СНАРТЕК

Reforming physician fee schedule updates and improving the accuracy of relative payment rates

## R E C O M M E N D A T I O N S

**1-1** The Congress should replace the current-law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (such as MEI minus 1 percentage point).

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

. . . . . .

**1-2** The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflect the costs of delivering care.

. . . . . . . . . .

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

### CHAPTER

# Reforming physician fee schedule updates and improving the accuracy of relative payment rates

### **Chapter summary**

Every year, the Commission assesses the adequacy of fee-for-service (FFS) payments made under the Medicare physician fee schedule (PFS) and recommends an appropriate update to those payments in our annual March report to the Congress. As part of that process, the Commission considers beneficiaries' access to clinician care. For many years, the Commission has found that this access has been as good as, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and the volume of and spending on fee schedule services per beneficiary has consistently grown. These trends coincide with the period from 2001 to 2020 during which growth in the Medicare Economic Index (MEI) (a measure of the growth in clinicians' input costs) exceeded payment-rate updates under the PFS by an average of just over 1 percentage point per year, suggesting that full MEI updates have not been necessary to maintain Medicare beneficiaries' access to care.

Nevertheless, the Commission is concerned about whether payment-rate updates under current law will remain adequate to ensure continued access to care in the future. Starting in 2026, payment rates will increase by 0.75 percent per year for qualifying clinicians participating in advanced alternative payment models (A–APMs) and by 0.25 percent for all other

### In this chapter

### Background

- Historically, beneficiary access to clinician care has been comparable with the privately insured, indicating adequate payment rates
- Concerns about the adequacy of future payments to clinicians
- Reforming physician fee schedule updates
- Improving the accuracy of relative payment rates for fee schedule services
- Appendix: Simulations of illustrative options to redistribute relative value units for indirect practice expenses

clinicians. Meanwhile, clinicians' input costs, as measured by the MEI, are expected to increase by an average of 2.2 percent per year from 2025 through 2034—exceeding the growth in PFS payment rates by a greater amount than in the two decades from 2001 to 2020. This larger gap between input-cost and payment-rate growth could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program.

### Alternative approach to updating PFS payment rates

In our March 2025 report to the Congress, the Commission recommended that the Congress should, for 2026, replace current-law updates for PFS services with a single update equal to MEI minus 1 percentage point. That recommendation applies only to one year—2026—but not future years. In contrast, this chapter addresses longer-term reforms to PFS updates. Specifically, this chapter contemplates what default updates should be for future years. Changes to default PFS updates would not obviate the need for continued monitoring of access but instead would set default updates at a level the Commission determines is adequate, in the aggregate, to ensure continued beneficiary access to care, given current knowledge. The Commission will continue to monitor trends in access to clinician care and, to the extent needed, recommend higher or lower updates in the future as part of its annual payment-adequacy analysis.

In our June 2024 report to the Congress, the Commission discussed an approach that would update PFS payment rates based on a measure of the growth in clinicians' input costs. Under this approach, the annual PFS updates specified in current law would be replaced with an update based on a measure of inflation below full MEI growth, such as MEI minus 1 percentage point. Based on historical evidence, such updates have been sufficient to maintain beneficiary access to care. In addition, they would:

- automatically adjust to changes in inflation;
- improve predictability for clinicians, beneficiaries, and policymakers;
- be simple to administer because they would apply across the board to all PFS services; and
- balance beneficiary access with beneficiary and taxpayer financial burden.

Given the Commission's concern about the adequacy of future PFS updates and the positive aspects of an update based on a portion of MEI, the Commission in this chapter recommends replacing the current-law updates to the PFS with an annual update based on a portion of the growth in the MEI, such as MEI minus 1 percentage point. This recommendation should maintain FFS beneficiaries' access to care by maintaining or improving clinicians' willingness and ability to treat them. We expect the recommended updates would increase federal program spending by between \$15 billion and \$30 billion over five years relative to current law and would also increase beneficiary premiums and cost-sharing liabilities.

In designing the specific update, policymakers could consider a range of reasonable options, such as whether updates of MEI minus 1 percentage point should be paired with a minimum update floor (e.g., half of MEI growth or 0 percent) or update ceiling (e.g., 75 percent of MEI growth). Regardless of the particular approach, PFS rates would be updated each year based on some portion of MEI, consistent with historical evidence suggesting that updates of full MEI have not been necessary to maintain access to care.

Under the approach of updating PFS rates by a portion of MEI growth, the Commission did not address how the A–APM bonus should be treated. While the Commission maintains that incentivizing A–APM participation via differential payment-rate updates (such as 0.75 percent for A–APM participants and 0.25 percent for nonparticipants) is a flawed approach, we assert that A–APMs continue to show promise. Policymakers thus may choose to include some form of a bonus as an important component of payment for clinician services as they seek policy changes to improve A–APM design and performance.

# Improving the accuracy of relative values under the fee schedule

While fee schedule updates are the main policy lever used to change aggregate spending on fee schedule services, relative value units (RVUs) determine how that spending is distributed among services and places of service. However, there are serious flaws in the way RVUs are calculated. These flaws likely lead to overpayment for some services and underpayment for others, which can have undesirable effects on the distribution of program spending, Part B cost sharing, and clinicians' decisions about how and where to practice medicine. These flaws may also create incentives for vertical consolidation between hospitals and clinicians.

Relative to current law, updating fee schedule rates by an amount similar to MEI minus 1 percentage point would substantially increase Medicare spending, which would magnify the effects of misvalued services. Higher spending on PFS services would also increase the financial burden on taxpayers and beneficiaries through higher cost sharing and premiums. Therefore, an approach that updates fee schedule rates based on a portion of MEI should be coupled with improvements to the accuracy of relative valuations in order to address the problematic effects of misvalued services and help ensure that taxpayer and beneficiary funds are used judiciously.

The Commission has previously noted that some of the flaws in the way RVUs are calculated could be addressed by CMS collecting more timely, objective data on the relative resources that are needed to furnish clinician services. There are a number of approaches policymakers could take to further improve the relative valuation of services in tandem with reforming fee schedule updates. For example, Medicare could:

- Pay more accurately for indirect practice expenses: When a clinician service is furnished in a facility, Medicare generally includes payments for indirect practice expenses (i.e., overhead costs) in both the PFS rate and the payment to facilities (e.g., under Medicare's hospital outpatient prospective payment system). This arrangement assumes that all clinicians who furnish services at a facility should be compensated for the costs of maintaining an independent, freestanding office outside of the facility. However, an increasing portion of clinicians may pay little or no indirect practice expenses because they do not maintain an independent office or their overhead expenses are covered by the hospital that employes them (or owns their practice). In addition, some clinicians, such as surgeons, maintain an independent office, but their clinical office space may increasingly be used by other clinicians (who are also being paid for indirect practice expenses) while the surgeons are furnishing services at a facility. Since the PFS does not make these distinctions, Medicare on average likely overpays some clinicians for services furnished in a facility. Medicare's payment for indirect practice expenses could be better aligned with actual costs by incorporating data that reflect more up-to-date practice patterns.
- Update the data used to calculate the aggregate allocation of RVUs: The share of total RVUs allocated to clinician work, practice expenses, and malpractice insurance is based on cost data from 2006. Using more up-to-date data would produce RVUs that more accurately reflect how costs are distributed among the three RVU categories in a typical clinician practice. However, questions remain about the most appropriate data source to use

for this purpose and how to treat the expenses of clinicians whose practice expenses are covered by other entities, such as hospitals.

• Address overvaluation of global surgical codes: Current RVUs for 10-day and 90-day global surgical codes include values for postoperative visits that often do not occur, resulting in substantial overvaluation. Lowering these codes' relative values to reflect only services that are furnished or unbundling these codes into 0-day codes would improve payment accuracy.

This list is not exhaustive. Policymakers should consider a wide range of problems with valuation and recognize the need for flexibility when pursuing improvements. The Commission recommends that the Congress direct the Secretary to improve the accuracy of relative values for clinician services by collecting and using timely data that reflect the current cost of delivering care. This recommendation could improve care for beneficiaries by reducing incentives for clinicians to overprovide or underprovide certain services; it is not expected to affect total program spending because of the budget-neutral implementation required by statute.

very year, the Commission assesses the adequacy of fee-for-service (FFS) payments made under the Medicare physician fee schedule (PFS) and releases the findings in our annual March report to the Congress. As part of that process, the Commission considers beneficiaries' access to care. For many years, the Commission has found that beneficiaries' access to care has been as good as, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and the volume of and spending on fee schedule services per beneficiary has consistently grown. In 2024, answers to newly fielded questions in the Commission's annual beneficiary survey also indicated that Medicare beneficiaries' wait times for appointments with new clinicians are comparable with or better than the wait times for privately insured people.

But the Commission is concerned about whether payment-rate updates under current law will remain adequate to ensure continued access to care in the future. Under current law, growth in clinicians' input costs is projected to exceed the growth in PFS payment rates by a greater amount than in the two decades before the coronavirus pandemic. The larger gap between input-cost and payment-rate growth could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program. At the same time, ongoing issues with the calculation of Medicare's relative values for individual clinician services likely lead to relative overpayment for some services and underpayment for others, which can have undesirable effects on the distribution of program spending, beneficiary cost sharing, and decisions about how and where clinicians practice medicine.

In this chapter, we briefly describe the history of fee schedule updates to provide context for the current issues policymakers face and summarize findings on FFS Medicare beneficiaries' access to care in recent years. We then review some key concerns about current-law updates to the fee schedule and recommend replacing those updates with an annual update based on a portion of the growth in the MEI, such as MEI minus 1 percentage point. Finally, we discuss flaws in the calculation of the fee schedule's relative value units (RVUs), which determine how spending is distributed among services and places of service, and make a recommendation to improve the accuracy of the RVUs by collecting and using timely data that better reflect the relative costs of delivering care.

### Background

In 2023, Medicare paid for about 9,000 services under the PFS. To determine FFS Medicare payment rates under the PFS, CMS allocates a certain number of RVUs to each service in the fee schedule.<sup>1</sup> RVUs represent the relative time and resources needed to perform a given service and do not reflect the absolute cost of those services. These relative values are multiplied by the PFS's conversion factor (a national dollar amount equal to \$32.35 in 2025) to produce a total payment rate for each service.

In 2023, about 1.4 million clinicians, including physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), therapists, chiropractors, and other practitioners, billed for services under the Medicare PFS. That year, the FFS Medicare program and its beneficiaries paid \$92.4 billion for PFS services, which represents just under 17 percent of total Medicare FFS spending.

The method for determining payment rates for clinician services and the way those rates are updated has evolved markedly since the Medicare program first came into existence.

### Setting payment rates

When the Medicare program was first established in 1965, the program adopted a method of paying for physician services that many commercial insurance plans used at the time. Like these private sector plans, Medicare based payments for clinician services on customary, prevailing, and reasonable (CPR) charges submitted by physicians.

Problems with the CPR payment system quickly became apparent. Within specified limits, the Medicare program paid whatever prices physicians charged, and Medicare beneficiaries generally would not move to another insurer or drop coverage if costs grew too high. In the years that followed, physicians sharply increased what they charged for services, as well as the volume of services furnished to Medicare beneficiaries (Physician Payment Review Commission 1987). As charges and payment rates steadily increased, so too did costs for taxpayers funding the program and for beneficiaries through higher cost sharing and premiums.

To address problems with the charge-based approach, the Omnibus Balanced Budget Act of 1987 required the Health Care Financing Administration (now CMS) to develop a fee schedule in which payment rates for physician services would be empirically based on the resources needed to furnish each service rather than what physicians charged for those services. This system came to be known as the Resource-Based Relative Value Scale (RBRVS). The RBRVS approach aims to assign each physician-furnished service a value that is relative to the value of every other physician service; the value of each service is measured in RVUs. The total RVU assigned to each Healthcare Common Procedure Coding System code is based on an assessment of the various resources that a typical practice requires when furnishing that service.

Each service's total RVUs are derived from three components that are each assigned their own relative values: clinician work, practice expense (PE), and malpractice (MP). The RVUs for clinician work are meant to reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for PE are meant to reflect the relative costs of renting office space, buying supplies and equipment, and hiring nonpractitioner clinical and administrative staff. The RVUs for MP are meant to reflect the relative differences in premiums clinicians pay for medical malpractice insurance.

For most fee schedule services, there are generally two sets of RVUs for each service: one for services furnished in nonfacility settings (e.g., freestanding clinician offices) and one for services furnished in facilities (e.g., hospitals, skilled nursing facilities). PE RVUs are generally lower when services are furnished at a facility setting rather than a nonfacility setting because facilities receive separate payments to cover their practice expenses through other payment systems (e.g., the hospital outpatient prospective payment system (OPPS)) and clinicians are assumed to use fewer of their own resources when services are furnished in a facility setting. RVUs for clinician work and MP are the same regardless of whether the service is furnished in a freestanding clinician office or a facility.

Under the RBRVS, the Medicare-allowed payment amount is determined by geographically adjusting each of the three national RVU components to reflect differences in local input prices (subject to certain restrictions, such as floors on certain payment adjustments), adding the geographically adjusted RVUs for the three components together and multiplying the total RVUs by a conversion factor, which is a national dollar amount.

Yearly changes in the conversion factor reflect two components: (1) a percentage specified in law (either through a formula or a fixed percentage) and (2) a percentage arrived at by CMS to ensure that any changes it makes to the set of codes available in the fee schedule and their relative values do not, in and of themselves, increase or decrease total PFS spending by more than \$20 million; this adjustment is referred to as CMS's "budget-neutrality adjustment" (see text box for more information on budget neutrality and conversion factors).

### Updating payment rates each year

Once Medicare moved away from the chargebased method of paying clinicians, a mechanism for updating payment rates each year was needed to ensure that payment rates remained adequate to support beneficiary access to high-quality care. Medicare has used three approaches to update payment rates for clinician services: the volume performance standard (VPS), the sustainable growth rate (SGR), and the updates specified by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Under all three of these approaches, payment rates are updated each year by changing the fee schedule's conversion factor: Increasing the conversion factor by 1 percent, for example, results in an across-the-board 1 percent increase in payment rates, notwithstanding changes in the conversion factor due to a budget-neutrality adjustment. (A discussion of lessons learned from these policy approaches appears in the text box on pp. 20-21.)

# Budget-neutrality adjustments and the conversion factor under the physician fee schedule

The physician fee schedule's (PFS's) budgetneutrality provision is a vital part of the annual update process that ensures that updating work relative value units (RVUs) does not, in itself, increase or decrease PFS spending. To ensure that changes to work RVUs do not increase or decrease PFS spending, CMS is required to adjust the conversion factor up or down.

# Overview of the PFS budget-neutrality provision

Budget-neutrality adjustments under the PFS are intended to ensure that changes in medical practice, coding changes, new data on the relative value of services, or the addition of new services does not increase or decrease PFS spending. Changes that CMS makes, often based on recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), that result in an aggregate increase or decrease in PFS spending of more than \$20 million are required to be offset in a budget-neutral manner. For example, if CMS proposed increasing the work RVUs of a service that is projected to increase PFS spending by \$100 million in the upcoming year, then CMS reduces the conversion factor by an amount that is projected to decrease spending by \$100 million. If the projected effect is \$20 million or less, then no budget-neutrality adjustment is required.

Changes to the conversion factor as a result of the PFS budget-neutrality provision are driven by changes in work RVUs, not practice expense (PE) or malpractice (MP) RVUs. For example, if services' work RVUs increase, the total pools of PE and MP RVUs also increase to maintain the ratio of work RVUs to PE and MP RVUs. Therefore, to maintain budget neutrality with a higher number of work, PE, and MP RVUs, CMS adjusts the conversion factor down.

Changes to PE or MP RVUs do not result in changes to the conversion factor.<sup>2</sup> For example, changes to services' PE RVUs are made budget neutral by adjusting PE RVUs up or down for other services rather than making a change to the conversion factor.

The PFS budget-neutrality provision does not apply to all services. Services that are novel, such as completely new types of services, are not subject to the PFS budget-neutrality provision when they are added to the PFS. Thus, novel services are permitted to increase spending without a budget-neutrality adjustment when the services are added to the PFS. Exempting novel services from budget neutrality encourages the adoption of new technology under the PFS. In contrast, existing services whose RVUs are revised and services that are newly unbundled and billable separately (e.g., certain care-coordination codes that were previously considered bundled with other evaluation and management codes) are subject to the budget-neutrality provision.

# The PFS budget-neutrality provision's effect on the conversion factor

Changes in work RVUs are made budget neutral by adjusting the conversion factor up or down.<sup>3</sup> On a utilization-weighted basis, work RVUs have tended to increase over time, and therefore offsetting reductions to the conversion factor have been made. Because the conversion factor is only one part of what determines a PFS service's payment rate (another part being the number of RVUs assigned to a given service), simply looking at changes in the conversion factor over time is not an accurate measure of the extent to which payment rates, in the aggregate, have increased or decreased over time or of changes in PFS spending, which are substantially affected by increases in the volume and intensity of PFS services over time.

Nearly all other Medicare payment systems have budget-neutrality provisions, and they accomplish the same basic objective—ensuring that changes in relative weights do not increase or decrease spending. However, PFS budget-neutrality

(continued next page)

# Budget-neutrality adjustments and the conversion factor under the physician fee schedule (cont.)

adjustments to the conversion factor are often larger than in other payment systems, not because of differences in underlying objectives, but rather because of technical differences in how various payment systems deal with changes in work RVUs (in the PFS) and relative weights (in other payment systems).<sup>4</sup> We compare the PFS with the hospital outpatient prospective payment system (OPPS) to demonstrate a key difference.

One key difference between the PFS and OPPS budget-neutrality adjustments is that the effects of changes in relative weights in the OPPS are not addressed through adjustments to the conversion factor. Under the OPPS, relative weights are recalculated annually using a combination of data from hospital cost reports and claims data. Using these data, CMS establishes relative weights on an annual basis; if one OPPS service becomes less (or more) expensive relative to a reference OPPS service (clinic visits), its relative weight goes down (or up). OPPS relative weights are also directly scaled to ensure that adjusting the relative weights does not result in overall spending increases or decreases. In contrast, clinicians do not submit cost reports, and under the PFS, work RVUs do not decrease (or increase) automatically in response to changes in other PFS services. For example, if CMS determines that work RVUs for some group of services merit

an increase, the work RVUs of other services do not automatically adjust (as the relative weights do under the OPPS). Instead, CMS reduces the PFS conversion factor to ensure overall budget neutrality.

The fact that the PFS budget-neutrality adjustment is used to account for the effects of changes in work RVUs, which can result in large adjustments relative to other payment systems, also makes it misleading to use changes in the PFS conversion factor as a measure of the increase or decrease in resources under the PFS or to compare the PFS conversion factor with the OPPS conversion factor. For example, when CMS increased the RVUs of evaluation and management office visits in 2021, the offsetting budget-neutrality adjustment to the conversion factor of -6.8 percent did not remove resources from the PFS; payments were only redistributed across different types of services. A more accurate measure of changes in the aggregate resources available under the PFS is total fee schedule spending per fee-for-service beneficiary, which reflects changes in RVUs, the conversion factor, and other factors, such as changes in the volume and intensity of services furnished. As seen in Figure 1-2 (p. 19) in this chapter, PFS spending per beneficiary has increased dramatically over time.

The VPS approach aimed to accomplish two main goals: (1) link updates in payment rates to growth in input costs (as measured by the MEI) and (2) restrain the growth in spending caused by increases in the volume and intensity of physician services delivered. In an attempt to target the policy's effects, the VPS used three conversion factors: one for surgical services, one for nonsurgical services, and one for primary care services. As time went on, however, clinicians and policymakers grew increasingly dissatisfied with the way the VPS operated. Since the VPS's spending targets were based in part on actual growth in the volume and intensity of physician services minus the performance standard factor, the formula created continuous pressure to reduce volume and intensity. However, since the targets were determined at the national level, individual clinicians had very weak incentives to reduce their own volume and intensity. In addition, the VPS's annual updates for each type of service were volatile and markedly diverged over time.

In 1997, the Congress replaced the VPS with the SGR method of annually updating payment rates in the PFS. The spending target formula for the SGR was similar to the one used for the VPS; the major difference was that the SGR's formula allowed for growth in volume and intensity based on real growth in gross domestic product (GDP) rather than historical volume and intensity growth (minus a performance standard). Another 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. 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 PFS 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 (due to the SGR 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.

In 2015, MACRA repealed the SGR formula and established a schedule of fixed annual updates to the PFS's payment rates coupled with incentives to perform well on quality measures or participate in A–APMs that create incentives for clinicians to improve the quality of the care they provide and/or reduce spending on their care. Under MACRA's original framework, payment rates were to be updated by 0.5 percent annually from July 2015 through December 2019, by 0 percent from 2020 to 2025, and by 0.75 percent for qualifying clinicians in A–APMs and 0.25 percent for all other clinicians starting in 2026 (Figure 1–1, p. 14).

These fixed updates were coupled with (1) an annual 5 percent bonus for clinicians who participate in A-APMs, available from 2019 through 2024, and (2) an annual performance-based payment adjustment to payment rates (which could be negative, neutral, or positive) for non-A-APM clinicians under the Merit-based Incentive Payment System (MIPS). Subsequent legislation amended MACRA's fixed updates, providing a 0.25 percent update in 2019 instead of 0.5 percent, and made temporary increases to the fee schedule's payment rates in 2021 through 2024. These temporary increases differ from traditional updates in that they each apply for one year only and are not built into subsequent years' base payment rates.

## Historically, beneficiary access to clinician care has been comparable with the privately insured, indicating adequate payment rates

Every year, the Commission assesses the adequacy of payments made under Medicare's PFS and releases the findings in our annual March report to the Congress. As part of that process, the Commission assesses beneficiaries' access to care. For many years, the Commission has found that beneficiaries' access to care has been comparable with, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and the volume of and spending on fee schedule services per beneficiary has grown. In 2024, newly fielded questions from the Commission's annual beneficiary survey also indicate that Medicare beneficiaries' wait times for appointments with new clinicians are comparable with or better than the wait times for privately insured people. Longer-term measures of access to care, such as applications to medical school, first-year enrollment in medical school, growth in the number of APRNs and PAs, and clinician incomes, have also remained positive.

### Survey data suggest beneficiaries' access to care is comparable with that of privately insured individuals

The Commission sponsors an annual survey of Medicare beneficiaries ages 65 and over and privately insured individuals ages 50 to 64. The goal of surveying these two groups is to identify whether any problems that Medicare beneficiaries have in accessing care are confined to that population (which could suggest issues with Medicare's payment rates) or are also experienced by other patients (which could suggest larger issues in the health care sector). Over two decades, our survey has found that Medicare beneficiaries' access to care is comparable with, or better than, that of privately insured people. For example, among survey respondents in 2024 who had received health care in the past year, a greater share of Medicare beneficiaries was satisfied with their ability to find health care providers who accepted their insurance (97 percent) compared with privately insured people (93 percent) (Medicare Payment Advisory Commission 2025).<sup>5</sup> These



## Statutorily specified updates to physician fee schedule payment rates, payment adjustments, and bonuses under MACRA and subsequent legislation



Note: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), MIPS (Merit-based Incentive Payment System), TBD (to be determined), A–APM (advanced alternative payment model). MIPS payment adjustments rounded to the nearest tenth of a percent. Fee schedule updates for 2021 through 2024 apply for one year only and were not incorporated into the following year's conversion factor. In 2024, fee schedule rates were updated by 1.25 percent through March 8, 2024, and then were instead updated by 2.93 percent from March 9, 2024, through December 31, 2024. These one-year-only updates and other changes (shown in gray) were made after the passage of MACRA. MIPS adjustments to payment rates can be positive, neutral, or negative. MACRA set maximum and minimum MIPS adjustments. The highest MIPS adjustments in 2025 and beyond are not yet known. MIPS adjustments and the A–APM participation bonus apply for only one year at a time and are not built into subsequent years' payment rates.

\* The A-APM bonus is worth 1.88 percent in 2026 but is not available in subsequent years.

Source: MedPAC analysis of MACRA and subsequent legislation.

data are consistent with findings from beneficiary focus groups the Commission conducts every year across cities and rural areas. Focus-group interviews generally find that Medicare beneficiaries report high satisfaction with their insurance coverage. For example, in 2024, the vast majority of Medicare beneficiaries in our focus groups rated their coverage "excellent" or "good" (NORC at the University of Chicago 2024).

In 2024, our survey began asking respondents to quantify wait times for appointments with clinicians. We found that the number of weeks Medicare beneficiaries reported waiting for appointments with new clinicians was comparable with or better than the wait times reported by privately insured people. For example, in 2024, 34 percent of Medicare beneficiaries waited two weeks or less for an appointment with a new primary care provider compared with 27 percent of privately insured people ages 50–64. We found similar results for specialist appointments: In 2024, 33 percent of Medicare beneficiaries waited two weeks or less for an appointment with a new specialist compared with 28 percent of privately insured people ages 50–64. On the other end of the distribution, we found that 18 percent of Medicare beneficiaries and 22 percent of privately insured people waited more than eight weeks for an appointment with a new primary care provider (not a statistically significant difference). Sixteen percent of Medicare beneficiaries and 22 percent of privately insured people waited more than eight weeks for an appointment with a new specialist (Medicare Payment Advisory Commission 2025). While our analyses indicate that some beneficiaries wait a substantial amount of time for appointments, the fact that Medicare beneficiaries' wait times were comparable with or better than that of individuals with private insurance (which has far higher payment rates) suggests that higher Medicare payment rates would not have resulted in substantially shorter wait times.

Looking more broadly among Medicare beneficiaries who recently had an office visit scheduled after the beneficiary reached out to a doctor's office to set it up (and not just appointments with new clinicians), the Commission's analysis of CMS's 2022 Medicare Current Beneficiary Survey (MCBS) data found that nearly three out of four beneficiaries were seen in two weeks or less. Comparing these results with the Commission's analysis of wait times with new clinicians suggests that once beneficiaries find a new clinician and establish a care relationship with them, subsequent appointments may be easier to schedule.

The Commission also uses data from the MCBS and other surveys in its assessment of payment adequacy, which likewise have tended to conclude that Medicare beneficiaries have good access to care, as described below:

- The Commission's analysis of the 2022 MCBS found that a relatively small share (8 percent) reported experiencing trouble getting care in the past year—more often due to cost than to clinicians not accepting Medicare (Medicare Payment Advisory Commission 2025).
- The Medical Expenditure Panel Survey found that around age 65, when most people gain eligibility for Medicare, there are fewer 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 65 (National Center for Health Statistics 2021).

• The Behavioral Risk Factor Surveillance System survey found that, compared with people who have 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).

## Clinicians accept Medicare at rates similar to those of commercial insurance

The Commission has found a substantial and growing difference between Medicare and commercial payment rates for clinician services. However, we have not found evidence that this payment differential impacts clinicians' willingness to accept new Medicare patients.

Using 2023 data from preferred provider organization (PPO) health plans that are part of a large national insurer, the Commission found that PPO payment rates for clinician services averaged 140 percent of Medicare's payment rates, with substantial variation across types of services (Medicare Payment Advisory Commission 2025). Other researchers have found similar ratios of commercial-to-Medicare payment rates for clinician services and have further explored the reasons for relatively high private-payer rates, such as increasing physician market power and vertical consolidation with hospitals (Congressional Budget Office 2022, KFF 2020). Further, the Commission has found that the difference between commercial and Medicare payment rates has widened over time. We found that, from 2011 to 2023, commercial PPO payment rates for clinician services increased from 122 percent of Medicare's payment rates to 140 percent of Medicare's rates (Medicare Payment Advisory Commission 2025).

Yet the share of clinicians who accept Medicare is comparable with the share who accept private health insurance. From 2014 to 2019, the share of nonpediatric office-based physicians who accepted Medicare was only 0 percentage points to 2 percentage points lower than the share who accepted private health insurance, according to the Centers for Disease Control and Prevention's National Electronic Health Records Survey (Ochieng et al. 2022). The 2021 National Ambulatory Medical Care Survey found that among the 94 percent of nonpediatric office-based physicians who reported accepting new patients, 89 percent said they accepted new Medicare patients and 88 percent said they accepted new privately insured patients (Schappert and Santo 2023).

A 2022 American Medical Association (AMA) survey of clinicians in a wider range of clinical settings found that among nonpediatric physicians accepting new patients, 96 percent accepted new Medicare patients and 98 percent accepted new commercial insurance patients (American Medical Association 2023b). One specialty with notably low acceptance of Medicare was psychiatry. However, psychiatrists' low acceptance rate is not a Medicare-specific issue; other research has shown that psychiatrists are less likely to accept new patients using Medicare or commercial insurance (Bishop et al. 2014, Ochieng et al. 2022).

Looking from the perspective of patients trying to find a new provider, a 2023 KFF survey found that Medicare beneficiaries (enrolled in FFS Medicare or Medicare Advantage) were less likely than privately insured people to encounter providers who did not accept their insurance. Specifically, the survey found that 83 percent of Medicare beneficiaries said they had not encountered a doctor or hospital that was not covered by their insurance in the past year compared with 73 percent of people with employer-sponsored insurance and 57 percent of people with individual health insurance purchased through a Marketplace (Pollitz et al. 2023).

There are many reasons that clinicians may choose to accept FFS Medicare despite payment rates that are usually lower than commercial rates. A substantial share of most clinicians' patients are covered by Medicare, and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their patient panels. In addition, almost all hospitals accept Medicare patients, and hospitals may expect their employed physicians to take Medicare patients given the important role these patients play in hospitals' mission and revenue streams. At the same time, though commercial rates may be comparatively high, commercial insurers often impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to appeal denied claims and complete insurers' prior authorization paperwork. A recent AMA survey found that physicians complete an average of 39 prior authorization requests per week, requiring 13 hours per week, and 40 percent of physicians have dedicated staff who work exclusively on completing prior authorizations (American Medical Association 2025). In contrast, FFS Medicare requires

prior authorization only for certain limited services and is known as a prompt payer since it is required to pay "clean" claims within 30 days of receiving a claim and must pay providers interest on any late payments. The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program's lower payment rates.

# Volume and intensity of services delivered per beneficiary has increased

The Commission analyzes the volume and intensity of services delivered per beneficiary as an indirect measure of access. Changes in the volume and intensity of care can result from multiple factors, including changes in clinical practice patterns, changes in coding practices, movement of services from clinician offices to hospital outpatient departments, beneficiary health and disease prevalence, coverage of Medicare benefits (e.g., coverage of new provider types or services), changes in technology, selection into Medicare Advantage, and beneficiary preferences. Nonetheless, increases in the volume and intensity of care per beneficiary are a positive indicator that beneficiaries can access care.

Since 2000, the volume and intensity of clinician services furnished to beneficiaries-and the resulting payments that clinicians have received-have increased substantially. For example, from 2000 to 2017, the cumulative per beneficiary growth in volume and intensity of imaging services was 75 percent (Medicare Payment Advisory Commission 2019). The increase in volume and intensity of major procedures and evaluation and management (E&M) services over the period was somewhat lower but still considerable (47 percent and 45 percent, respectively). With the exception of a dip in utilization during the coronavirus pandemic, the volume of care that beneficiaries receive has continued to increase in more recent years (Medicare Payment Advisory Commission 2024b). For example, from 2022 to 2023, the average volume of services per FFS beneficiary increased by 5.4 percent (Medicare Payment Advisory Commission 2025).

## Longer-term measures of access to care have remained positive

In the long term, access to health care also depends on the supply of clinicians. While less immediately related to PFS payment rates than our short-term measures of access, we review evidence on multiple measures of clinician supply—clinician incomes, the number of applicants to and first-year enrollees in medical school, the increase in the number of APRNs and PAs, and the number of clinicians who bill the fee schedule.

Physicians' incomes are an important long-term indicator because declining incomes (either nominally or in real, inflation-adjusted terms) could dissuade some college students from entering the medical profession. Also, since the Commission lacks data that would allow us to calculate clinicians' all-payer profit margins from delivering services, we use clinician compensation data as a rough proxy for all-payer profitability. Similarly, a decrease in the number of medical school applicants or the number of clinicians billing the fee schedule could signal a declining interest in entering the medical field or treating Medicare beneficiaries, respectively.

Overall, our long-term measures of access to care are positive:

- Clinician incomes (including for physicians and other clinicians, such as nurse practitioners (NPs) and PAs) have kept pace with (or exceeded) inflation over the long term (Medicare Payment Advisory Commission 2024a).
- Growth in applications to and first-year enrollment in medical school has exceeded total U.S. population growth over a period of four decades and by a greater amount in the last decade. For example, from the 2013–2014 to the 2023-2024 academic years, first-year enrollment in medical schools increased by 2.3 percent per year while the total U.S. population grew by 0.6 percent per year (Medicare Payment Advisory Commission 2025).
- The number of APRNs and PAs, who represent an increasingly large share of the clinician workforce, has grown rapidly, suggesting robust interest in becoming an APRN or PA. For example, the number of certified PAs in the U.S. has quadrupled over the last two decades, increasing from about 43,500 in 2003 to 95,600 in 2013 to 178,700 in 2023 (National Commission on Certification of Physician Assistants 2023, National Commission on Certification of Physician of Physician Assistants 2014).
- The number of clinicians billing the fee schedule has increased substantially (due to rapid growth

among APRNs and PAs and modest growth among specialist physicians, while there has been slow or slightly negative growth among primary care physicians); the share of clinicians opting out of Medicare has remained very low; and the share of clinicians who are participating providers (meaning they cannot balance bill Medicare beneficiaries) has increased over time (Albanese 2023, Medicare Payment Advisory Commission 2024a).

(For more information on these measures, see the Commission's June 2024 and March 2025 reports to the Congress.)

# Concerns about the adequacy of future payments to clinicians

The Commission's past assessments have generally indicated that Medicare beneficiaries have relatively good access to care. However, we are concerned about whether beneficiaries will maintain adequate access to care in the future since growth in clinicians' input costs is expected to exceed growth in Medicare PFS payment rates by a greater amount than it did in the two decades prior to the coronavirus pandemic. This larger gap could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program.

## The impact of inflation on the future adequacy of PFS payment rates

MACRA has achieved one of its policy goals of stabilizing updates to fee schedule payment rates: Since MACRA was enacted, payment rates have been higher and more predictable than what would have occurred under the SGR. But recent increases in the costs of running clinician practices and projections of higher inflation over the next several years compared with the prepandemic period have led to concerns about the adequacy of current-law updates to fee schedule payment rates scheduled under MACRA.

## The MEI measures annual changes in input costs for clinician services

The MEI is a measure of inflation that was originally used in the 1970s in Medicare's charge-based payment

system for clinician services to limit year-to-year payment increases. While Medicare no longer uses the MEI to increase (or limit) PFS payment rates, CMS still maintains the index for various other purposes.

The MEI measures the weighted average price change for various inputs involved in furnishing clinician services. Specifically, the MEI is a fixed-weight input price index composed of two broad categoriesclinician compensation and practice expenses (which includes malpractice insurance). According to the 2017-based MEI, on average, clinician compensation accounts for 47.5 percent of the cost of furnishing clinician services and includes wages and benefits for physicians and other clinicians who bill the PFS directly (e.g., NPs and PAs). Practice expenses (including malpractice insurance) account for the remaining 52.5 percent. In the 2017-based MEI, CMS determined the distribution of expenses largely based on the U.S. Census Bureau's Service Annual Survey (SAS), supplemented by several other data sources. The SAS provides annual nationwide estimates of revenue, expenses, and other measures for most traditional service industries (Census Bureau 2021).

The distribution of expenses is directly related to payments under the PFS. Later in this chapter, we discuss this relationship and CMS's decision not to rescale fee schedule RVUs based on updated MEI data.

Once CMS establishes the distribution of expenses reflected in the MEI, the next step is to determine how the prices in each of the categories of expenses grow over time. To do so, CMS relies on a sample of commercial professional liability insurance carriers and three data sources from the U.S. Bureau of Labor Statistics to measure changes in the input costs of maintaining a physician office:

- the Employment Cost Index (ECI), which measures the change in the hourly labor cost to employers over time;
- the Producer Price Index, which measures the average change over time in the selling prices received by domestic producers for their output; and
- the Consumer Price Index (CPI), which measures the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services.

The decision about which price proxy to use is limited by available data and involves trade-offs. For example, in 2012, when considering the price proxy for clinician compensation, the Medicare Economic Index Technical Advisory Panel, established by the Secretary of the Department of Health and Human Services, sought an index that reflected a highly skilled occupational mix that was not heavily influenced by trends in actual physician wages that could create endogeneity or circularity concerns. The panel considered a broad index that included all private industry workers, for which the share of total employees who were physicians was only 0.6 percent. The panel also considered a slightly narrower index composed of professional workers, for which the share of total employees who were physicians was slightly higher at 4.0 percent. The panel recommended the slightly narrower index because it better reflected a more highly skilled mix of occupations and was still only minimally influenced by the actual wages of physicians (Berndt 2012).

Unlike many other market baskets used to update FFS Medicare payment rates, the MEI has long been adjusted to include a measure of productivity growth. Currently, the MEI includes an adjustment that reflects the 10-year moving average of private nonfarm business (economy-wide) total factor productivity. Therefore, reported MEI growth figures in this chapter include a built-in adjustment for productivity growth.

## MEI growth has outpaced statutory fee schedule updates

MEI growth has consistently exceeded fee schedule payment-rate updates. From 2000 to 2023, the cumulative increase in fee schedule updates totaled 14 percent compared with MEI growth of 52 percent (Figure 1-2). The growing gap between statutory fee schedule updates and MEI growth means that Medicare payments per service (unadjusted for increases in intensity, coding, and other changes) have declined substantially in inflation-adjusted terms over time.

At the same time, the volume and intensity of clinician services delivered per beneficiary has increased, which has resulted in fee schedule spending per FFS beneficiary growing by 101 percent over the same time period.<sup>6,7</sup> These data indicate that, even after adjusting for inflation, each FFS Medicare beneficiary generated more revenue for clinicians in 2023 than they did in

FIGURE 1-2

#### Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule updates, 2000–2023



Note: FFS (fee-for-service), MEI (Medicare Economic Index). The MEI measures the change in clinician input prices. MEI data are from the 2017–based MEI and include updated total factor productivity data that CMS released as part of the second quarter of 2024 market basket data. "Spending per FFS beneficiary" is based on incurred spending under the physician fee schedule. The graph shows updates to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments or bonuses for participating in advanced alternative payment models. One-time payment increases of 3.75 percent in 2021, 3.0 percent in 2022, and 2.5 percent in 2023 are included in the update line and also impact spending per beneficiary.

Source: MedPAC analysis of Medicare regulations, CMS market basket data, and reports from the Boards of Trustees of the Medicare trust funds.

2000. Because increases in volume and intensity often increase costs (e.g., furnishing an additional service may require clinicians to purchase additional supplies, and a more intense service may require more clinician time), the growth in fee schedule spending per FFS beneficiary should not be interpreted as profit growth. Nonetheless, the substantial growth in volume and intensity (and the Commission's broader finding that Medicare beneficiaries report relatively good access to care) suggests that below-MEI updates have not impeded access and that simply comparing changes in fee schedule updates with MEI growth is insufficient to capture changes over time in clinicians' ability to provide services to Medicare beneficiaries.

Because the coronavirus pandemic and the associated relief funds that clinicians began receiving in mid-2020

make it more difficult to interpret how trends in access relate to PFS rates, we split evidence from more than two decades into two time periods—the two decades largely before the pandemic and 2021 and beyond.

On an annual basis, for the two decades from 2001 to 2020, MEI growth exceeded fee schedule updates by an average of just over 1 percentage point per year (1.6 percent vs. 0.6 percent annually).

From 2021 to 2023 (which was the most recent year of MEI data available at the time we conducted this analysis), MEI growth exceeded fee schedule updates by a greater amount than in the previous two decades. Over that period, MEI growth averaged 3.6 percent per year and PFS rates under MACRA were scheduled to receive no updates. However, the Congress provided

### Lessons learned from past approaches to fee schedule updates

ooking back at events over the last 60 years, several lessons emerge about setting and updating Medicare's payment rates for clinician services. These lessons can be helpful in developing a new update policy going forward.

One important observation is that regardless of how fee schedule payment rates are set, the system has built-in features and incentives that can lead to increases in volume and intensity. If fee-for-service (FFS) Medicare payment rates are larger than the marginal costs of furnishing a service, a provider has a financial incentive to increase the volume of services furnished.<sup>8</sup> Some studies have shown that increases in Medicare payment rates for clinician services, especially services that are considered discretionary, are correlated with increases in volume (Clemens and Gottlieb 2014). These increases, in turn, can cause spending to increase for both beneficiaries (in the form of higher cost sharing and premiums) and taxpayers (in the form of higher financing costs).

Since Medicare moved away from the charge-based payment approach, policymakers have used two strategies for controlling spending growth on fee schedule services. The first strategy was to establish formulaic spending targets where the size of annual conversion-factor updates was governed by whether actual spending was above or below the targets. The volume performance standard (VPS) and sustainable growth rate (SGR) formulas both used this approach. A second strategy for controlling spending growth has been to set fixed payment-rate updates at less than input cost inflation. This approach was included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), along with incentives to participate in advanced alternative payment models (A–APMs).

The spending-target approach used by the VPS and SGR formulas was abandoned for a number of reasons. First, determining updates based on spending-target formulas can lead to highly variable updates from year to year. For instance, the SGR formula resulted in a 5.1 percent increase in payment rates in 2001, but, starting in 2002, the formula called for a series of annual reductions of 4 percent to 5 percent for a number of years. Beginning in 2003, the Congress passed a series of bills to override the SGR-specified fee schedule reductions. The primary rationale for overriding cuts called for by the SGR formula was a fear that allowing the scheduled reductions to take effect would cause physicians to reduce services provided to Medicare beneficiaries and that they would perhaps stop participating in the program (Boards of Trustees 2014, Medicare Payment Advisory Commission 2011c).

(continued next page)

one-time payment increases of 3.75 percent in 2021, 3.0 percent in 2022, and 2.5 percent in 2023.<sup>9</sup> In addition, as part of a broader set of laws related to the coronavirus pandemic, clinician offices received billions of dollars in funding from sources outside of the fee schedule, such as payments through the Provider Relief Fund (PRF) and Paycheck Protection Program (PPP) loans. For example, as of December 2022, the Government Accountability Office found that clinicians and other health care practitioners received \$12.7 billion through the PRF (Government Accountability Office 2023). Other research found that physician offices received more than \$17 billion in PPP loans through August 8, 2020 (Chen et al. 2022). PPP loans can be forgiven if applied toward approved expenses and if employment and compensation levels are maintained. As of December 2021, about 83 percent of PPP loans had been forgiven, in full or in part (U.S. Small Business Administration 2021).

### Lessons learned from past approaches to fee schedule updates (cont.)

Importantly, the VPS and SGR formulas imposed incentives to reduce volume and intensity growth at the national level, but individual practitioners had almost no incentive to practice efficiently or look for ways to reduce the volume or intensity of services they delivered (Medicare Payment Advisory Commission 2011c). Because the formulas applied payment adjustments on an across-the-board basis, the approach neither rewarded individual clinicians who restrained unnecessary volume growth nor penalized clinicians who contributed most to inappropriate volume increases.

The second strategy for controlling spending, and the one used in MACRA, has been to make relatively low annual updates to the conversion factor and encourage clinicians to participate in A-APMs designed to increase incentives to provide efficient care. While relatively low legislatively specified updates do provide a measure of stability and can act to restrain spending growth, this approach does not respond to changing conditions such as high inflation. Concerns about low updates in current law relative to the higher inflation that began during the pandemic led the Commission to recommend that clinician payment rates be increased by a portion of MEI growth in its March 2023, 2024, and 2025 reports to the Congress (Medicare Payment Advisory Commission 2025, Medicare Payment Advisory Commission 2024b, Medicare Payment Advisory Commission 2023b).

Well-designed A-APMs are a key piece of the second strategy for controlling spending and improving incentives for providers to practice efficiently. The Commission maintains that A-APMs show promise, but it has been challenging to design voluntary A-APMs that maximize program savings (because of weak incentives for clinicians to reduce their spending in these models, for example). To date, evidence on the performance of A-APMs has been modest, though some models have produced gross savings (Congressional Budget Office 2023). The Commission made recommendations in June 2021 for how to improve APMs moving forward and will continue to monitor their implementation and performance (Medicare Payment Advisory Commission 2021).

The differential updates in MACRA based on A–APM participation are intended to incentivize clinicians to participate in A–APMs. However, the differential-update approach is flawed since it initially produces weak incentives and then will begin to produce strong incentives by creating a payment differential between clinicians who participate in A–APMs and those who do not, which could become untenably large. The Commission did not address how the A–APM bonus should be treated in this work. As APMs develop, the Congress may decide to incorporate a redesigned A–APM bonus payment to achieve its goals. ■

Beneficiaries' access to care remained comparable with private insurance enrollees' access over the pandemic and postpandemic period. However, the unprecedented nature of the coronavirus pandemic and the emergency funding that clinicians received over that period make it difficult to evaluate whether fee schedule updates that occurred during that period were sufficient to ensure access in the absence of emergency funding. Therefore, while updates of 1 percentage point per year below MEI growth from 2001 to 2020 did not undermine beneficiary access to care, we cannot conclude that updates of substantially less than 1 percentage point below MEI (which occurred during the pandemic) would be sustainable over the long term.

### MEI growth is projected to exceed fee schedule updates by more in the future than it has in the past

MEI growth was relatively low for two decades preceding the coronavirus pandemic, averaging 1.6 percent per year from 2001 to 2020. Beginning in 2021, MEI growth accelerated, reaching an annual rate of 4.4 percent in 2022. MEI growth slowed to 4.0 percent in 2023, and CMS expects MEI growth to slow further in the coming years: 3.3 percent in 2024, 2.8 percent in 2025, and 2.3 percent in 2026.<sup>10</sup> Despite this moderation, MEI growth is still projected to remain somewhat above the levels experienced in the two decades prior to the pandemic, averaging 2.2 percent per year from 2025 through 2034, about 0.6 percentage points higher than the two decades prior to the pandemic. In comparison, after a series of one-time payment-rate updates that were in place from 2021 to 2024 expired, aggregate updates have been flat from 2020 to 2025.<sup>11</sup> Starting in 2026, rates will increase by 0.75 percent per year for qualifying clinicians in A-APMs and 0.25 percent per year for clinicians not in A-APMs. As a result, the average annual difference between projected MEI growth and fee schedule updates from 2025 to 2034 is expected to be 1.5 percentage points for clinicians in A-APMs and 2.0 percentage points for clinicians not in A-APMs. Thus, while projecting future inflation rates is subject to substantial uncertainty, MEI growth is projected to exceed fee schedule updates by more than it did for the two decades from 2001 to 2020.

### Clinicians' incentives to participate in A–APMs could diminish in the near term but become very large in the future

From 2019 to 2024, qualifying clinicians participating in A–APMs have received a bonus equal to 5 percent of their Medicare payments for fee schedule services. The bonus decreases to 3.5 percent in 2025 and 1.88 percent in 2026. In 2027 and beyond, there is no bonus (Figure 1-1, p. 14). Bonus payments are in addition to any shared savings payments or other payments that may be realized through participation in an A–APM.

Instead of using bonuses to incentivize participation in A–APMs, starting in 2026, fee schedule payment rates will increase by 0.75 percent per year for qualifying clinicians participating in A–APMs and by 0.25 percent for all other clinicians. These payment-rate differentials are set to continue each year in 2026 and beyond, so the cumulative effect starts out small and grows larger over time. For example, in 2027, A–APM clinicians' payment rates will be only 1 percent higher than those of other clinicians, but by 2045, that differential will be 10.5 percent. An incentive this large could be unwarranted and inequitable, especially if many clinicians continue to have limited access to A–APMs due to their geographic location, medical specialty, or other circumstances.

## Reforming physician fee schedule updates

Under current law, future fee schedule paymentrate updates are fixed in statute, set at relatively low levels compared with projected inflation, and provide inconsistent incentives for clinicians to participate in A–APMs. An alternative approach would be for the Congress to require CMS to update fee schedule rates based on some measure of the growth in the costs of running a clinician practice and design separate policies to create appropriately sized and structured incentives for clinicians to participate in A–APMs, which could involve bonuses or A–APM payments (e.g., shared savings) only. Here we discuss changes to the update but not the A–APM payments.

Under this approach, the dual physician fee schedule updates that are set to begin in 2026 based on A-APM participation would be replaced with a single update based on a portion of MEI growth, such as MEI minus 1 percentage point. (The MEI has a built-in adjustment for productivity. Therefore, the additional 1 percentage point below MEI is in addition to the standard productivity adjustment.) The objective of such an option is to set default updates at a level the Commission considers sufficient, in the aggregate, to ensure continued beneficiary access to care. Of course, setting default updates based on a portion of MEI growth would not negate the need for future monitoring of payment adequacy. The Commission would continue to monitor trends in access, inflation, volume of care, quality, and other indicators and, to the extent needed, recommend higher or lower updates in the future.

Three principles have guided the Commission's assessment of the adequacy of fee schedule updates: (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. Using these principles to craft an appropriate policy for updating PFS payment rates requires reviewing the available empirical evidence from the Commission's past assessments of access and related academic literature, as well as the Commission's judgment. To elucidate the rationale for a change in PFS update policy, we use an illustrative policy that would update rates at MEI minus 1 percentage point. We also discuss how various update floors and ceilings would affect such updates. Based on our review of the available evidence, an annal update of MEI minus 1 percentage point would be an appropriate default for fee schedule services, but policymakers may choose other reasonable alternatives. Regardless of the particular approach chosen, the critical concept is that fee schedule rates should increase based on some portion of the MEI since an annual full-MEI update could result in financial burdens that are larger than necessary for beneficiaries and the program.

MEI minus 1 percentage point could be implemented prospectively, as in most other FFS Medicare payment systems. For example, if MEI growth in the coming year is projected to be 4 percent, the update would be set at 3 percent (4 percent minus 1 percentage point). If the update were coupled with a floor of 0 percent, the update floor for the year would be 0 percent, so the actual update would be the higher of the two: 3 percent. In contrast, in a year in which the MEI is projected to grow by 0.5 percent, the MEI minus 1 percentage point calculation would result in an update of -0.5 percent, but the floor would set the actual update at 0 percent.

The Commission's preference for updating fee schedule rates based on inflation but below full MEI growth is based on several key factors:

 It would automatically adjust to changes in inflation: As demonstrated by the spike in inflation during the coronavirus pandemic, anticipating future rates of input cost growth for clinician practices is difficult. Therefore, setting default updates that change based on an objective measure of growth in practice costs (e.g., the MEI) would improve how well fee schedule updates match changes in the cost of running a clinician practice. Different formulations of sub-MEI growth updates would improve the responsiveness of fee schedule updates to actual inflation conditions relative to current law. For example, an update of half of MEI would likely be adequate in the short term and, based on current CMS projections of MEI growth, in the long term as well.<sup>12</sup> However, if inflation in the long term is higher than currently projected by CMS, then updates of half of MEI might not be sustainable, based on historical evidence. For example, if MEI growth averaged 4 percent, an update of half of MEI would be 2 percent (2 percentage points below MEI growth). While annual updates of 2 percentage points below MEI growth might be sustainable, our analysis of past fee schedule updates allows us to conclude only that updates set at 1 percentage point below MEI growth are likely sustainable in the long term.

An update of MEI minus 1 percentage point could also be coupled with an update floor. If the update floor were set at half of MEI, updates would at least cover increases in practice costs on average (since practice expenses account for about half of the costs of running a clinician practice, according to the 2017-based MEI). If an update floor were set at 0 percent, updates could not be negative, which could otherwise occur during times of low inflation. For example, if updates of MEI minus 1 percentage point had been in place from 2001 to 2020, updates would have been negative in each of the four years from 2009 to 2012.<sup>13</sup>

An update of MEI minus 1 percentage point could also be coupled with an update ceiling to address a concern that, in periods of rapid inflation, the appropriate gap between MEI and updates necessary to maintain access may be greater than 1 percentage point. To illustrate the effect of such a policy, we use hypothetical values of MEI growth of 6 percent and an update ceiling of 75 percent of MEI growth. Under this scenario, an update of MEI minus 1 percentage point would result in an increase of 5 percent (6 percent - 1 percent) versus 4.5 percent with the illustrative ceiling in place (6 percent  $\times$  0.75). Such an update would still cover the growth in practice expenses and limit the financial burden on beneficiaries and taxpayers. From 2000 to 2023, a 75 percent ceiling would only once (in 2022) have reduced an update that was based on MEI minus 1 percentage point and, based on projections of MEI growth, would not affect such updates through 2034.<sup>14</sup> Nevertheless,

a ceiling could be a useful policy tool to reduce unnecessarily high updates if MEI growth is higher than currently projected.

- It would improve predictability for clinicians, beneficiaries, and policymakers: Having updates that automatically adjust to the current inflation environment would allow clinicians to more reliably predict whether updates will keep pace with the costs of running their practices. Over time, greater predictability and stability may also help beneficiaries as clinicians maintain their practices (and access for beneficiaries) and more energy is focused on reforming care delivery rather than adequate updates. Appropriate default updates would also allow policymakers to focus on improving other aspects of the fee schedule rather than enacting numerous one-time or short-term patches to ensure that updates are adequate.
- It should be sufficient, based on historical evidence, to maintain beneficiary access to care: After factoring in a series of congressional patches to override fee schedule updates specified under the SGR, fee schedule updates averaged about 1 percentage point below MEI growth for the two decades preceding the coronavirus pandemic. Over that time, Medicare beneficiaries' access to care remained comparable with patients who had private insurance. This historical evidence suggests that updates of MEI minus 1 percentage point have been sufficient to maintain access to care. The addition of an update floor would make updates based on MEI minus 1 percentage point more generous during periods of low inflation. For example, from 2001 to 2020, updates averaged 1 percentage point below MEI growth. However, if an update policy of MEI minus 1 percentage point with a half of MEI floor were in place over that period, cumulative updates would have been 7 percentage points higher than actual fee schedule updates.<sup>15</sup> This difference suggests that a policy that updated PFS payment rates by MEI minus 1 percentage point with a floor of half of MEI would be higher than what has occurred historically and that the method therefore errs on the side of slightly higher updates to ensure beneficiary access.
- It would be simple to administer and apply to all PFS services: An MEI-based update would be simple for CMS to administer and similar to other

FFS payment systems. The updates would also apply uniformly to all services (and therefore all clinician specialties).

It would balance beneficiary access with beneficiary and taxpayer financial burden: Some physician organizations have called for annually updating PFS payment rates based on full MEI (American Medical Association 2023a). Our analysis suggests that doing so would likely increase Medicare and beneficiary spending beyond what is necessary to maintain access to care. In addition to creating a financial burden on taxpayers, unnecessarily increasing payment rates can be detrimental to beneficiaries' ability to afford (and therefore access) health care by raising their premiums and cost sharing. This burden may disproportionately impact subgroups of beneficiaries who, according to the Commission's analysis of CMS's 2022 Medicare Current Beneficiary Survey, are already more likely to report problems paying medical bills: FFS Medicare beneficiaries with no supplemental coverage, beneficiaries under the age of 65 (most of whom are disabled), and partial-benefit dually eligible beneficiaries (who do not qualify for the same Medicaid benefits that full-benefit dually eligible beneficiaries receive) (Medicare Payment Advisory Commission 2025). Given the relatively low current-law fee schedule updates, even updating rates below full MEI growth could substantially increase Medicare program and beneficiary spending.

#### **RECOMMENDATION 1-1**

The Congress should replace the current-law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (such as MEI minus 1 percentage point).

### RATIONALE 1-1

Medicare lacks data on the costs and revenues associated with running clinician practices, which serve as the foundation of payment-adequacy analyses in other sectors, but the Commission has found that beneficiary access to clinician care has been as good as, or better than, that of privately insured individuals. However, MEI growth is projected to exceed fee schedule updates by even more in the future than it has in the past. The Commission is therefore concerned about whether current-law payment-rate updates—which are fixed in statute without regard to inflation—will remain adequate to ensure continued access to care.

Because Medicare lacks data on clinician practice costs and revenues, it is difficult to determine sufficient updates. An update based on inflation growth—a feature that is common to many other Medicare fee schedules—would allow PFS rates to automatically adjust to changes in costs. However, inflationbased updates could increase Medicare's payments for clinician services relative to current law, which could financially burden beneficiaries and taxpayers. Therefore, the Commission's goal is to recommend a change to current-law updates that balances the goal of maintaining beneficiary access by ensuring that Medicare's payments reflect trends in inflation growth with the desire to limit beneficiary and taxpayer financial burden.

The Commission maintains that the weight of the historical evidence on beneficiary access to care, clinicians' acceptance of Medicare, rapid growth in fee schedule spending, and other metrics suggest that it is prudent to set updates based on a portion of MEI growth, such as MEI minus 1 percentage point, rather than full MEI growth. Sub-MEI growth in updates has been sufficient to maintain beneficiary access to care. Such updates would automatically adjust to changes in inflation; would improve predictability for clinicians, beneficiaries, and policymakers; would be simple to administer and apply to all PFS services; and would limit the financial burden on beneficiaries and taxpayers. The Commission will continue to monitor trends in access, inflation, volume of care, quality, and other indicators and, to the extent needed, recommend higher or lower updates in the future.

Policymakers may also wish to consider setting update floors and ceilings. Update floors could increase stability by ensuring that a default update of MEI minus 1 percentage point does not result in negative updates (in the case of a 0 percent update floor) or would at least cover the growth in overall practice expenses (if the floor were half of MEI since practice expenses account for about half the costs of running a clinician practice, according to the 2017-based MEI). Update ceilings could address a concern that in periods of rapid inflation, the appropriate gap between MEI and updates necessary to maintain access may be greater than 1 percentage point. For example, if MEI were 6 percent, an update of MEI minus 1 percentage point would result in an increase of 5 percent (6 percent – 1 percent) versus 4.5 percent with an illustrative ceiling of 75 percent of MEI growth (6 percent  $\times$  0.75).

Under the approach of updating PFS rates by a portion of MEI growth, the Commission did not address how the A–APM bonus should be treated. While the Commission maintains that incentivizing A–APM participation through differential payment-rate updates (such as 0.75 percent for A–APM participants and 0.25 percent for nonparticipants) is a flawed approach, we assert that A–APMs continue to show promise. Policymakers thus may choose to include some form of a bonus as an important component of payment for clinician services as they seek policy changes to improve A–APM design and performance.

### IMPLICATIONS 1-1

### Spending

• We expect that the recommendation would increase federal program spending by between \$15 billion and \$30 billion over five years relative to current law.

### **Beneficiary and provider**

- We expect that this recommendation would maintain FFS Medicare beneficiaries' access to care by maintaining or improving clinicians' willingness and ability to treat them.
- We expect that this recommendation would increase Part B premiums and coinsurance for Medicare beneficiaries.

# Improving the accuracy of relative payment rates for fee schedule services

While fee schedule updates are the main policy lever used to change the aggregate value of fee schedule services, RVUs determine how that spending is distributed among services and places of service. In addition, other payers (including Medicaid) often base

# Previous MedPAC recommendations on improving the way clinician services are valued

n numerous occasions, the Commission has expressed concerns about the way relative value units (RVUs) for clinician services are calculated and updated over time.

Of particular concern are issues related to data timeliness and accuracy and whether the current RVUs accurately reflect changes in the way medical care is organized and delivered. The Commission has also raised concerns about CMS's reliance on the Relative Value Scale Update Committee (RUC) to make recommendations on relative values. The RUC is a private entity that was formed in 1991 by the American Medical Association (AMA) and physician specialty societies. In addition to representatives from the AMA, 22 of the RUC's 32 members are appointed by major national medical specialty societies. (Four seats rotate on a two-year basis, with two reserved for representatives of primary care, one for an internal medicine subspecialty, and one for any other specialty not already represented at the RUC.) The RUC makes annual recommendations to CMS

on the relative values for new services, as well as for services that have been redefined. Under a specified review process, the RUC also reviews and makes recommendations on the relative values of existing services that may have become misvalued. As part of these processes, specialty societies survey clinicians and the RUC uses findings from those surveys to make recommendations to CMS about what relative values should be. CMS reviews and sometimes refines the RVUs recommended by the RUC.

In 2006 and 2011, the Commission made five recommendations for how the valuation process could be improved (Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2006).

The Commission recommended the following in 2006:

• The Secretary should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC.

(continued next page)

payments on fee schedule RVUs, so misvaluations can affect other parts of the health care system. The Commission has previously outlined flaws in the way RVUs are calculated. These flaws include use of outdated and/or inaccurate data, assumptions that certain services require more resources than they actually do, and double payment for certain costs (Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2011a, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2006).

Because overvalued services benefit more from higher across-the-board updates, larger fee schedule updates also magnify the effects of misvalued services, which include the underprovision of some services, the overprovision of others, and incentives for vertical consolidation between hospitals and clinicians. These effects make relying on changes in fee schedule updates an inefficient, and potentially counterproductive, way to address relatively mispriced services. Instead, coupling any increase in updates with improvements to the accuracy of relative values would help address the effects of misvalued services and help ensure that taxpayer and beneficiary funds are used judiciously.

On several occasions, the Commission has made targeted 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

# Previous MedPAC recommendations on improving the way clinician services are valued (cont.)

The group should include members with expertise in health economics and physician payment, as well as members with clinical expertise. The Congress and the Secretary should ensure that this panel has the resources it needs to collect data and develop evidence.

- The Secretary, in consultation with the expert panel, should initiate the five-year review of services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may indicate changes in physician work.
- In consultation with the expert panel, the Secretary should identify new services likely to experience reductions in value. Those services should be referred to the RUC and reviewed in a time period specified by the Secretary.
- To ensure the validity of the physician fee schedule, the Secretary should review all services periodically.

The Commission recommended the following in 2011:

• The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

In the years since the Commission made these recommendations, CMS has been more active in revaluing certain codes, and the Congress has enacted legislation directing CMS to expand the scope of efforts to identify misvalued codes. That said, the agency has limited resources with which to collect additional data and conduct reviews. Reliance on data from outside organizations with a financial interest in payment rates can generate better data but bias valuations (Chan and Dickstein 2019). The agency has also not addressed changes such as growth in vertical consolidation. As such, deficiencies in the valuation process persist.

the main body that recommends relative values for fee schedule services to CMS (Medicare Payment Advisory Commission 2006) (see text box on the Commission's previous recommendations). And in 2011, the Commission 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 overvalued fee schedule services (Medicare Payment Advisory Commission 2011b).

Implementing our past recommendations would help to improve the data and valuation process, but the recommendations do not address some of the broader issues with the way RVUs are determined. In particular, valuations often do not fully reflect current practice patterns or cost structures. They also largely have not accounted for changes in how medicine is organized, such as increases in the share of clinicians who are vertically consolidated with a hospital and how that affects their costs.

In this section, we present three examples of changes in payment policy and RVU valuation methodology that could address misvaluation issues:

- changing the allocation of indirect practice expenses to better reflect relative costs of facilitybased clinicians;
- updating the allocation of RVU shares, which is currently based on 2006 MEI data, by using more up-to-date MEI data; and

• addressing relative values of global surgical codes, for which there is substantial evidence of overpayment.

The three policies discussed in this section are not an exhaustive list of ways that RVU valuation could be improved. There are numerous other issues with the way services are valued, and there is no one-sizefits-all solution. The Commission's goal is to use the examples described in this section to illustrate different approaches to improving the valuation of services and urge policymakers to address those issues in tandem with reforming fee schedule updates.

### Changing indirect practice expenses to better reflect costs of facility-based clinicians

The physician fee schedule has two types of payment rates for clinician services: nonfacility and facility. When a service is furnished in a nonfacility setting, such as a freestanding office, the fee schedule payment includes payment for work, both direct and indirect PE, and MP. With the exception of global surgical codes, when a fee schedule service is performed in a facility setting, such as a hospital outpatient department or ambulatory surgical center, the PE portion of fee schedule RVUs is reduced so that it includes payment for work, indirect practice expenses (e.g., rent, utilities, and administrative staff), and MP, but it does not usually include payment for direct practice expenses (e.g., equipment and supplies).<sup>16,17</sup> Medicare fees paid directly to the facility where the service was performed (e.g., OPPS payments) cover both the direct PE and the facility's indirect PE costs for each service.<sup>18</sup> This arrangement assumes that facilities should be compensated for all of their costs (both direct and indirect) and that clinicians should be compensated for the indirect PE expenses of maintaining an independent, freestanding office outside of the facility.

Using an example of a widely used service (30- to 39-minute E&M office visit), Figure 1-3 shows which costs are included in payments made under the physician fee schedule (nonfacility and facility) and OPPS. As shown in the bar on the left side of the figure, when a service is furnished in a nonfacility setting, PFS payment includes payment for work, malpractice insurance, and both indirect and direct PE. As shown in the bar on the right side, when a service is furnished in a facility, PFS payments include work, malpractice insurance, and indirect PE (but not direct PE), while the OPPS payment is for a combination of direct and indirect costs. In cases when clinicians practice exclusively or almost exclusively in a facility, or where a facility is financing indirect PE for clinicians, payment to both entities for indirect PE costs may be duplicative and unnecessary.

This approach to paying for services furnished in a facility is based on two key assumptions: (1) the facilities, not clinicians, are paying for direct costs incurred during the service (such as medical equipment), as well as indirect costs (such as maintaining the building and other operating expenses), so facilities should be compensated for both types of PE; and (2) even though some clinicians furnish most or even all of their services in a facility, they also need to be compensated for overhead costs related to maintaining a freestanding office.

When the RVU system was developed in the late 1980s, paying indirect PE for clinician services furnished in a facility was more empirically sound because fewer clinicians practiced exclusively in a hospital (or other facility), and few were financially affiliated with hospitals. Two trends have emerged that indicate that the relationship between clinicians and facilities has changed since then. First is the growth in the number of facility-based clinicians who practice exclusively, or almost exclusively, in a facility setting. This trend can be seen in the increasing number of hospitalists who follow patients admitted to a hospital rather than clinicians who split time between seeing patients in an office and facility. The second trend is a steady increase in the portion of physicians who are employed by a hospital or work in a practice that is owned by a hospital.

One way to gauge whether clinicians maintain independent offices is to use CMS claims data to measure what percentage of each clinician's total services was furnished in a facility. Table 1-1 (p. 30) shows the percentage of clinicians from different specialties that furnish 90 percent or more of their services in a facility setting. The table lists nine specialties in which at least 60 percent of the clinicians who billed Medicare furnished 90 percent or more of their services in facility settings. These findings suggest that some specialists are practicing exclusively, or almost exclusively, in facility settings and may not



## Payments under the physician fee schedule and outpatient prospective payment system for an E&M office visit in 2024



Note: E&M (evaluation and management), PFS (physician fee schedule), OPPS (outpatient prospective payment system), PE (practice expense). The terms "facility" and "nonfacility" refer to the setting in which a service is performed. Examples of facility settings include hospital outpatient departments, hospital inpatient departments, and ambulatory surgical centers. Examples of nonfacility settings include clinician offices, retail health clinics, and urgent care centers. Figure based on 2024 payment rates for Healthcare Common Procedure Coding System code 99214 (30-to 39-minute evaluation and management visit for an established patient) and ambulatory payment classification 5012.

Source: National Physician Fee Schedule Relative Value File; Addendum A: OPPS APCs for calendar year 2024.

maintain an independent office. While these data can provide a sense of the prevalence of the share of clinicians who are practicing predominantly in a facility, it is important to note that many facilitybased clinicians may have separate offices where administrative costs are not financed by the facility. In other cases, facility-based clinicians may not maintain a separate office, but administrative expenses like billing and scheduling are not financed by the facility.

In addition, studies have found that a growing number of clinicians have a financial affiliation with hospitals (Burgette et al. 2021, Nikpay et al. 2018, Wachter and Goldman 2016). Affiliation arrangements can vary, but according to a survey administered by the AMA, a growing percentage of physicians are in practices that have some form of hospital ownership or are employed by a hospital, while the percentage of physicians in practices that are independent of a hospital has been shrinking (Kane 2023). Table 1-2 (p. 30) summarizes the results of this survey over the 2012 to 2022 period.

While the AMA's survey broadly indicates that a growing portion of physicians have a financial affiliation with a hospital, there is not a definitive data source that shows whether a given clinician is financially affiliated. Researchers have used various methods for determining financial affiliation, including a recent study that measured vertical integration between physicians and hospitals using a combination of data sources, including CMS records, survey responses, and Internal Revenue Service data (Luo et al. 2024).

### Share of clinicians who furnish a majority of their services in facility settings, by selected specialties, 2023

Clinician specialty	Clinicians furnishing 90 percent or more of services in facility settings			
Hospitalist	95.3%			
Emergency medicine	91.2			
Critical care (interventionalist)	84.6			
Hospice and palliative care	81.2			
Pathology	70.6			
Hematology	67.2			
Infectious disease	65.5			
Interventional radiology	65.2			
Radiation oncology	63.8			

Note: Clinician specialties include those in which at least 60 percent of clinicians furnished 90 percent or more of their services in a facility setting.

Source: MedPAC summary of Actuarial Research Corporation analysis of 2023 Medicare claims data.

#### How practice expense RVUs are calculated

In 2023, approximately 46 percent of total fee schedule payments were for the PE component (physician work accounted for roughly 50 percent and malpractice insurance about 4 percent) (Figure 1-4). PE RVUs are designed to reflect two different types of practice

expenses: direct and indirect. Direct practice expenses include three types of input costs: nonpractitioner clinical labor (e.g., nursing staff), medical supplies, and medical equipment. Indirect practice expenses include administrative costs, rent, office supplies, and information technology. In 2023, indirect PE accounted

## 

### A growing share of physician practices have a financial affiliation with a hospital

	Percentage of physicians		
Practice ownership structure	2012	2022	
Wholly owned by physicians (private practice)	60.1%	46.7%	
Direct hospital employee/contractor	5.6	9.6	
At least some hospital ownership	23.4	31.2	
Wholly owned by hospital	14.7	20.1	
Jointly owned by physicians and hospital	6.0	6.7	
Unknown, either wholly or partly owned	2.6	4.5	
Wholly owned by nonprofit foundation	6.5	5.2	
Private equity	N/A	4.5	
Other	4.4	2.6	

Note: N/A (not available). Other arrangements include managed care organizations. Components may not sum to totals due to rounding.

Source: Kane 2023.

for about \$31 billion in total fee schedule payments (just over one-third of total payments), and direct PE represented about \$11 billion.

The current PE cost–allocation methodology is complex and rests on a number of assumptions about how costs are allocated and the relationship between work and PE costs. Figure 1–5 (p. 32) walks through the process used to calculate PE RVUs.

The first step in the process for calculating PE RVUs is to set the overall pools for PE RVUs and MP RVUs. A given year's total PE pool is calculated as the product of that year's total work RVU pool and the ratio of the previous year's total PE RVUs to total work RVUs. In practice, this process results in pools of work, PE, and MP RVUs that generally align with the cost-share ratios indicated by the MEI.<sup>19</sup>

Next, the total PE pool is divided into two parts: direct costs (e.g., equipment, supplies, and nonphysician clinical labor) and indirect costs (e.g., administrative overhead). This split is based on the weighted sum of specialty-specific direct and indirect costs per hour. Because the shares of direct and indirect costs within the overall pool of PE RVUs are fixed, any changes to either direct or indirect costs become a zero-sum game within that component of PE. In other words, if the indirect PE allocation increases for certain services, indirect PE for other services will decrease so that total indirect PE RVUs across all services do not change. Similarly, a change to service-level direct costs would lead to reallocation of direct PE RVUs for all services.

Service-level PE RVUs are then assigned. Direct PE RVUs are allocated to reflect variation in costs for each service using sample data to estimate expenses for equipment, medical supplies, and nonphysician clinical labor.<sup>20</sup> Since by definition indirect costs cannot be measured at the service level, the indirect PE pool is allocated according to a formula that takes into account each service's direct PE RVUs and work RVUs (or clinical labor when there is no physician work component), adjusted for specialty-level differences in reported indirect costs.

### Policy approaches for reducing PE for certain services when furnished in a facility

Growth in the portion of clinicians who are facility based or in financial affiliation between clinicians and

### FIGURE

### 1-4 Dist

#### Distribution of physician fee schedule spending, by type of RVU, 2023



of 2023 Medicare claims and payment data. Percentages in the figure reflect the actual distribution of RVUs in 2023 and do not match cost shares from 2006 MEI due to year-to-year changes in service volume and other factors.

hospitals suggests that assumptions that all physicians are maintaining an independent office may no longer be valid. For clinicians who furnish most of their services in a facility or are in practices owned by a hospital, Medicare is paying the clinician for indirect practice expenses that may not exist or are being paid as part of the program's facility payment.

When the PFS makes indirect PE payments for services delivered in a facility and performed by clinicians who are not maintaining or financing a separate office, there are several implications:

• For facility-based clinicians who do not maintain a separate office, these payments can result in payment of overhead costs for an office that does not exist.



### How practice expense RVUs are valued



медрас

- For clinicians who are employed by a facility or work for a practice that is owned by a facility, the fee schedule's approach can result in payment for the same indirect costs (i.e., administrative overhead) twice—through both the PFS and the hospital OPPS.
- Because indirect PE RVUs are allocated according to a fixed pool of total PE RVUs, overpaying for indirect costs for some services furnished in a facility effectively reduces PE RVUs for other services, including all services furnished in an office.

Ideally, policies to reduce or eliminate fee schedule indirect PE RVUs for facility services should be targeted toward clinicians who do not pay indirect PE costs because they do not maintain or finance a separate practice. There are several approaches that could be used to identify circumstances in which indirect PE RVUs should be reduced or eliminated to address the potential overpayment. Medicare claims data could be used to determine whether a given clinician primarily practices in a facility or a service is furnished primarily in a facility, or a combination of both. Appendix 1-A (p. 42) presents simulated changes in RVUs and total spending using four claimsbased approaches to identify circumstances in which indirect PE could be reduced. Alternatively, data about facility employment status and the financial relationship between clinicians and facilities could be used, although these data are not currently available for every clinician who bills the fee schedule.

Because of the zero-sum nature of allocating PE RVUs, addressing inaccuracies resulting from the current valuation rules would result in a redistribution of payments across the fee schedule and differential impacts across clinicians. The impact of each scenario depends on where individual clinicians furnish services and what kinds of services they deliver. In general, in the policy scenarios presented in the appendix to this chapter, clinicians who perform services in facilities (where current payment rules likely result in some overpayment of indirect PE) would see revenue declines. In contrast, revenue would increase for clinicians who perform services in nonfacility settings. For services commonly furnished in both settings, increased nonfacility payments could encourage clinicians to furnish more

services in a nonfacility setting and fewer in facilities. Reducing facility payments and increasing nonfacility payments could also reduce financial incentives for vertical consolidation between independent clinician practices and hospitals. The implications are less clear for reducing indirect PE for individual services that are furnished predominantly in facilities (e.g., emergency department services or major surgical procedures). The policy could encourage practices that are independent but provide services primarily in hospitals to financially integrate with a hospital. For these types of clinicians, the incentives would depend on the specifics of the policy.

Both rescaling RVUs based on updated MEI data (discussed in the next section) and changing indirect practice expenses to better reflect costs of facilitybased or hospital-affiliated clinicians could have substantial impacts on the distribution of fee schedule payments. Depending on the mix and location of services that clinicians furnish, the combined effect of these policies could result in even larger changes than either policy in isolation. If both these policies were implemented, policymakers would need to be cognizant of the combined effects and would likely need to implement policies to limit the short-term impacts, such as transitioning to these policies over a period of multiple years. Using the updated MEI shares would be consistent with CMS's past practices and help keep the data underlying the fee schedule more up-to-date, while modifying the way that indirect costs are allocated represents an innovation in the PE methodology.

### Overlap with site-neutral payment policies

The Commission has recommended reducing or eliminating the difference in total Medicare payments for certain services that can be performed in multiple settings (Medicare Payment Advisory Commission 2023a). This site-neutral approach is intended to reduce financial incentives to provide clinician services in facilities if they can be safely provided in an office. Since the total Medicare payments (including facility PFS and OPPS payments) for services furnished in a facility are generally larger than nonfacility PFS payments, the larger payments provide an incentive to furnish services in a facility. The OPPS payment for services subject to site-neutral adjustments would be reduced so that total Medicare payments are the same for the two settings. Effectively, this approach pays the clinician for work, indirect PE, and malpractice costs and pays the hospital for the portion of practice expenses that are not included in the fee schedule's payment.

By reducing OPPS payments in this way, the siteneutral approach would accomplish some of the same goals as reducing or eliminating indirect PE RVUs for some clinician services furnished in a facility. To the extent that changes to indirect PE were implemented concurrently with site-neutral payments, total payments (PFS plus OPPS) would continue to be aligned across settings. However, the site-neutral policies that the Commission recommended in 2023 (and site-neutral proposals by others) would apply to only a portion of services that take place in a facility, whereas the clinician PE policy contemplated in this chapter could apply to a broader array of services. In addition, reducing indirect PE RVUs for some facilitybased services would result in those RVUs being redistributed to other fee schedule services, thus increasing payment rates for other services.

The interaction between site-neutral and indirect PE policies would have important redistributive implications, but the presence of a site-neutral policy does not negate the justification for reductions in facility PE RVUs or vice versa. Thus, reducing PE RVUs for some facility-based services is consistent with the Commission's site-neutral policy and should be viewed as a complement to that policy rather than a replacement.

## Updating the distribution of RVUs based on more up-to-date MEI data

In aggregate, total RVUs for work, PE, and MP are supposed to reflect the average distribution of these costs across clinician practices. The basis of this distribution has historically been the MEI. In other words, if the MEI indicates that clinician work accounts for half of the costs of running a typical clinician practice, then half of total RVUs should be associated with clinician work. Likewise, the share of total RVUs that are for PE and MP are guided by the distribution of costs indicated by the MEI.

CMS periodically rebases the MEI, which entails updating the base-year data used to establish the distribution of costs associated with furnishing clinician services. For example, CMS rebased the MEI in 1998 (moving the base year from 1992 to 1996), 2004 (moving the base year from 1996 to 2000), and 2011 (moving the base year from 2000 to 2006). In 2022, CMS again rebased the MEI (moving the base year from 2006 to 2017).

Traditionally, when CMS rebases the MEI, the agency rescales RVUs to match the distribution of expenses under the MEI. But in 2022, CMS revised and rebased the MEI using 2017 data but did not rescale the RVUs under the fee schedule. The agency delayed rescaling in light of the AMA's efforts to collect more up-to-date data on the costs associated with running a clinician practice and to promote stability and predictability within the fee schedule when data sources are updated (Centers for Medicare & Medicaid Services 2023, Centers for Medicare & Medicaid Services 2022). In the meantime, the distribution of RVUs under the fee schedule remains based on data reflecting physicians' practice costs in 2006.

In early 2025, the AMA conveyed a summary of the results of its most recent Physician Practice Information (PPI) survey to CMS and subsequently released the data publicly (American Medical Association 2024b). The PPI survey gathers information from physician practices and does not include data on certain other clinicians who bill the PFS.<sup>21</sup> The most recent survey collected data for fiscal years ending on or after June 30, 2022, which means that practices could report data on fiscal years ending in 2022 or 2023 (Grau et al. 2024). The extent to which CMS will use these data to rebase the MEI or rescale RVUs under the fee schedule was unclear at the time this chapter was drafted, but such changes in the past have involved notice–and–comment rulemaking.

Over time, the shares of costs associated with work, PE, and MP have changed according to different iterations of the MEI and newly released AMA data. According to the MEI data, the share of costs associated with work declined from 1996 to 2017, falling from 54.5 percent to 47.5 percent (Table 1-3). However, the newly released AMA data suggest that the share of costs associated with work in 2022/2023 was 60.8 percent. Because PE accounts for most of the remaining costs, the trends for PE followed the opposite pattern—increasing from 42.4 percent to 51.1 percent in the MEI cost–share data from 1996 to 2017 and then declining to 37.0 percent according to the newly released AMA data. MP costs represent a small overall share of costs, and multiple data sources

## Estimated share of costs associated with work, practice expenses, and malpractice insurance, 1996–2023

Type of cost	Year of cost data				
	1996	2000	2006*	2017	2022/2023**
Work	54.5%	52.5%	50.9%	47.5%	60.8%
Practice expenses	42.4	43.7	44.8	51.1	37.0
Malpractice insurance	3.2	3.9	4.3	1.3	2.3

Note: Figures may not sum to 100 percent due to rounding. Cost shares for 1996 and 2000 were based on the American Medical Association's Socioeconomic Monitoring System Survey; cost shares for 2006 and 2022/2023 were based on the American Medical Association's Physician Practice Information Survey; cost shares for 2017 were based predominately on data from the U.S. Census Bureau's Services Annual Survey. \* The distribution of relative value units under the physician fee schedule is currently based on these data.

\*\* These data are from the American Medical Association's recent Physician Practice Information survey and have not been incorporated into the Medicare Economic Index. These figures exclude expenses from certain practices consisting of clinicians who are not physicians, such as physical therapists. Data for such clinicians were collected in a separate survey, the Clinician Practice Information survey.

Source: MedPAC analysis of CMS regulations and American Medical Association data.

indicate that they have declined substantially as a share of overall costs since 2006 (Table 1-3).

The current distribution of RVUs under the fee schedule is based on cost-share data that are nearly two decades old. If RVUs were rescaled using more up-to-date data, the aggregate distribution of RVUs could change substantially. However, given that newer sources of data have found conflicting results, it is not clear how the distribution would change. Given the impact that rescaling RVUs can have on relative payment rates for fee schedule services, we provide an overview of the process CMS has used to rescale RVUs when new MEI data are incorporated. We then analyze the likely high-level impacts of such changes and discuss a few topics-the importance of incorporating more up-to-date data when establishing the distribution of RVUs, issues that may help explain the differences between the 2017-based MEI and the AMA's newly released data, and factors policymakers may want to consider when rescaling RVUs.

In the past, when rescaling RVUs under the fee schedule in response to new MEI data, CMS has:

- held the aggregate pool of work RVUs constant,
- increased or decreased the aggregate pools of PE and MP RVUs so that the distribution of RVUs matches the new MEI cost shares,

- increased or decreased the conversion factor so that any aggregate changes in the number of PE and MP RVUs is budget neutral, and
- allocated PE and MP RVUs to individual billing codes using the updated pools of RVUs.

To examine how the distribution of RVUs would have changed if CMS used the MEI cost weights from 2017 (instead of those from 2006), the Commission contracted with Actuarial Research Corporation (ARC).<sup>22</sup> Following the process CMS has previously used to rescale RVUs, the pool of work RVUs would be unchanged, and ARC's simulation found that total PE RVUs across all settings would be about 18 percent higher, and total MP RVUs would be about 65 percent lower.<sup>23</sup> The reduction in MP RVUs would partly offset the increase in PE RVUs, but since the pool of PE RVUs is larger, the net change in total RVUs would be positive in aggregate. Therefore, to ensure that total fee schedule spending did not change, the increase in total RVUs would require a -5.4 percent budget-neutrality adjustment to the conversion factor.

Due to this budget-neutrality adjustment, overall spending would not change. However, on average, spending on nonfacility services would increase while spending on facility services would decrease because the increase in PE RVUs would be larger for services furnished in nonfacility settings. The difference results from the fact that most facility PE RVUs do not include direct PE costs, so they experience smaller changes than nonfacility PE RVUs. Therefore, even though the direct and indirect pools grew by the same percentage, the service-level effects of the change in the two pools are different.

The simulation also found that the effect of using 2017 MEI cost shares would vary across types of service. For example, while total RVUs in all settings would be 5.5 percent higher for E&M office visits, they would be 12.3 percent higher for nonmajor vascular procedures; 9.1 percent higher for physical, occupational, and speech therapy; and 5.6 percent lower for major cardiovascular procedures. The variation across different services is largely a function of two factors: (1) the ratio of PE RVUs, MP RVUs, and work RVUs and (2) the ratio of facility and nonfacility services. Nonmajor vascular procedures tend to have relatively high PE RVUs, and most services are furnished in nonfacility settings, so those services would see large increases in total RVUs. Major cardiovascular procedures have relatively low PE RVUs (because these services are furnished in facility settings) and have relatively high MP RVUs, so using the updated MEI cost weights would lead to a substantial reduction in both total RVUs and payment rates. The impact on individual clinicians would depend on what services they furnish and where the services are furnished.

The AMA's newly released data were not available at the time ARC analyzed the effects of rescaling RVUs using the 2017-based MEI data. However, given our experience analyzing the effects of rescaling using the 2017-based MEI, the following high-level effects are likely if the 2022/2023 AMA data were used to rescale RVUs without any methodological changes regarding how the data would be incorporated. Compared with the 2006-based MEI, the AMA's newly released data suggest that work accounts for a higher share of the costs of running a clinician practice, with PE and MP accounting for lower shares. Because the aggregate pool of work RVUs would be held constant, we would expect the number of PE and MP RVUs to be reduced substantially to match the distribution of costs. To make those RVU reductions budget neutral, the conversion factor would then need to be increased. In contrast with the effects of rescaling RVUs to match the 2017-based MEI, we expect rescaling using the AMA's newly released data would, on average, decrease payment rates for services furnished in

nonfacility settings and increase rates for services in facility settings. We would also expect that services with relatively large PE costs, such as those requiring significant medical equipment or supplies, would experience payment-rate reductions while services with low PE costs would experience increases. A number of factors could change the ultimate clinicianand service-level impacts of incorporating the AMA's newly released data. For example, the new data on PE per hour collected in the AMA's survey could have substantial service-level effects above and beyond the effects of rescaling RVUs.

In general, the RVU system is more empirically sound if more timely data about cost shares are used to allocate RVUs, which underscores the importance of collecting up-to-date information on a regular basis. The problem with delaying the rescaling of RVUs to reflect more current data is that the costs of clinician practices have changed substantially since 2006. These changes include:

- increased vertical consolidation—including more hospital employment of clinicians (Capps et al. 2017, Nikpay et al. 2018);
- an increase in the percentage of physicians in large practices (50 or more physicians) and a decrease in the percentage of physicians in small practices (10 or fewer physicians) (Kane 2023);
- an increase in the number of NPs and PAs (AMN Healthcare 2023, Gallegos 2024);
- increases in operating costs due to increases in expenses like staff salaries and supplies (Medical Group Management Association 2023b);
- an increase in administrative costs associated with quality reporting and prior authorization (Casalino et al. 2016, Medical Group Management Association 2023a);
- technology-driven changes in costs, such as widespread adoption of electronic health record systems (Leventhal 2016); and
- changes in the medical malpractice market (Guardado 2022).

By not updating the distribution of RVUs to reflect these types of changes, Medicare could be underpaying for some services and overpaying for others. Using up-to-date data on the distribution of costs is important for payment accuracy, but the 2017-based MEI data and the 2022/2023 AMA data suggest very different distributions of the costs of running clinician practices. Numerous timing and methodological differences likely contribute to these incongruous findings. One key underlying difference between the two data sources is how to treat PE associated with the increasing share of physicians who are employed by hospitals.

The 2017-based MEI relies on data from the U.S. Census Bureau's Services Annual Survey (supplemented by other data sources, such as the Bureau of Labor Statistics' Occupational Employment and Wage Statistics) to calculate the shares of clinician practice costs that are associated with work, PE, and MP. As part of this analysis, CMS intentionally excluded physicians who were directly employed in hospitals (and certain other facilities). CMS said that including costs for physicians who do not incur any operating expenses associated with running a practice, such as physicians who are directly employed by a hospital, would not be technically appropriate (Centers for Medicare & Medicaid Services 2022).

The AMA's newly released data come from its PPI survey. The PPI survey collected practice expense data from a sample of physician practices and practices that volunteered or were recruited to report their data.<sup>24</sup> Physicians who practiced in facilities and/or were directly employed by a hospital were included in the sample. To the extent that physicians' practice expenses were covered through other payment systems (e.g., the hospital inpatient prospective payment system), survey participants were instructed to exclude those expenses. Therefore, if a physician was employed by a hospital and most of their PE was financed by payments to the hospital or other facility, the expenses reported in the survey would mostly be associated with work and MP.

Therefore, the 2017-based MEI disproportionately includes situations in which the full array of the costs of running a clinician practice (including work, PE, and MP) is measured, whereas the PPI survey collected data from more practices in which some of the PE was borne by facilities.

The question of how to account for the PE of physicians who are employed by hospitals or practice predominantly in hospitals has become increasingly important. Over time, there have been substantial increases in vertical consolidation and other changes in the practice of medicine (e.g., the shift from primary care physicians rounding on hospital inpatients to hospitalists performing those services). The underlying changes in the organization of medical practice suggest that any updates in the MEI shares used to rescale RVUs might be coupled with reforms regarding allocating practice expense RVUs to services furnished in facilities. The previous section of this chapter discusses some possible reforms concerning how indirect PE is allocated to account for facility-based services and/or clinicians (see p. 28).

At the time this chapter was written, we did not have sufficient information to judge the relative merits of updating MEI shares using the 2017-based MEI versus the newly released AMA PPI data. For example, releasing the PPI survey results by practice location (e.g., facility vs. nonfacility) and/or ownership categories could be useful since these characteristics appear to be a major factor driving the large differences from prior results and could inform changes in how these data are incorporated. Additional information on other technical matters could also be helpful in understanding the merits of using these data to revise MEI shares and in the broader PE RVU allocation process. For example, the difficulty in obtaining responses led to the PE per hour data being based on a small number of practices for some specialties, acceptance of practices that volunteered or were recruited to report their data, and physicianspecialty categories being consolidated in certain circumstances (and not in others).<sup>25</sup> Low response rates are a common and increasing problem that affects many surveys and may suggest collecting data without regard to specialty or within broad specialty groups could improve the quality and feasibility of such data collection in the future, an option that other stakeholders have identified (Burgette et al. 2021).

## Addressing issues with global surgical codes

Global surgical codes are single codes that are valued to include a procedure as well as pre- and postoperative visits related to the procedure when provided by the clinician who performed the procedure (or other clinicians in that practice) over a specified period of time. For the most part, global surgical codes cover care provided on the day of the sugical procedure plus postoperative care furnished over the following 10- or 90-day period.<sup>26</sup> In 2023, these codes acounted for nearly half of the fee schedule's 9,000 billing codes, and Medicare's spending under the PFS and beneficiaries' spending amounted to about \$2.3 billion on 10-day codes and \$6.1 billion on 90-day codes (the combined amounts represent about 10 percent of total fee schedule spending). About 300 global codes account for 94 percent of spending on 10-day global codes and 72 percent of spending on 90-day global codes (Crespin et al. 2021).

Determining RVUs for global surgical codes involves making assumptions about the number and intensity of postoperative vists a patient typically receives from the rendering clinician over the 10- or 90-day period. These assumptions are informed by provider surveys administered by the RUC. Unless there is a transfer of care, any postoperative visits furnished by other providers are not included in the global codes but are paid separately on a FFS basis. In some cases, follow-up visits assumed in the global payment are simply not occuring. In other cases, a follow-up visit is furnished by a clinician not involved with the procedure, which means that Medicare is essentially paying twice for the same visit (once to the clinician who performed the procedure and once to the provider who furnished the postoperative visit). Both of these situations represent overpayments by Medicare.

Studies have found large differences between the number of postoperative visits that the fee schedule assumes clinicians will deliver after a surgical procedure and the number they actually deliver. In 2012, the Department of Health and Human Services' Office of Inspector General (OIG) sampled 300 global surgical codes and found that for 165 of those codes, the relative values used by Medicare included too many postoperative visits (Office of Inspector General 2012).<sup>27</sup> More recently, a landmark study by RAND found that, at most, only 17 percent of the postoperative visits assumed in 10-day global surgical codes were actually provided, and only 47 percent of postoperative visits assumed in 90-day global surgical codes were provided (Crespin et al. 2021).<sup>28</sup> These findings suggest that RVUs for 10- and 90-day surgical codes are too high, and thus Medicare beneficiaries are overpaying for these services. Because RVUs are calculated on a budget-neutral basis, overpaying for one group of services reduces payment rates for all other services.

The Commission has historically expressed support for episode-based payment approaches. In 2022, it expressed support for a national episode-based payment program to complement any similar programs established by accountable care organizations (Medicare Payment Advisory Commission 2022). When implemented effectively, episode-based payments can encourage efficient use of resources and act to restrain spending during each episode. One of the most important features of effective bundled-payment programs is accurate pricing of the surgical and postsurgical costs included in the bundled payment. Global surgical codes have the potential to encourage efficent provision of postsurgical care and restrain spending, but evidence indicates that valuations of these codes are systemically too high. This misvaluation results in overpayments and undermines the effectiveness of global payments in restraining spending.

## Strategies for improving the accuracy of global payments

Improving the accuracy of payment rates for global surgical codes could be done in two ways. One approach is to convert all 10- and 90-day global codes to 0-day codes. The 0-day code would include all services provided on the day of a procedure, and clinicians would bill separately for each postoperative visit. The second approach is to retain the global codes but base payment rates on more accurate data about the number of visits that are actually provided by rendering clinicians during the postoperative period. Implementing either approach would represent a substantial improvement from the current situation of assuming that too many postoperative visits take place.

Implementing either of these options would address current payment inaccuracies by reducing payment for global services. Without legislation directing otherwise, these reductions would be redistributed to other fee schedule services to maintain budget neutrality, which would result in payment increases for all services other than global surgical services.

### Convert 10- and 90-day global codes to 0-day codes

Under this approach, CMS would stop paying for postoperative visits that do not occur by replacing 10- and 90-day global surgical codes with 0-day global codes—meaning the clinician who performed a surgical procedure would receive a lump-sum payment for all services provided on the day of a procedure (including pre- and postoperative visits provided that day) but all pre- and postoperative visits provided on other days would be billed on a FFS basis (Medicare Payment Advisory Commission 2014).

In the agency's 2015 proposed rule, CMS proposed converting all 10-day global surgical codes to 0-day global codes in 2017 and all 90-day global surgical codes to 0-day global codes in 2018 (Centers for Medicare & Medicaid Services 2014). The RUC expressed concerns about this change, arguing that changing 4,200 codes would take more time than CMS envisioned and that backing out postoperative visits from code values (which CMS had proposed doing ) would yield "inappropriate" work RVUs for some procedures, with nearly half of minor and major surgical procedures having work RVUs that reflect a low intensity (American Medical Association 2015). The RUC and AMA also pointed out that converting global surgical codes to 0-day codes could result in an increase in postoperative E&M visits being billed under the fee schedule. Given these concerns, CMS could instead ask the RUC to propose new values for 0-day global codes. Given the large number of 10- and 90-day global codes to be revalued, the RUC could revalue codes in tranches-for example, prioritizing those 10- and 90-day codes that generate the largest amount of spending and/or are billed most frequently (Medicare Payment Advisory Commission 2024a).

Another concern raised by stakeholders is that while converting all global codes to 0-day codes would decrease beneficary cost-sharing liability for the procedure itself, beneficiaries would face cost-sharing liability for each follow-up visit (to the extent that they occur). Currently, beneficiaries pay a single cost-sharing bill covering all of the care that is expected to be provided by the clinician who furnishes their procedure during a global period, so beneficiaries cannot currently lower their costsharing liability by skipping a postoperative visit offered by that clinician.

These risks are likely outweighed by the benefits of converting 10- and 90-day global surgical codes to 0-day codes. An advantage of this policy for beneficiaries is that, on net, their cost-sharing liability would decrease in most cases because they would pay for fewer postoperative visits than they are currently billed for under 10-day and 90-day global surgical codes. Clinicians other than proceduralists would also benefit from this policy since payment rates for other services would increase to offset the decrease in payments for global surgical codes. Further, Medicare would stop overpaying clinicians who provide fewer postoperative visits than are assumed in surgical global codes and stop underpaying clinicians who provide more of such visits. Medicare would also stop double-paying for postoperative visits in instances when the clinician who performed a procedure is paid for postoperative visits through the global surgical code but another clinician (e.g., a primary care provider) is also paid for postoperative care through separately paid E&M office visits.

Ultimately, a provision in MACRA prevented CMS from converting 10- and 90-day global surgical codes to 0-day global codes. This MACRA provision also directed the agency to collect data on the actual number of visits furnished during global periods (no later than 2017) and to use these data to appropriately value surgical services (in 2019). In accordance with this MACRA provision, CMS collected no-pay claims data starting in 2017 from practices in nine states, documenting the provision of postoperative visits after selected procedures. The agency released findings from analyses of these data but did not revalue these codes; instead, it asked the public for input on the optimal way to use the findings about postoperative visits to revalue global surgical codes (Crespin et al. 2021). After reviewing the comments it received, CMS announced that it anticipated continuing to assess and develop an approach to revalue global surgical codes (Centers for Medicare & Medicaid Services 2019).<sup>29</sup>

**Revalue global codes** Another option for improving the accuracy of 10- and 90-day global surgical codes is to retain the current episode durations of global surgical codes but revalue the codes' RVUs to reflect the actual average number of postoperative visits provided.

RAND explored revaluing global surgical codes by comparing the number of postoperative visits reported on the claims with the expected number of visits used for valuation (Mulcahy et al. 2021). Their study found that revaluing global codes by removing work RVUs, physician time, and direct PE inputs for visits that were assumed but not provided would reduce total RVUs for global surgical codes by 28.5 percent. RAND estimated that the net reduction across all RVUs would be 2.6 percent, which would have the effect of increasing payment rates for other codes to maintain budget neutrality. When including the budget-neutrality adjustment, RAND estimated total Medicare payments for certain surgical specialties would decline by up to 18 percent, while payments to specialties such as primary care would increase by just under 3 percent.

### Recommendation

An important goal of the fee schedule is to ensure that relative values for clinician services approximate the relative costs of the efficient provision of care. Misvaluations create inappropriate incentives for care delivery and vertical consolidation between clinicians and hopsitals.

Taking steps to ensure that RVUs are as accurate as possible is a desirable policy on its own merits, but it is even more important when coupled with a policy to increase conversion-factor updates. Over time, compounded across-the-board increases in payment rates can magnify the clinical and market distortions that misvalued codes can create.

### **RECOMMENDATION 1-2**

The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflect the costs of delivering care.

### RATIONALE 1-2

The fee schedule's RVUs determine how payments are distributed among services and places of service. However, there are flaws in the way RVUs are calculated that likely lead to overpayment for some services and underpayment for others. The misvaluation of RVUs thus can have undesirable effects on the distribution of program spending, beneficiary cost sharing, and clinicians' decisions about how and where to practice medicine. RVU misvaluation may also create incentives for vertical consolidation between hospitals and clinicians. At the same time, other payers (including Medicaid) often base payments on fee schedule RVUs, so misvaluations can affect other parts of the health care system.

The fee schedule's RVUs are misvalued in several ways. For example, with the growth in facility-based clinicians and vertical consolidation, some practice expenses may no longer exist (e.g., freestanding offices), and facilities are increasingly paying for indirect practice expenses that used to be financed by clinicians. Since Medicare pays both clinicians and facilities for indirect practice expenses—most frequently through both the physician fee schedule and the hospital OPPS—in circumstances where clinicians do not maintain or finance a separate office, Medicare may be overpaying for these costs.

Also contributing to misvaluation is the use of data from 2006 to allocate total RVUs across work, practice expenses, and malpractice expenses. Using more up-to-date data would help ensure RVUs more accurately reflect how costs are distributed between the three RVU categories, although there are questions about the source of these data and how to account for the growth of hospital-based clinicians.

Another example of misvaluation relates to global surgical codes. Substantial evidence indicates that, in aggregate, billing clinicians do not furnish as much postoperative care as is assumed by the RVUs for global surgical codes, meaning that in many cases, Medicare is paying for visits that are not occurring.

All three examples raise important issues about valuation, but there are numerous other concerns about potentially misvalued services. Because overvalued services benefit more from higher acrossthe-board updates, larger fee schedule updates magnify the effects of misvalued services. Therefore, any increase in updates should be coupled with improvements to the accuracy of relative values to help ensure that taxpayer and beneficiary funds are used judiciously.

Given the complex nature of the relative value system, the Commission's recommendation is broad, urging policymakers to consider a wide range of problems with valuation and recognizing that flexibility will be needed when pursuing improvements. In addressing those problems, policymakers should direct the Secretary to develop data-driven policies that fully and accurately reflect practice costs, changes in practice patterns, financial relationships between clinicians and hospitals, and other reasons that relative values may be misvalued.

### IMPLICATIONS 1-2

### Spending

• No effect on total program spending is expected due to the required budget-neutral implementation.

### **Beneficiary and provider**

 This recommendation could benefit beneficiaries by reducing incentives for clinicians to overprovide or underprovide certain services. It could have redistributive effects on payments to providers.



# Simulations of illustrative options to redistribute relative value units for indirect practice expenses

**T** o get a sense of the impact of reducing or eliminating indirect practice expense (PE) in certain circumstances, the Commission contracted with Actuarial Research Corporation (ARC) to conduct several simulations. Each simulation is based on different approaches to identifying clinicians or services for which indirect PE for facility services could be reduced or eliminated. It is important to emphasize that the identification approaches presented below are meant to be illustrative and provide a measure of how relative value units (RVUs) and fee schedule spending could be affected if a given policy were adopted. None of the approaches presented here should be viewed as a Commission recommendation or endorsement.

Three of the approaches described below would require creating a second type of facility RVU in which indirect PE would be reduced or eliminated for clinicians or services that meet specified criteria. Another approach would be to change the way facility PE RVUs are calculated so that the valuation of facility services better reflects the practice expenses that clinicians actually pay.

While all four approaches described below have their drawbacks, there are also drawbacks to maintaining the status quo. To the degree that the fee schedule is relatively overpaying for indirect PE, fee schedule spending is maldistributed toward facility-based clinicians and away from all other clinicians. Because the total pool of PE RVUs is constant, reducing or eliminating indirect PE RVUs for facility-based clinicians would have the effect of increasing PE RVUs for clinicians who do not practice at facilities. At a high level, the combination of decreasing PE RVUs for facility-based clinicians and increasing RVUs for all other clinicians could reduce the financial incentives for clinicians and facilities to vertically consolidate.

• Reduce or eliminate indirect PE RVUs for services furnished by facility-based clinicians. This approach would reduce physician fee schedule (PFS) indirect facility PE payments for services provided by clinicians who furnish most or all of their services in a facility. This approach would be based on the presumption that facility-based clinicians do not need to maintain separate offices and that fees paid to the facility would cover overhead costs for these clinicians. Medicare claims could be used to identify facility-based clinicians. For instance, indirect PE could be reduced for clinicians who furnish a specified portion of their services (e.g., at least 90 percent) in a facility setting.

Using claims data to identify facility-based clinicians would be relatively straightforward, but there are some potential drawbacks to this approach. For instance, the determination of which clinicians are considered facility based is likely to be sensitive to the threshold used to make that determination. For some specialties, using a threshold of 90 percent of facility services could result in many more clinicians being considered facility based than if a threshold of 100 percent were used. In addition, many clinicians who predominantly work in a facility are not actually employed by a facility and incur some indirect PE costs, which would no longer be paid by the fee schedule. In these circumstances, completely eliminating indirect PE could make it difficult for clinicians who are not employed by a facility to maintain an independent office and could incentivize them to consolidate with facilities. One way to address this concern would be to reduce, but not eliminate, indirect PE so that facility-based clinicians who have independent offices would still receive some payment for indirect PE under the fee schedule.

Reduce indirect PE RVUs for services that are predominantly performed in a facility setting. Instead of reducing indirect PE for clinicians who primarily practice in a facility, this approach would target indirect PE reductions at services that are primarily performed in a facility. For instance, a service that is performed more than 90 percent of the time in a facility such as a hospital could have its indirect PE RVU reduced or eliminated. This approach would focus PE reductions on facilitybased services, such as emergency department services. Unreduced indirect PE payments would be made for office-based services, such as most outpatient evaluation and management (E&M) visits, even if many of those services are furnished in a facility. This approach could be combined with the facility-based clinician approach discussed above so that reductions in indirect PE would affect only services that are primarily performed in a facility when furnished by clinicians who primarily practice in the facility (i.e., indirect PE would be reduced for services that are performed more than 90 percent of the time in a facility when provided

by clinicians who perform more than 90 percent of their services in a facility).

A service-based approach to reducing indirect PE suffers from some of the same drawbacks as the clinician-based approach. Identifying facilitybased services would be sensitive to the thresholds used to make that determination. Reducing or eliminating facility indirect PE payments for certain services assumes that all clinicians who perform those services (regardless of their affiliation with the facility) do not need the indirect PE payments. A service-based approach is also bound to exclude services furnished by some facility-based clinicians, resulting in potential overpayment of indirect PE when billed by those clinicians. A hybrid approach (based on information about both clinicians and services) may be more accurate than either approach on its own, but it would still be subject to judgment calls about what thresholds should be used and payment cliffs between clinicians who are subject to the payment reduction and all other clinicians.

Reduce or eliminate indirect PE RVUs for facility services furnished by clinicians who are financially affiliated with a hospital. Concerns have been raised that for some services performed in a facility, Medicare may be paying for the same indirect practice costs to both the clinician and the facility. Given the growth in hospital-employed clinicians and hospital-owned physician practices, this concern is primarily raised about services furnished in hospital outpatient departments. A policy that would reduce or eliminate indirect PE for clinicians who are financially affiliated with a hospital is based on the premise that hospitals receive payments for indirect practice expenses through the outpatient prospective payment system and the hospital is likely paying overhead costs for employed clinicians, as well as clinicians who are part of hospital-owned practices. (PE payments would not be reduced for services furnished in nonfacility settings even if a clinician is financially affiliated with a hospital because the hospital does not receive any indirect PE payments for those services.)

A drawback of this approach is that it is difficult to identify which clinicians are affiliated with a hospital. The financial relationship between clinicians and hospitals is not always obvious, and CMS does not currently collect comprehensive data on these relationships. To address this difficulty, new data could be collected about the financial relationships between clinicians and facilities. Alternatively, clinicians who are affiliated with a hospital could indicate the relationship on claims, just as they indicate whether a service has been furnished in a facility or not. Under either approach, it would be important to clearly and accurately define who is considered a hospitalaffiliated clinician. In addition, the financial relationships between hospitals and hospitalowned practices vary significantly, so the hospital may not finance indirect PE for hospital-affiliated clinicians in all cases.

Change the way practice expense is calculated. Without new data collection, claims-based approaches to identifying facility-based services and facility-based clinicians would be imprecise and lead to false positives and false negatives. An alternative way of addressing concerns about overpayment of indirect PE would be to change the way PE RVUs are calculated. Under the current methodology, the indirect PE for each service is calculated using a weighted average of per hour costs among the specialties that typically perform that service. The per hour cost data that are currently used to calculate RVUs are from survey data that are almost 20 years old and do not reflect how PE costs have changed because of the increased number of clinicians who practice primarily in a facility (in some cases because they are financially affiliated with a hospital).

RAND has explored numerous alternatives to the current PE RVU allocation methodology, including updating the practice survey data (or collecting alternative data) to account for differences in costs across various practice characteristics such as those with facility- and nonfacility-based clinicians (Burgette et al. 2020). Alternatively, RAND has suggested removing specialty-specific cost measures as part of the PE valuation process and focusing instead on characteristics of the services themselves. For example, if a particular specialty's indirect PE is higher than average due to the costs associated with housing a large piece of medical equipment, such costs could be tied directly to the utilization of the equipment rather than being accounted for, indirectly, at the specialty level (Burgette et al. 2021). Some have also argued that the PE allocation methodology could account for differences in practice size because there is evidence that larger practices may be able to reduce the marginal cost of certain expenses (e.g., electronic health records systems) through economies of scale (Burgette et al. 2018). Relatedly, the trend toward larger practices and increasing numbers of nurse practitioners (NPs) and physician assistants (PAs) may result in changes in indirect PE due to more efficient use of office space. Some clinicians in larger practices who perform procedures in a facility, such as surgeons, may share clinical space with other clinicians (e.g., NPs and PAs) who see patients in that space while the surgeons are furnishing services in a facility rather than leaving the space unused.

## Impact of eliminating indirect PE RVUs using claims-based approaches

Policies to reduce or eliminate indirect PE RVUs for certain services would affect how total RVUs (and therefore Medicare spending) are distributed. Because total indirect PE RVUs are allocated from a fixed pool of total indirect PE RVUs, reductions in indirect PE RVUs for some services would result in a redistribution of PE RVUs among the entire indirect PE pool. Since the policies discussed in this section are designed to reduce indirect PE RVUs for certain services performed in a facility, nonfacility RVUs would tend to increase, as would PE RVUs for facility services that are not subject to reductions in indirect PE.

To gauge the effect that these types of changes would have, we simulated the impact on PFS RVUs and spending under three claims-based approaches for identifying services and clinicians for which indirect PE could be eliminated for facility services.<sup>30</sup> Under these policies, a third place of service would be created in the fee schedule (in addition to nonfacility and facility), which would be facility payments that do not include payment for indirect PE. Our policy simulations would eliminate indirect PE RVUs when a given service is performed in a facility and (1) the service is furnished in a facility 90 percent or more of the time, (2) the service is provided by a clinician who is furnishing 90 percent or more of all their services in a facility, or (3) the service meets the criteria for both simulations 1 and 2 (i.e., the service is provided by a clinician who furnishes at least 90 percent of their services in a facility and is furnished at least 90 percent of the time in a facility).

These simulations show that, even when limited to a narrow set of services and clinicians, a substantial amount of fee schedule spending for indirect PE is mistargeted. In the first simulation, we found that fee schedule spending for services that met our inclusion criteria totaled \$19.8 billion in 2024. About \$14.3 billion and \$10.5 billion met our inclusion criteria in our second and third simulations, respectively. Of those totals (which include payments for work, PE, and malpractice (MP)), about \$4.5 billion, \$3.4 billion, and \$2.4 billion, respectively, was associated with indirect PE and was redistributed in our simulation.

Table 1-A1 (p. 46) shows the projected effect of changes in total PFS spending for each of three scenarios by broad type of service category and the setting for those services. Among all services, aggregate spending would not change because reductions in indirect PE RVUs would be redistributed to other services to maintain the size of the existing pool of indirect PE RVUs. As a result, spending on services furnished in nonfacility settings would increase to varying degrees under every scenario. Conversely, spending on services furnished in facilities decreases under almost every scenario. Medicare spending on each service and type of service (both increases and decreases) would also vary under each scenario. For instance, under the first scenario, total spending on other procedures would increase by 1 percent: Spending on these services in the nonfacility setting would increase by 6 percent and decrease by 12 percent when furnished in a facility. The variation in spending changes would be larger among more specific groups of services. For instance, under the third scenario (providers and services both equal to or greater than 90 percent in facility), spending would increase most for pulmonary function tests (11 percent), nursing facility services (9 percent), and non-oncologic injections and infusions (7 percent). Payments would decline most for observation-care services (-14 percent), emergency department services (-12 percent), and hospital inpatient services (-10 percent) (data not shown).

#### Simulated impact of indirect PE RVU policy scenarios on total Medicare spending, by type of service and setting

Type of service	Setting	Services ≥90% in facility	Providers ≥90% in facility	Providers and services both ≥90% in facility	Nonfacility services, facility-based providers
All services	Both settings	0%	0%	0%	0%
All services	Nonfacility	7	4	2	1
All services	Facility	–11	-6	-4	-2
E&M	Both settings	0	0	0	0
E&M	Nonfacility	9	6	1	2
E&M	Facility	-14	-10	0	-4
Major procedures	Both settings	-12	-2	-2	1
Major procedures	Nonfacility	7	2	1	1
Major procedures	Facility	-18	-3	-3	1
Other procedures	Both settings	1	1	1	1
Other procedures	Nonfacility	6	2	1	1
Other procedures	Facility	-12	-4	-1	0
Treatments	Both settings	1	0	0	1
Treatments	Nonfacility	1	0	0	1
Treatments	Facility	-1	1	0	1
Imaging	Both settings	4	1	0	1
Imaging	Nonfacility	4	1	0	1
Imaging	Facility	1	0	0	0
Tests	Both settings	5	3	1	1
Tests	Nonfacility	6	3	1	1
Tests	Facility	3	2	1	0

Percent change in total fee schedule spending

Note: PE (practice expense), RVU (relative value unit), E&M (evaluation and management). The terms "facility" and "nonfacility" refer to the setting in which a service is performed. Examples of facility settings include hospital outpatient departments, hospital inpatient departments, and ambulatory surgical centers. Examples of nonfacility settings include clinician offices, retail health clinics, and urgent care centers. Estimated changes in spending include the effects of redistributing indirect PE RVUs within the indirect PE pool, as well as small adjustments to the conversion factor needed to maintain budget neutrality.

Source: MedPAC summary of Actuarial Research Corporation analysis of 2023 Medicare claims data.

### Reducing indirect practice expense RVUs among codes that are not inherently facility based when provided by facilitybased clinicians

One criticism of using claims to identify hospitalaffiliated clinicians is that some services, such as emergency department or hospital inpatient E&M visits, must be done in a facility. Thus, relying on the place of service to identify hospital-affiliated clinicians could flag some clinicians as hospital affiliated who are not. While many clinicians who perform services that are inherently facility based are employed by hospitals (and their indirect PE payments could therefore be duplicative), we ran a simulation that examined the magnitude of indirect PE associated with services that can be performed in both facility and nonfacility settings. To do so, we eliminated (and redistributed) indirect PE for facility services furnished by clinicians that performed 90 percent or more of their services in a facility setting but only for services that were not considered inherently facility based.<sup>31</sup>

We examined this approach in the fourth simulation, in which we found that fee schedule spending for services that met these criteria totaled \$3.8 billion in 2024. Of that total, more than \$1 billion was associated with indirect PE and was redistributed in our simulation. This approach would have the largest effect on E&M services. According to our simulations, facility spending for all E&M services would decrease by 4 percent and nonfacility E&M spending would increase by 2 percent; overall spending on E&M services would not change. Such a policy to reduce (and redistribute) indirect PE only from services that are not inherently facility based is too narrow to address the broader issue of indirect PE for all hospital-affiliated clinicians because many services with potentially duplicative indirect PE payments are always or commonly performed in a facility (e.g., inpatient E&M visits). However, such a policy would be directionally consistent with a broader solution and may be more practicable to implement with current data.

Future research could build off this work and seek to analyze the redistributive effects of reducing or eliminating indirect PE for facility services furnished by hospital-affiliated clinicians, who could be identified through a tax ID method used by Luo and colleagues (Luo et al. 2024). Regardless of any potential identification strategies researchers implement, CMS would need accurate and up-to-date information for every clinician that identifies whether they are affiliated with a hospital. Reducing indirect PE for hospital-affiliated clinicians and increasing PE for clinicians in private practice could reduce incentives for providers to consolidate with hospitals. ■

## Endnotes

- 1 Our count includes unique Healthcare Common Procedure Coding System codes for which Medicare made at least one payment during the year. We treat codes that have modifiers as a single code, and we do not include codes that clinicians could have billed for but did not.
- 2 One exception to this general rule is when RVUs are rescaled in response to new Medicare Economic Index data. We discuss this issue further in the chapter.
- 3 At various points in the past, CMS has implemented the PFS budget-neutrality provision by directly reducing services' work RVUs or by applying a budget-neutrality adjuster to work RVUs (i.e., work RVUs did not change but the payment for work RVUs was reduced). However, stakeholders objected to such adjustments on the basis that they undermined the relativity of the PFS and caused confusion with other payers who rely on RVUs established by Medicare. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required CMS to implement the PFS budget-neutrality provision through the conversion factor.
- 4 For example, from 2020 to 2025, the average budgetneutrality adjustment under the PFS was twice as large as the average OPPS budget-neutrality adjustment. Over the same period, the PFS budget-neutrality adjustment was 1.0 percent or higher (in absolute-value terms) in three out of six years compared with only once under the OPPS.
- 5 In addition, among beneficiaries who had received health care, a greater share of Medicare beneficiaries was satisfied with their ability to find health care providers that had appointments when they needed them (88 percent) compared with privately insured people (79 percent).
- 6 We considered calculating Medicare spending per clinician over time, but such a statistic would be difficult to interpret appropriately. For example, our data include only FFS beneficiaries, but actual total spending per clinician depends on the mix of patients seen by clinicians (e.g., FFS Medicare and Medicare Advantage (MA) patients). Therefore, because MA enrollment has increased rapidly over time, calculating FFS spending per clinician would be artificially depressed. Further, interpreting spending per clinician is made more difficult by the changing mix of clinicians, such as the increasing number of NPs and PAs over time.
- 7 Especially during the second half of this period, the growth in PFS spending per beneficiary was restrained by the shift of services from clinician offices to hospital outpatient departments. While this trend increases Medicare's total

spending generated by PFS services (PFS spending plus associated hospital outpatient spending), it makes PFS payments lower than they otherwise would be because of Medicare's payment rules.

- 8 Likewise, if payments do not cover the marginal cost of furnishing a service, a provider has a financial incentive to furnish fewer such services.
- 9 The Congress also provided one-time payment increases in 2024 of 1.25 percent from January 1, 2024, through March 8, 2024, and 2.93 percent from March 9, 2024, through December 31, 2024. Because the 2021 to 2024 payment-rate increases were one-time-only updates, their effects to do not cumulate over time.
- 10 MEI-growth data included in this chapter differ from data published in physician fee schedule rules because of timing differences. MEI-growth data included in this chapter reflect the MEI growth that occurred or is projected to occur in a given year. In contrast, MEI-growth data in fee schedule rules reflect the most recently available actual historical data at the time of publication. For example, the final rule for payment year 2025 uses MEI growth from the second quarter of 2024 (i.e., actual historical MEI growth from the third quarter of 2023 to the second quarter of 2024). MEI growth reported in this chapter for 2025 is based on projected MEI growth from the fourth quarter of 2025 (i.e., projected MEI growth from the first quarter of 2025 to the fourth quarter of 2025). We also incorporate a productivity adjustment to match the period from which MEI growth was analyzed.
- 11 Over this period, the conversion factor declined primarily because CMS increased the RVUs for many E&M services and created a new add-on code. These increases required offsetting decreases in the conversion factor to remain budget neutral. The underlying updates over this period, excluding temporary payment increases, were 0 percent.
- 12 Using CMS projections of MEI growth as of the third quarter of 2024, the average annual fee schedule update from 2025 to 2034, if updates were based on MEI minus 1 percentage point rather than half of MEI, would be 1.2 percent instead of 1.1 percent.
- 13 This statement is based on actual MEI data published by CMS in 2024. Results may have been different if updates were set prospectively based on projected MEI growth.
- 14 This analysis is based on actual or projected MEI growth (including a productivity adjustment) that occurred in a

calendar year, using the most recently available market basket data at the time we wrote this report.

- 15 The higher cumulative payment rate results from half of MEI being higher than MEI minus 1 percentage point in 16 out of the 20 years from 2001 to 2020.
- 16 Direct PE is included in facility PE RVUs for some services. Most of these services are global surgical codes, which include direct PE for postoperative visits assumed to take place during the global payment period (even though substantial evidence suggests that many of these visits do not actually take place). Direct PE is also included in facility payments for several dozen nonglobal Healthcare Common Procedure Coding System codes to account for nonphysician clinical labor related to activities that take place outside the facility, such as quality-assurance activities, discharge management, and postprocedure services.
- 17 Reduction of indirect PE for facility services applies to most fee schedule services. However, some services, such as "incident to" services and physical therapy services, have special payment rules.
- 18 Payments for continuing medical education (CME) expenses are included in the PFS's indirect PE RVUs but are not included in the facility fee (e.g., under the OPPS). If PFS PE RVUs for facility services are adjusted to exclude other types of indirect PE, consideration should be given to how to compensate clinicians for expenses related to CME.
- 19 MEI cost shares and the pools of RVUs may not match exactly due to year-to-year changes in service volume and other factors.
- 20 Nonphysician clinical labor includes registered nurses, medical technicians, and similar clinical staff. It does not include APRNs and PAs, who are included in the work component of RVUs.
- 21 Practices were included in the PPI survey only if they employed at least one physician (Whicher et al. 2025). Data on other practices, such as physical therapy practices, were collected in a separate survey—the Clinician Practice Information survey. A summary of the results of this survey was also released in 2025 (American Medical Association 2024a).
- 22 This analysis is based on the same data and methodology used to develop fee schedule RVUs for 2024.
- 23 Under statute, the total RVUs for a given service may not decline by 20 percent or more in a single year. This provision had a minimal impact on the results of this simulation.

However, in other simulations, such as changing indirect PE RVUs to better reflect costs of facility-based clinicians, the 20 percent limitation could have a larger effect.

- 24 A total of 380 physician practices responded to the AMA's PPI survey. Of those, 327 practices responded based on being part of the original survey design, and 53 practices were not: 36 practices that volunteered their data (and completed the survey), 6 practices that the AMA recruited to pretest the survey, and 11 practices that were identified as part of a separate survey and subsequently completed the PPI survey (Grau et al. 2024). The 53 practices were allowed to submit their data in response to difficulty obtaining completed surveys, especially in certain specialties. According to the AMA, at the department level, the volunteer, pretest, and data from the other survey accounted for 11 percent of the 831 departments, 11 percent of the 18,086 physicians in those 831 departments, and, when weighted, 7 percent of the physician population.
- 25 The PPI survey response rate was calculated using the following formula: response rate = number of completed interviews / (number of cases in the sample – estimated number of ineligible cases). The AMA assumed that practices that did not click on the link for the survey were ineligible. Using this assumption, the response rate was 6.8 percent (Grau et al. 2024).
- 26 A number of 0-day global surgical codes include services during the procedure service date but not postsurgical visits related to the procedure. For 0-day codes, CMS generally does not allow providers to bill a separate E&M visit on the same day that a procedure is furnished.
- 27 The study also found that 46 codes included fewer postoperative visits than had been assumed. Among the remaining 89 codes, either payment rates reflected the actual number of postoperative visits or OIG was unable to determine whether the number of postoperative visits was accurate.
- 28 We report results of a sensitivity analysis by RAND that was restricted to the subset of clinicians who billed for any postoperative visits during 90-day global periods. We report these results rather than RAND's main results because some specialty societies contend that the reason some clinicians did not bill for any postoperative visits was that their billing system did not allow them to submit the 99024 no-pay billing code that was used by RAND to identify postoperative visits (American Academy of Facial Plastic and Reconstructive Surgery et al. 2022). However, we caution that it is also possible that some clinicians did not report any postoperative visits because they did not provide any. The results we report should therefore be interpreted as conservative and possibly overrepresenting how many postoperative visits were provided.

- 29 In the 2025 final rule, CMS continued to assess how to improve Medicare's payment policies for global surgical codes. The agency finalized changes that are intended to obtain information and allow for more accurate payment to reflect the time and resources spent on postoperative care associated with global surgical services. Specifically, CMS expanded the use of a modifier for clinicians who intend to perform only the surgical portion of a global surgical service and added a new add-on code to be billed by clinicians who do not perform the surgical procedure within a global package but provide a related postoperative visit during the global period. These policies are not intended to address the overvaluation of global surgical codes discussed in this chapter.
- 30 Certain codes required special rules in the simulations. The professional component of codes in which the technical and

professional components can be paid separately (mainly imaging studies and tests) were exempted from reductions in indirect practice expense. We implemented this rule so that, regardless of where the professional component was performed, our simulations comport with a CMS policy that the professional and technical component RVUs sum to the total RVUs when both components are combined into one payment. Indirect PE for global surgical codes were only partially reduced because some indirect PE is included in follow-up visits that can occur in a nonfacility setting rather than a facility setting. Carrier-priced codes are excluded because information about indirect PE is not available.

31 We defined services as inherently facility based if 90 percent or more of volume was provided in a facility.



## References

Albanese, J. 2023. Escaping from Medicare's flawed physician payment system. Washington, DC: Paragon Health Institute.

American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Ophthalmology, American Academy of Otolaryngology–Head and Neck Surgery, et al. 2022. Comment letter to CMS on the proposed rule entitled: Medicare program; CY 2023 payment policies under the physician payment schedule and other changes to Part B payment policies—global surgical packages. September 6. https://www.breastsurgeons.org/docs/ advocacy/2022\_09\_06\_Surgical\_Coalition\_Global\_Codes\_ Comments.pdf.

American Medical Association. 2025. 2024 AMA prior authorization physician survey. Chicago, IL: AMA. https://www. ama-assn.org/system/files/prior-authorization-survey.pdf.

American Medical Association. 2024a. Table 1. Results from the 2024 clinician practice information survey. Chicago, IL: AMA. https://www.ama-assn.org/system/files/table-1-results-from-cpi-final.pdf.

American Medical Association. 2024b. Table 1. Results from the 2024 physician practice information survey. Chicago, IL: AMA. https://www.ama-assn.org/system/files/table-1-results-from-ppi.pdf.

American Medical Association. 2023a. Letter to House and Senate leaders. March 15.

American Medical Association. 2023b. Slide presentation to MedPAC conveying selected results from the 2022 AMA Physician Practice Benchmark Survey. September 20.

American Medical Association. 2015. Letter to Sean Cavanaugh re: response to the Centers for Medicare and Medicaid Services (CMS) concerning the transition from surgical global periods to 000-day global period. March 3. https://www.ama-assn.org/ system/files/2019-12/ruc-recommendation-for-surgical-globalunbundling-policy.pdf.

AMN Healthcare. 2023. Number of nurse practitioners doubles in a decade. https://www.amnhealthcare.com/blog/advanced-practice/locums/number-of-nurse-practitioners-doubles-in-a-decade/.

Berndt, E. 2012. Memo to Kathleen Sebelius regarding final report from the Medicare Economic Index Technical Advisory Panel. Cambridge, MA: Massachusetts Institute of Technology. https:// www.cms.gov/regulations-and-guidance/guidance/faca/ downloads/mei-review-report-to-hhs.pdf. Bishop, T. F., M. J. Press, S. Keyhani, et al. 2014. Acceptance of insurance by psychiatrists and the implications for access to mental health care. JAMA Psychiatry 71, no. 2 (February): 176–181.

Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2014. 2014 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Washington, DC: Boards of Trustees.

Burgette, L., C. C. Cohen, J. O. Hero, et al. 2020. Practice expense methodology and data collection research and analysis: Interim phase II report. Santa Monica, CA: RAND.

Burgette, L., J. O. Hero, J. Liu, et al. 2021. Practice expense data collection and methodology: Phase II final report. Santa Monica, CA: RAND.

Burgette, L., J. L. Liu, B. Miller, et al. 2018. *Practice expense methodology and data collection research and analysis*. Santa Monica, CA: RAND.

Capps, C., D. Dranove, and C. Ody. 2017. Physician practice consolidation driven by small acquisitions, so antitrust agencies have few tools to intervene. *Health Affairs* 36, no. 9 (September 1): 1556–1563.

Casalino, L. P., D. Gans, R. Weber, et al. 2016. U.S. physician practices spend more than \$15.4 billion annually to report quality measures. *Health Affairs* 35, no. 3 (March): 401–406.

Census Bureau. 2021. Service Annual Survey (SAS). https://www.census.gov/programs-surveys/sas.html.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. Medicare and Medicaid programs; CY 2024 payment policies under the physician fee schedule and other changes to Part B payment and coverage policies; Medicare Shared Savings Program requirements; Medicare Advantage; Medicare and Medicaid provider and supplier enrollment policies; and Basic Health Program. Final rule. *Federal Register* 88, no. 220 (November 16): 78818–80047.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. Medicare and Medicaid programs; CY 2023 payment policies under the physician fee schedule and other changes to Part B payment and coverage policies; Medicare Shared Savings Program requirements; implementing requirements for manufacturers of certain single-dose container or single-use package drugs to provide refunds with respect to discarded amounts; and COVID-19 interim final rules. Final rule and interim final rules. *Federal Register* 87, no. 222 (November 18): 69404–70700. Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2019. Medicare program; CY 2020 revisions to payment policies under the physician fee schedule and other changes to Part B payment policies; Medicare Shared Savings Program requirements; Medicaid Promoting Interoperability Program requirements for eligible professionals; establishment of an ambulance data collection system; updates to the Quality Payment Program; Medicare enrollment of opioid treatment programs and enhancements to provider enrollment regulations concerning improper prescribing and patient harm; and amendments to physician self-referral law advisory opinion regulations final rule; and coding and payment for evaluation and management, observation and provision of self-administered esketamine. Final rule. *Federal Register* 84, no. 221 (November 15): 62568–63563.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014. Medicare program; revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, access to identifiable data for the Center for Medicare and Medicaid Innovation Models & other revisions to Part B for CY 2015. Final rule. *Federal Register* 79, no. 219 (November 13): 67547–68092.

Chan, D. C., and M. J. Dickstein. 2019. Industry input in policy making: Evidence from Medicare. *The Quarterly Journal of Economics* 134, no. 3 (August).

Chen, K., L. Lopez, 3rd, J. S. Ross, et al. 2022. Distribution of Paycheck Protection Program loans to healthcare organizations in 2020. *Journal of General Internal Medicine* 37, no. 8 (June): 2132–2133.

Clemens, J., and J. D. Gottlieb. 2014. Do physicians' financial incentives affect medical treatment and patient health? *American Economic Review* 104, no. 4 (April): 1320–1349.

Congressional Budget Office. 2023. Federal budgetary effects of the activities of the Center for Medicare & Medicaid Innovation. Washington, DC: CBO. September. https://www.cbo.gov/ system/files/2023-09/59274-CMMI.pdf.

Congressional Budget Office. 2022. The prices that commercial health insurers and Medicare pay for hospitals' and physicians' services. Washington, DC: CBO. https://www.cbo.gov/publication/57422.

Crespin, D. J., A. M. Kranz, T. Ruder, et al. 2021. Claims-based reporting of post-operative visits for procedures with 10- or 90day global periods: Updated results using calendar year 2019 data. Santa Monica, CA: RAND. https://www.cms.gov/files/ document/rand-cy-2019-claims-report-2021.pdf. Gallegos, A. 2024. Physician assistant workforce sees ongoing growth, income rise, report finds. *Medscape*, April 4. https://www.medscape.com/viewarticle/physicianassistant-workforce-sees-ongoing-growth-income-2024a10006cy?=null&icd=login\_success\_email\_match\_ fpf&form=fpf.

Government Accountability Office. 2023. COVID-19 provider relief fund: HRSA continues to recover remaining payments due from providers. GAO-23-106083. Washington, DC: GAO. September.

Grau, E., P. Bajaj, D. Whicher, et al. 2024. 2023–2024 Physician Practice Information survey: Methodology report. Chicago, IL: American Medical Association. December 31. https://www.amaassn.org/system/files/ppi-survey-methods-report.pdf.

Guardado, J. R. 2022. Policy research perspectives: Prevalence of medical liability premium increases unseen since 2000s continues for fourth year in a row. Chicago, IL: American Medical Association. https://www.ama-assn.org/system/files/prp-mlmpremiums-2022.pdf.

Jacobs, P. D. 2021. The impact of Medicare on access to and affordability of health care. *Health Affairs* 40, no. 2 (February): 266–273.

Kane, C. K. 2023. Policy research perspectives: Recent changes in physician practice arrangements: Shifts away from private practice and towards larger practice size continue through 2022. Chicago, IL: American Medical Association. https://www.amaassn.org/system/files/2022-prp-practice-arrangement.pdf.

KFF. 2020. How much more than Medicare do private insurers pay? A review of the literature. Washington, DC: KFF.

Leventhal, R. 2016. MGMA: IT costs for healthcare organizations continue to rise. https://www.hcinnovationgroup.com/finance-revenue-cycle/news/13027285/mgma-it-costs-for-healthcare-organizations-continue-to-rise.

Luo, Q. E., B. Black, D. J. Magid, et al. 2024. A more complete measure of vertical integration between physicians and hospitals. *Health Services Research* 59, no. 4 (August): e14314.

Medical Group Management Association. 2023a. Annual regulatory burden report. Englewood, CO: MGMA. https:// www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20 Report%20FINAL.pdf.

Medical Group Management Association. 2023b. Higher costs persist for medical groups even as inflation's growth slows. MGMA Stat. https://www.mgma.com/mgma-stat/higher-costspersist-for-medical-groups-even-as-inflations-growth-slows.



Medicare Payment Advisory Commission. 2025. Report to the Congress: Medicare payment policy. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2024a. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2024b. Report to the Congress: Medicare payment policy. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2023a. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2023b. Report to the Congress: Medicare payment policy. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2022. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2021. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2019. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2014. MedPAC comment letter on CMS's proposed rule entitled: "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the CMMI Models & Other Revisions to Part B for CY 2015," August 24. https://www.medpac.gov/wp-content/ uploads/import\_data/scrape\_files/docs/default-source/ comment-letters/08282014\_comment\_letter\_2015\_pt\_b\_ rule\_final.pdf.

Medicare Payment Advisory Commission. 2011a. *Exploring alternative approaches to valuing physician services*. A report prepared for the Medicare Payment Advisory Commission by staff from the University of Minnesota, Division of Health Policy and Management. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2011b. Moving forward from the sustainable growth rate (SGR) system. Letter to the Congress. October 14.

Medicare Payment Advisory Commission. 2011c. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2006. Report to the Congress: Medicare payment policy. Washington, DC: MedPAC.

Mulcahy, A., H. Liu, T. Ruder, et al. 2021. Using claims-based estimates of post-operative visits to revalue procedures with 10and 90-day global periods. Santa Monica, CA: RAND. February 5.

National Center for Health Statistics. 2021. Health, United States, 2019. Hyattsville, MD: NCHS. https://www.cdc.gov/nchs/data/hus/hus19-508.pdf.

National Commission on Certification of Physician Assistants. 2023. Statistical profile of board certified physician assistants. Johns Creek, GA: NCCPA.

National Commission on Certification of Physician Assistants. 2014. 2013 statistical profile of board certified physician assistants. Johns Creek, GA: NCCPA.

Nikpay, S. S., M. R. Richards, and D. Penson. 2018. Hospitalphysician consolidation accelerated in the past decade in cardiology, oncology. *Health Affairs* 37, no. 7 (July): 1123–1127.

NORC at the University of Chicago. 2024. Beneficiary and clinician perspectives on Medicare and other issues: Findings from 2024 focus groups in select states. Report prepared by staff from NORC at the University of Chicago for the Medicare Payment Advisory Commission. Chicago, IL: NORC.

Ochieng, N., J. Fuglesten Biniek, M. Rae, et al. 2022. Most officebased physicians accept new patients, including patients with Medicare and private insurance. Washington, DC: KFF. https:// www.kff.org/medicare/issue-brief/most-office-basedphysicians-accept-new-patients-including-patients-withmedicare-and-private-insurance/.

Office of Inspector General, Department of Health and Human Services. 2012. Musculoskeletal global surgery fees often did not reflect the number of evaluation and management services provided. No. A–05–09–00053. Washington, DC: OIG.

Physician Payment Review Commission. 1987. Medicare physician payment: An agenda for reform. Washington, DC: PPRC.

Pollitz, K., A. Montero, L. Lopes, et al. 2023. KFF Survey of Consumer Experiences with Health Insurance. Washington, DC: KFF. https://www.kff.org/private-insurance/poll-finding/kffsurvey-of-consumer-experiences-with-health-insurance/.

Schappert, S. M., and L. Santo, Department of Health and Human Services. 2023. Percentage of office-based physicians accepting new Medicare, Medicaid or privately insured patients in the United States: National Ambulatory Medical Care Survey, 2021. Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/data/namcs/2021-P3P4-NAMCS-Provider-Data-Dictionary-COVID-Dashboard-RDC-Researcher-Use-508.pdf. U.S. Small Business Administration. 2021. Forgiveness platform lender submission metrics. Washington, DC: SBA. https://www. sba.gov/sites/default/files/2021-12/2021.12.26\_Weekly%20 Forgiveness%20Report\_Public-508.pdf.

Wachter, R. M., and L. Goldman. 2016. Zero to 50,000: The 20th anniversary of the hospitalist. *New England Journal of Medicine* 375, no. 11 (September 15): 1009–1011.

Whicher, D., E. Grau, S. Albanese, et al. 2025. *Clinician Practice Information survey methodology report*. Chicago, IL: American Medical Association. January 31. https://www.ama-assn.org/system/files/cpi-survey-methods-report-main-report.pdf.

Wray, C. M., M. Khare, and S. Keyhani. 2021. Access to care, cost of care, and satisfaction with care among adults with private and public health insurance in the U.S. JAMA *Network Open* 4, no. 6 (June 1): e2110275.

