HMA

Medicare Physician Fee Schedule Reform: Structural Topics and Recommendations

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TODAY'S EXPERTS:

Amy Bassano
Managing Director
Washington, DC
HMA

Rachel Kramer
Principal
Washington, DC
The Moran Company

Rachel Matthews
Consultant
Washington, DC
The Moran Company

Jared Staheli
Consultant
Washington, DC
Leavitt Partners

Full speaker bios can be found at www.healthmanagement.com/team

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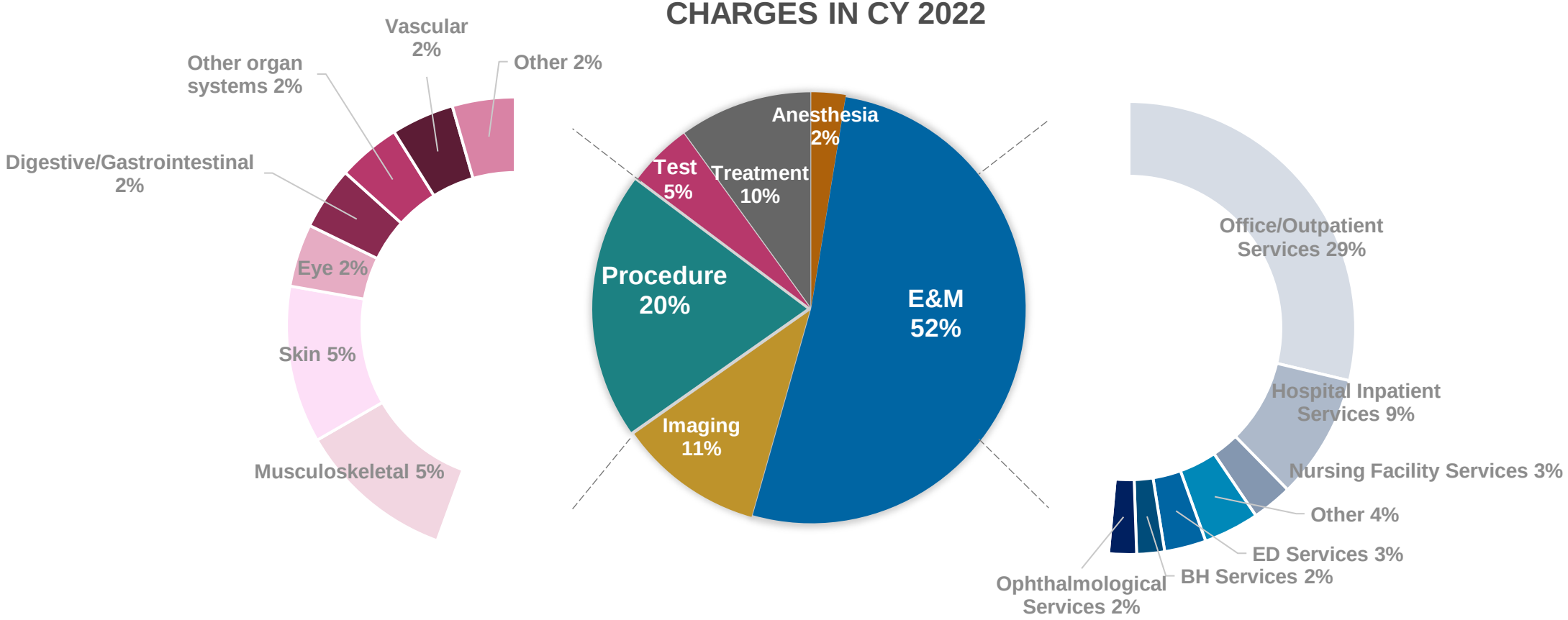
AGENDA

- The Medicare Physician Fee Schedule (PFS), a brief “101”
- What’s the problem?
- Momentum for reform
- Structural challenges in more detail
- Recommendations within CMS authority to implement

THE MEDICARE PHYSICIAN FEE SCHEDULE 101: IT'S BIG

Payment system approaching $100 billion for over 8000 services

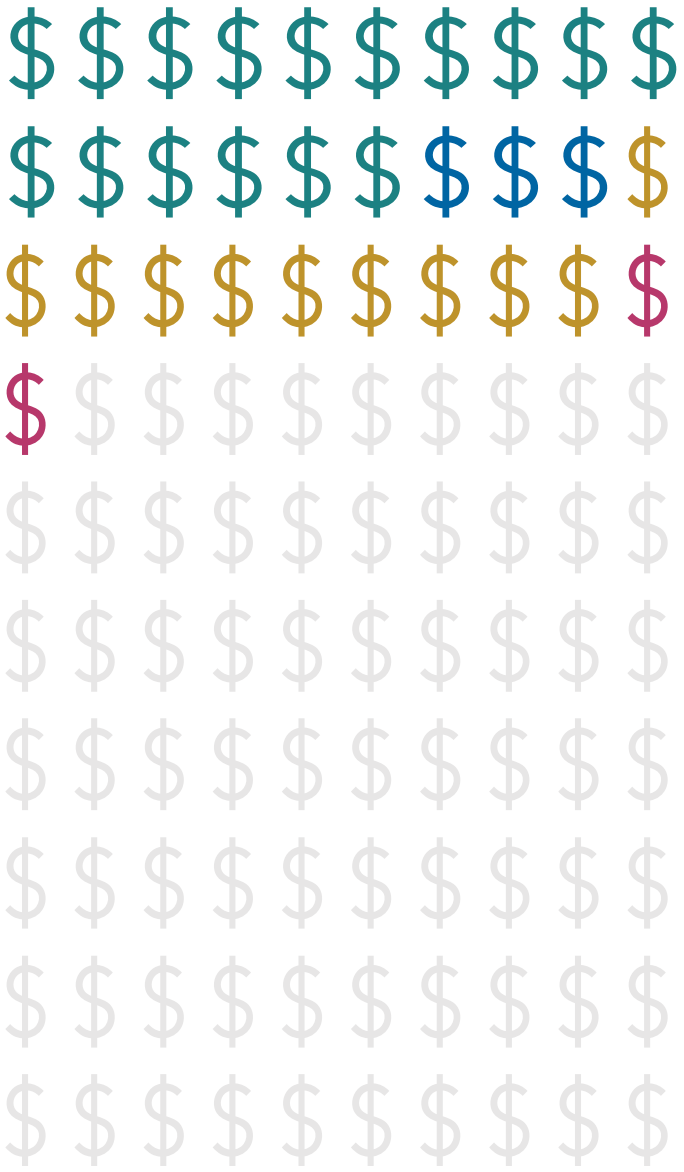
FIGURE 1. ~ $91.7 BILLION IN PFS TOTAL ALLOWED CHARGES IN CY 2022



Source: 2022 Physician/Supplier Procedure Summary (PSPS) data, restricted to PFS services with Status Indicators A, C, R, T, and J
Notes: E&M = Evaluation and Management, ED = Emergency Department, and BH = Behavioral Health

REIMBURSEMENT TO MORE THAN 1 MILLION CLINICIANS

FIGURE 2. SPECIALTY DISTRIBUTION OF ALLOWED CHARGES IN PFS CY 2022



16%
Primary care
(6 specialties, 252,190 providers)

3%
Behavioral health
(5 specialties, 112,207 providers)

10%
Advanced practice providers
(5 specialties, 390,355 providers)

2%
Other suppliers
(22 specialties, 75,717 providers)

69%
All other specialties
(72 specialties, 699,602 providers)

A RESOURCE BASED RELATIVE VALUE SYSTEM (RBRVS)

Medicare reimbursement to clinicians is based on a geographically adjusted resource-based relative value scale (RBRVS)

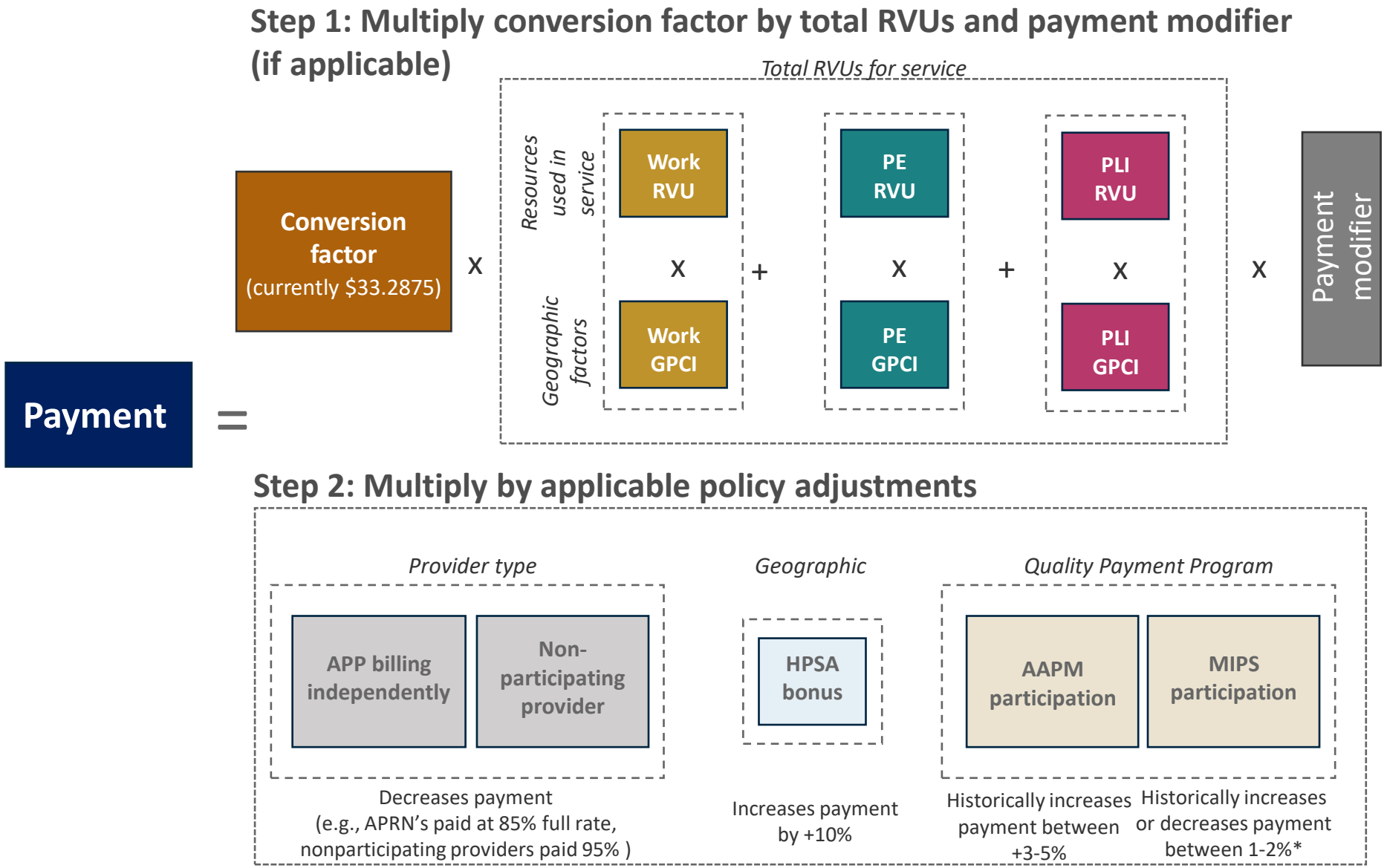
Established in the early 1990s to replace reimbursement based on customary, prevailing, and reasonable charges

Intended to value services relative to the resources consumed when furnishing care to a typical patient

A service that requires more resources is valued higher than services that involve fewer resources

In theory, if the resources are accurate, the RBRVS should limit financial incentives to furnish one service rather than another

Key Elements of Payment: Granular and Highly Technical



Source: MedPAC. Payment Basics: Physician and Other Health Professional Payment System. Revised October 2023. Available here.
Notes: RVU = Relative value unit, GPCI = Geographic practice cost indices, PE = Practice expense, PLI = Professional liability insurance, APP = Advanced practice provider, APRN = Advanced practice registered nurse, HPSA = Health professional shortage area, AAPM=Advanced Alternative Payment Method, MIPS = Merit-based Incentive Payment System

OVERARCHING PROBLEMS

- Despite significant legislative and regulatory refinements, there is concern that the PFS has not sufficiently evolved to adequately address new healthcare delivery models, support person-centered care or account for changing economic conditions
- Payment instability
  - Fraught conversion factor history
  - More than a decade of short term “patches”
- Critiques that aspects of the payment system and opaque processes perpetuate pricing distortions or allow services to become misvalued over time
- Goals envisioned in MACRA not fully achieved

CONCERNS CONTRIBUTE TO PRESSING POLICY ISSUES WITH WIDESPREAD IMPLICATIONS

- Implications for federal spending, taxpayers and beneficiaries
- Access to affordable care
- Payment stability and viability of independent physician practice
- Influence extends broadly into other payer contracting, Medicare Advantage (MA) and Alternative Payment Models (APMs)
- Consolidation
- Workforce challenges
- Clinician wage gaps
- Site neutral payments
- Administrative burden
- Promoting value-based care as intended in MACRA
- Achieving CMS goal of 100 percent accountable care by 2030

MOMENTUM IS BUILDING FOR REFORM

Varying viewpoints and calls for repair ramping up

VIEWPOINT

Medicare Physician Payment in Need of Major Repair

Jack S. Resneck Jr, MD
Department of Dermatology and Philip R. Lee Institute for Health Policy Studies, University of California–San Francisco School of Medicine, San Francisco.

More than 3 decades have passed since Congress enacted and the Centers for Medicare & Medicaid Services (CMS) implemented the Resource-Based Relative Value Scale (RBRVS) as the basis for the Medicare physician payment system. During that period, the American Medical Association/Specialty Society RVS Update Committee (RUC), an independent expert panel that recommends updates to CMS for the relative valuations of medical services, has faced scrutiny. Some critics have raised policy concerns about RUC's methodology and membership [1-4] and phy-

technical skill, physical effort, mental effort and judgment, and psychological stress), practice expense (labor, equipment, supplies, rent, and other overhead), and professional liability insurance costs for the thousands of medical service codes. CMS then applies a conversion factor and recognizes geographic differences to establish Medicare payment amounts from those relative values.

The RUC is an independent panel of 32 experts from a variety of medical and surgical specialties, assembled so

VIEWPOINT

The Medicare Physician Fee Schedule and Unethical Behavior

Robert A. Berenson, MD
The Urban Institute, Washington, DC.

Ezekiel J. Emanuel, MD, PhD
Medical Ethics and Health Policy, University of Pennsylvania, Philadelphia.

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The Medicare Physician Fee Schedule (MPFS) directly determines nearly $200 billion in Medicare spending and indirectly affects an additional $600 billion or more in payments to physicians by other payers.[1] Yet the fee schedule has widely recognized flaws: paying whether the service rendered is medically necessary, is performed efficiently, or meets acceptable quality standards. At its core, clinician fee schedules attempt to pay for clinicians' time and effort, not whether the care maintains or improves patients' health.

Many hoped that value-based payment models would make MPFS flaws moot. Paradoxically, virtually all the alternative payment models that the Centers for Medicare and Medicaid Innovation and other payers are testing are built on the MPFS foundation. Consequently, the MPFS flaws have not been supplanted but instead transferred into alternative payment models

RVUs to CMS, which accepts them approximately 95% of the time or makes only minor adjustments.

The Inherent Conflict of Interest in RVU Determination

How the government determines spending for professional services is essentially determined by surveys of a few thousand physicians estimating time and work intensity based on physician-authored service descriptions. Both the Government Accountability Office and the Medicare Payment Advisory Commission have criticized CMS for relying on the flawed RUC processes.[3,4] But there is a deeper problem with the RVU process: it entrenches a physician conflict of interest in determining reimbursement by having physicians, whose pay is directly determined by the fee schedule, assess time and intensity and therefore incentivize them to exaggerate

Recent bipartisan mobilization in Congress

- Senate Committee on Finance white paper (May 2024)
- Senators Whitehouse/Cassidy release Request for Information (RFI) (May 2024)
- Senate Committee on the Budget hearing (March 2024)
- Senators form Medicare payment reform workgroup (February 2024)
- House Energy & Commerce Subcommittee on Health hearing (October 2023)
- Several Centers for Medicare and Medicaid Services (CMS) RFIs issued through rulemaking

STRUCTURAL CHALLENGES OF THE PFS

The Medicare Physician Fee Schedule is structurally organized as an interrelated system

(One element of the PFS influences other elements)

“Structural” refers to how an element of the payment system is constructed or addressed

“Structural challenge” refers to something that could jeopardize the stability and reliability of the system

BUDGETARY CONCERNS

Issue # 1
Budgetary Concerns

- System in near-constant state of transition. Lack of stability and inflationary update may incentivize vertical integration between practitioners and health systems.
- Affordable and accessible care is critical to patients' health.

Invested Stakeholders:

Common stakeholder refrains:

- Conversion factor cuts from RVU changes are unsustainable
- Providers need stable payments to remain financially secure (particularly those in community practice)
- Reforming the budget neutrality requirement is critical to the health of the fee schedule
- Advanced Alternative Payment Model (AAPM) bonus payments motivate physicians to join value-based arrangements

RECENT SUBSTANTIVE PFS CHANGES HAVE TRIGGERED BUDGET NEUTRALITY (BN) ADJUSTMENTS

Calendar Year (CY)	BN Adjustment to the Conversion factor	Primary Policy Triggering Adjustment
2024	-2.18%	Creation of the O/O E/M visit inherent complexity add-on code (G2211)
2023	-1.60%	Revaluation of other E/M codes (hospital visits, emergency department visits, home visits and nursing facility visits)
2022	-0.14%	Revaluation of misvalued codes
2021	-10.20%	Revaluation of O/O E/M codes
2020	+0.14%	Revaluation of misvalued codes

System Reality Check

The Centers for Medicare and Medicaid Services (CMS) must work within statutory requirements.

CMS has no authority to set conversion factor updates, waive budget neutrality or beneficiary cost sharing without Congressional intervention.

Notes: O/O E/M = Office/outpatient evaluation and management

VALUATION AND PRICING DISTORTIONS

Issue # 2: Valuation Process & Pricing Distortion

- CMS presupposes services are valued correctly to maintain system integrity.
- Conflict of interest concerns with AMA's RUC (CMS's main collaborator in valuation).
- Heavy reliance on physician survey data that is viewed as incomplete at best, inherently biased at worst.
- Structural components of the PFS allow physician services to become misvalued over time.
- Distorted work and/or practice expense values for certain services.

Invested Stakeholders:

MEDPAC

The Commonwealth Fund

RAND CORPORATION

URBAN INSTITUTE

AdvaMed Advanced Medical Technology Association

AMA

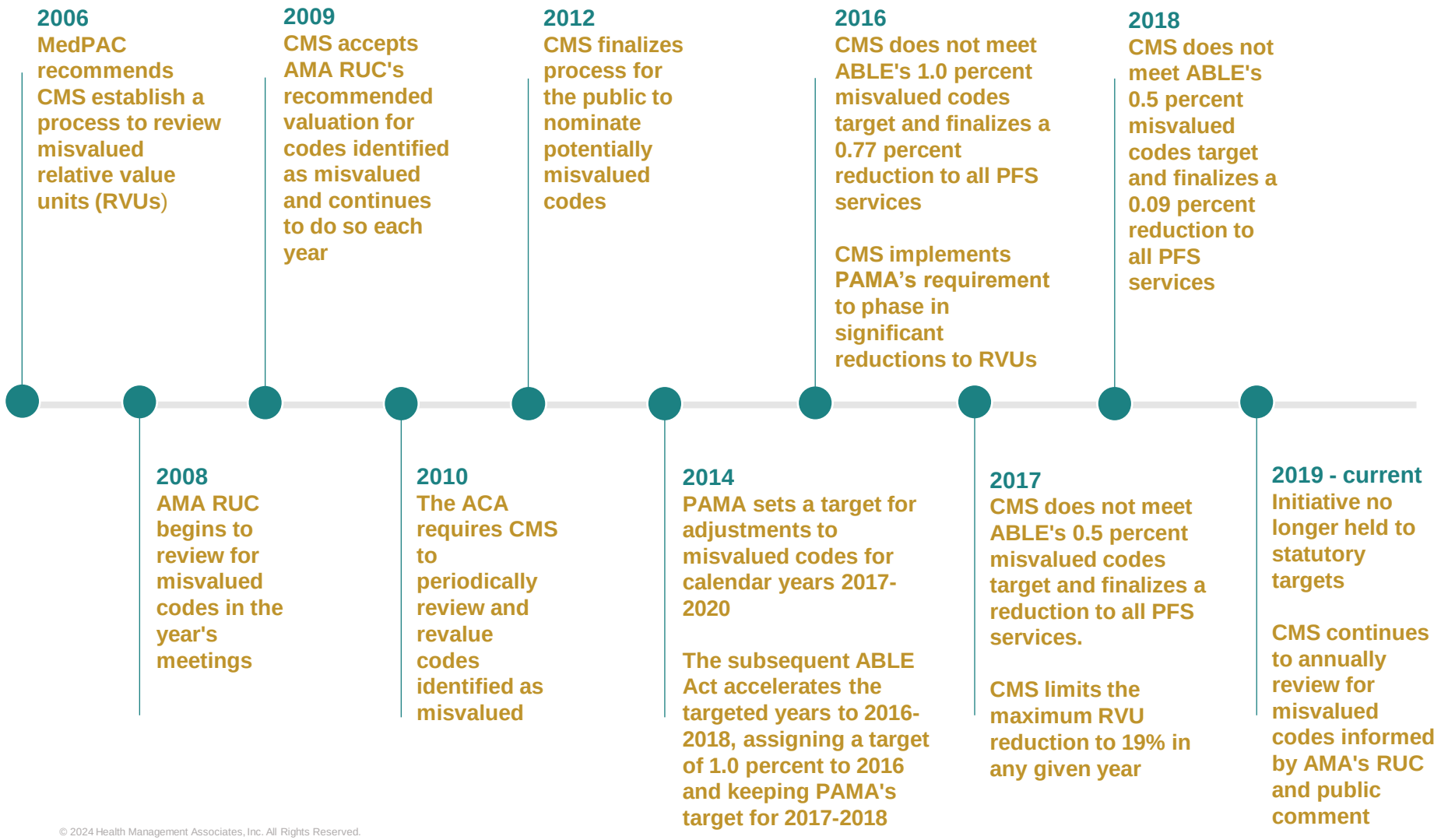
USC Schaeffer

Common stakeholder refrains:

- Critique of granular, code-by-code valuation process
- Advocate for critically examining data sources used in valuation
- Urge need to correct illogical physician work values for certain services and account for efficiency gains
- The methodology and main data source to determine practice expense (PE) reimbursement is out-of-date and drives distortions

Notes: AMA's RUC = American Medical Association/Specialty Society's Relative Value Update Committee (RUC)

PROCESSES ARE IN PLACE TO REFINE RELATIVE VALUES, BUT DISTORTIONS PERSIST



System Reality Check

PFS is a resource-based relative value scale (RBRVS) where "value" is based on typical "cost" inputs.

CMS may address process improvements, data sources and methods used to develop and refine relative value units (RVUs), however more comprehensive reform requires Congressional intervention.

Notes: PAMA = Protecting Access to Medicare Act of 2014 (PL 113-93); ABLE Act = Achieving a Better Life Experience (ABLE) Act of 2014, signed as part of PL 113-295

SUPPORTING PERSON CENTERED CARE

Issue # 3: Adequately Supporting Primary Care, Care Coordination, and Behavioral Health

- Chronic undervaluation has led to inequities between cognitive/longitudinal vs. episodic-based care, amplified by current workforce crisis.
- Fee schedule passively devalues services that do not experience efficiency gains from technology, techniques, and clinical practice (i.e., most codes in primary and behavioral health care).

Invested stakeholders:

Common stakeholder refrains:

- Structural weaknesses of fee schedule create artificially fixed pool, forces winner and loser dynamics across specialties
- Urge the need to compensate for the market's rapid inflation of practice expenses
- Calls for more routine data updates rather than periodic overhauls that bring large-scale redistribution

EMERGING TECHNOLOGIES

Issue # 4: Emerging Technologies

- Potential influx of new technology-based services that are not easily incorporated into current system.
- New technology may introduce questions on data governance, digital equity, safeguards to patient safety and Medicare program integrity, and appropriate payment policy.
- Coding system incentivizes technology innovators to seek reimbursement for each individual item.

Invested Stakeholders:

Common stakeholder refrains:

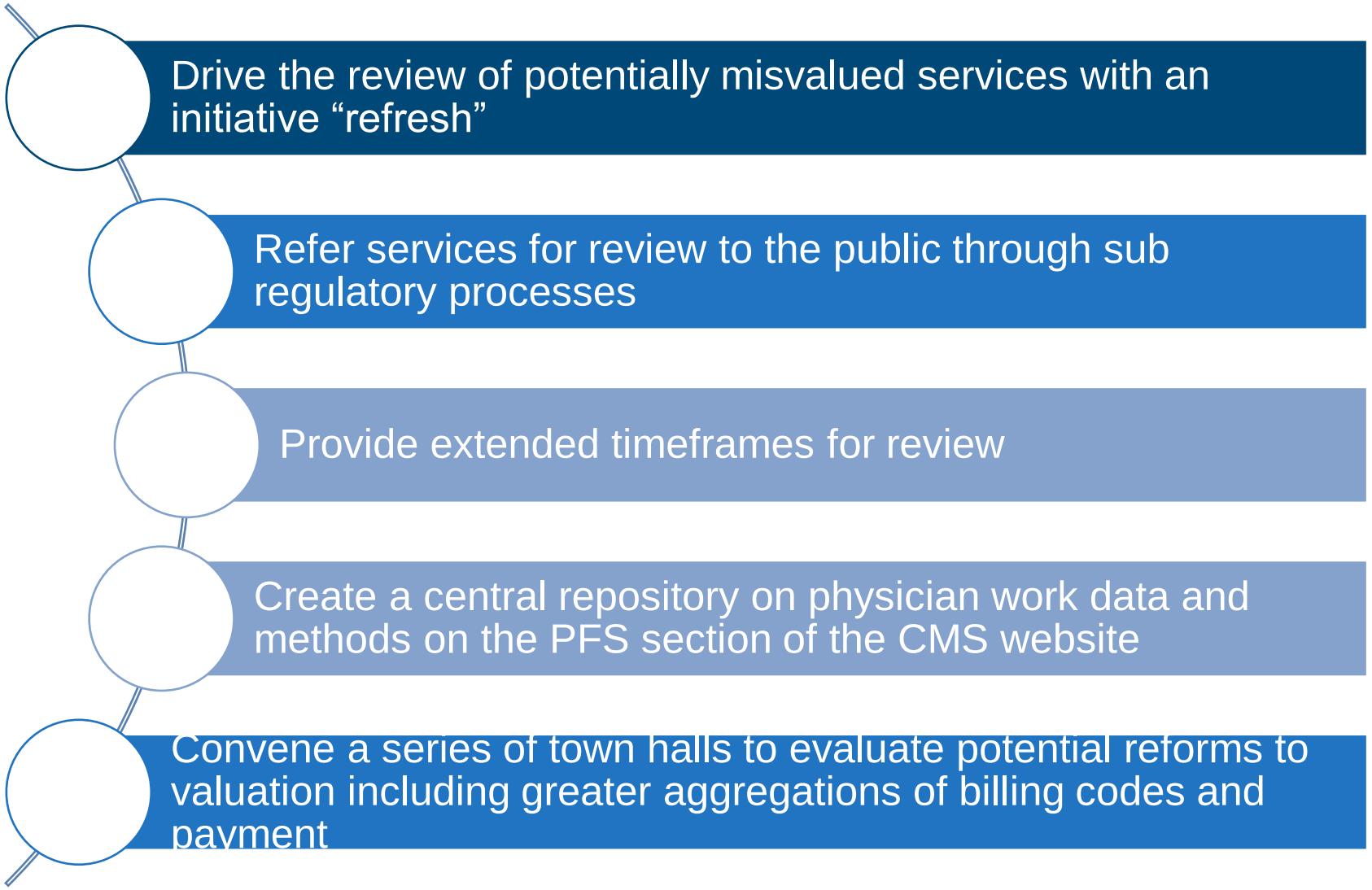
- Digital health has the potential to address workforce shortages/burnout, increase access, and improve disparities across physical and behavioral health
- Urge CMS to permanently recognize PHE-era telehealth and RPM flexibilities
- Advocate for CMS to recognize the cost of artificial intelligence (AI) and software algorithms as practice expense (PE) resource inputs

Notes: PHE = Public health emergency, RPM = Remote patient monitoring

CMS CAN STRENGTHEN THE PFS

- Immediate action to evaluate and address services where indicators suggest a pricing concern
- Further improve transparency and increase stakeholder engagement
- Employ greater aggregations in rate setting
- Utilize the Innovation Center authority including more payment waivers to incentivize participation in advanced alternative payment models

IMPROVE PROCESSES, PRICING AND FLEXIBILITY



KEY TAKEAWAYS

- The PFS is extremely complex
- While CMS must work within the statutory requirements to develop the values that are used as the basis of payment to clinicians, the agency does have authority to implement changes that will improve processes, fee schedule pricing, and help strengthen the system
- Broader change will require Congressional intervention and consideration of how to fund reform solutions, potentially by shifting funding across and within parts of Medicare to achieve change without incurring substantial cost to the government and taxpayers

REPORT AND E-TIMELINE AVAILABLE FOR DOWNLOAD WWW.HEALTHMANAGEMENT.COM

Medicare Physician Fee Schedule Reform: Structural Topics and Recommendations to Strengthen the System for the Future - Health Management Associates

Comprehensive e-timeline covering several topics

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WHAT CAN WE DO FOR YOU?

Our depth and breadth of experience has helped an incredibly diverse range of healthcare industry leaders.

Questions?

Amy Bassano
Managing Director
abassano@healthmanagement.com

Rachel Kramer
Principal
rskramer@themorancompany.com

Rachel Matthews
Consultant
rmatthews@themorancompany.com

Jared Staheli
Consultant
jared.staheli@leavittpartners.com