later evaluations, see Julie Somers et al., "CMS Bundled Payments for Care Improvement Advanced Model: Fourth Evaluation Report," Lewin Group, June 2023, https://www.cms.gov/priorities/innovation/data-and-reports/2023/bpci-adv-ar4 (did not account for Year 4 spending impacts); Lewin Group, "CMS Comprehensive Care for Joint Replacement (CJR) Model: Performance Year 5 Evaluation Report — Executive Summary," April 2023, https://www.cms.gov/priorities/innovation/data-and-reports/2023/cjr-py5-ar-exec-sum; Author's calculations from impact estimates of Part A and B per-beneficiary-per-month expenditures and number of Comprehensive Primary Care Plus beneficiaries in Tables 5.A.1 and 5.A.10 of Mathematica, "Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Fourth Annual Report," May 2022, https://www.cms.gov/priorities/innovation/data-and-reports/2022/cpc-plus-fourth-annual-eval-report-app; Jason Rotter et al., "Evaluation of the Maryland Total Cost of Care Model: Quantitative-Only Report for the Model's First Three Years (2019 to 2021)," Mathematica, December 2022, https://www.cms.gov/priorities/innovation/data-and-reports/2022/md-tcoc-qor2; Kristina Hanson Lowell, "Next Generation Accountable Care Organization (NGACO) Model Evaluation: Fifth Evaluation Report," National Opinion Research Center (NORC), University of Chicago, November 2022, https://www.cms.gov/priorities/innovation/data-and-reports/2022/nextgenaco-fifthevalrpt (does not present impacts on claims-based quality measures); and Sai Loganathan, "Evaluation of the Vermont All-Payer Accountable Care Organization Model: Third Evaluation Report," NORC, July 2023, https://www.cms.gov/priorities/innovation/data-and-reports/2023/vtapm-3rd-eval-full-report. For the Medicare Shared Savings Program, see HHS, "Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-Quality Care," press release, August 24, 2023, https://www.hhs.gov/about/news/2023/08/24/medicare-shared-savings-program-saves-medicare-more-1-8-billion-2022-continues-deliver-high-quality-care.html; National Association of ACOs, "Medicare ACO Program Results: 2021 Edition," https://www.naacos.com/assets/docs/pdf/2023/NAACOS2021MSSP-SavingsResource.pdf; and National Association of ACOs, "Medicare ACOs Saved $4.2 Billion in 2022 Shared Savings ACOs Continue to Deliver Savings, Improve Health," press release, August 24, 2023, https://www.naacos.com/press-release--medicare-acos-saved--4-2-billion-in-2022.

Quality Payment Program Reform

Lawmakers should also address MACRA's Quality Payment Program as part of broader payment reforms. The performance incentives under MIPS have been ineffective and burdensome for participating physicians. Many stakeholders, such as physician groups and

accountable care organizations, may prefer that Medicare provide bonuses for participating in advanced APMs rather than requiring pay-for-performance in MIPS, but there is no evidence that the bonuses increase APM participation.[41] Extending bonuses at just 1.75 percent is estimated to boost Medicare spending by about $680 million per year.[42] APMs themselves have also had a mixed record; models developed and managed by the Center for Medicare and Medicaid Innovation (also called the CMS Innovation Center) have been found to cost $5.4 billion on net from 2010 to 2019 rather than saving $2.8 billion as expected, and the Congressional Budget Office now projects that new models will likely increase spending on average.[43] Only three out of nine models with advanced components have lowered costs, of which two had non-advanced tracks that did not have separate evaluations, as Table 1 above shows. Furthermore, studies have cast doubt on the official results of the Medicare Shared Savings Program.[44] It makes little sense to continue to reward participation in models that often do not work.[45]

Policymakers should ideally eliminate MIPS and advanced APM bonuses, including the differential payment updates between their participants. Instead of MIPS, CMS should encourage private payers and other entities to provide quality metrics that enable patients to shop between providers on the basis of quality. To the extent CMS does measure quality, it should focus its efforts on penalizing poor performers based on misdiagnosis, mistreatment, or appropriateness metrics.

If lawmakers do not eliminate MIPS, or if they otherwise choose to extend APM bonuses, they should at least significantly modify the bonuses. For example, they could require clinicians to take on more downside risk or encourage more participation in all-payer APMs rather than Medicare APMs in order to encourage private payers, including MA plans, to develop more successful and innovative payment models. Other design changes could fine-tune these financial incentives even more and encourage greater parity in their availability to providers, such as proportionally basing bonuses on the share of patients that participate in qualifying

41 Albanese, "MACRA: Medicare's Fitful Quest for Value-Based Care."

42 CBO, "Estimated Budgetary Effects of the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act and Certain Provisions of the Modernizing and Ensuring PBM Accountability (MEPA) Act," November 6, 2023, https://www.cbo.gov/system/files/2023-11/SFC_MentalHealth_ChairMark_11-6-23.pdf.

43 CBO, *Federal Budgetary Effects of the Activities of the Center for Medicare and Medicaid Innovation*, September 2023, https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf.

44 J. Michael McWilliams and Alice J. Chen, "Understanding the Latest ACO 'Savings': Curb Your Enthusiasm and Sharpen Your Pencils — Part 1," *Health Affairs Forefront*, November 12, 2020, https://www.healthaffairs.org/content/forefront/understanding-latest-aco-savings-curb-your-enthusiasm-and-sharpen-your-pencils-part-1

45 See testimony of Joe Albanese in "What's the Prognosis? Examining Medicare Proposals to Improve Patient Access to Care and Minimize Red Tape for Doctors," hearing before the House Committee on Energy and Commerce, Subcommittee on Health, October 19, 2023, https://energycommerce.house.gov/events/health-legislative-hearing-what-s-the-prognosis-examining-medicare-proposals-to-improve-patient-access-to-care-and-minimize-red-tape-for-doctors.

models rather than providing or withholding the full bonus based on a specific threshold and limiting the amount of time clinicians can receive bonuses.

Beyond Fee-for-Service

In the absence of performance-based quality programs, substantial changes across traditional Medicare's payment systems would be necessary to move it beyond FFS. Shifting more financial risk from taxpayers to health care providers could incentivize quality improvement and cost savings. Two examples of this would be to implement episode-or population-based payments in order to encourage more efficient health care delivery while reducing the government's need to set prices for individual services. Enacting such policies directly in Medicare payment systems would be more effective than relying on APMs, which have overlapping impacts that diminish their effectiveness, incentive payments that nullify potential cost savings, limited downside risk, and limited scope (i.e., they are temporary and typically targeted toward specific provider types, health care procedures, or geographical areas).

Episode-based payments, such as bundling, would provide a single payment for all the services for a single episode of care or condition. CMS would set a target price for a primary procedure and any other ancillary items and services that are typically related to it, and a provider who delivers care at a lower cost would retain a profit, while those who exceed it would incur losses. Population-based reimbursement, such as capitation, offer providers fixed, regularly occurring payments per patient. Providers again retain any surplus or deficit they incur from delivering care. A more incremental approach is shared savings, where a provider receives a target price and retains a share of the difference between it and the actual costs as either a profit or a loss.

Congress could fully or partially replace the PFS with episode-based payments or population-based reimbursement or combine the two to mitigate the risks of fully relying on any single approach. However, such payment policies would be most effective when implemented across payment systems, as a single patient or episode of care might require services from multiple providers, requiring policymakers to substantially restructure Medicare. There would still be some risk of CMS calculating the wrong payment rates or target prices, which could reduce the ability to estimate savings in practice (and has been a flaw of accountable care organization-based models that are based on administrative benchmarks). There would also be a limited ability to assess performance by individual physicians. Still, episode-or population-based payments offer an improvement on these fronts compared to the status quo in Medicare, and policymakers could mitigate the former risk by calculating target prices and capitation rates based on private payer data rather than simply using PFS rates as a basis.

Another long-term approach to Medicare reform is building on MA's success. MA plans have more flexibility to design their contracts, negotiate payments with providers and manage utilization, which encourages them to secure discounts and deliver care more efficiently than traditional Medicare. They also receive risk-adjusted capitated payments from CMS, incentivizing them to maximize the value of care for their enrollees, including those with higher health care costs, by bearing risk for the total cost of their care. Finally, MA plans are required to pass along savings from the bidding process onto enrollees in the form of extra benefits or lower cost-sharing and compete with other plans that MA enrollees can choose from. Many of these flexibilities and payment mechanisms echo the features of advanced APMs, with a key difference being that MA plans have an economic incentive to adapt to market conditions in order to deliver core benefits more efficiently, unlike CMS.

MA has already grown rapidly to about half of all Medicare beneficiaries. Policies that enable it to compete on equal footing with traditional Medicare will help deliver better physician (and other) services to seniors on a more efficient basis.

CONCLUSION

Years of tinkering with Medicare payment policy for physicians have not produced a suitable long-term approach. Enacting yet another government-driven approach to payment would only replicate the same problems and fail to balance access to care with fiscal sustainability. The dissatisfaction with the status quo presents an opportunity for policymakers to take steps to move the PFS — and Medicare as a whole — away from FFS administrative pricing toward a long-term vision that bases payment on the value of health care services to patients themselves.