FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

The Nuts and Bolts of Medicare Physician Payment — And Why It Needs Reform

Introduction

All families and people across our nation should have access to the health care they need at a price they can afford. But our health care system is currently designed to rake in the highest possible profits for big health care corporations rather than deliver the highest-quality care for the lowest possible cost. The way the U.S. pays for health care drives large health care corporations to buy up community doctors' offices to form medical monopolies, set inflated prices, and generate high volumes of the highest-priced services with no accountability for health care affordability or health outcomes.[1,2] The business model of these large health care corporations fundamentally relies on and takes advantage of fee-for-service payments, which serve as the predominant reimbursement model for health care services delivered by our country's physicians and other health care professionals.[3]

Simply put, how health care providers and physicians are paid directly impacts how our health care system delivers care, including the quality of care that patients receive and the extent to which health care services are integrated and coordinated across multiple providers and care settings to effectively meet patients' needs.[4] And far too often, decisions about physician payment incentives are dominated by the health care industry and specialty interests focused on preserving their status quo business model at the expense of advancing pro-consumer payment reforms. We need a new approach to health care payment, one that is reoriented to meet the health and

affordability needs of consumers and patients. Consumer advocates and allied stakeholders have an important role to play in providing a meaningful counterweight to health care industry interests and influence on health payment policy. U.S. health care payment and delivery systems should be meaningfully designed to provide the affordable, high-quality health care and health that all of our nation's families deserve.

The failings of a fee-for-service health system

Fee-for-service (FFS) payments incentivize health care providers to make money by performing more high-profit or high-margin procedures rather than by allowing providers to generate revenue based on keeping people healthy and reducing disparities.[5] The U.S. health care system incentivizes specific procedures and services that generate higher fees — like surgeries, hospital admissions and medical tests — without any real link to the quality of care or health outcomes.[6] At the same time, it disincentivizes services that make care more accessible and effective, such as care coordination or patient education services, which are often priced too low or not reimbursed at all.[7] Moreover, under FFS, patients can be billed for each additional service that is delivered, leaving them vulnerable to receiving high volumes of low-value services that can directly harm their financial well-being, and ultimately leading to higher copays and out-of-pocket costs for all of our nation's families.[8]

By its very definition, FFS payment provides a very narrow view of health and health care and signals to providers they should prioritize delivering the kind of clinical care that determines only 10% to 20% of health while limiting them from helping patients address the multitude of social, economic, lifestyle and other factors that drive a person's overall health.[9] The U.S. health care payment system actually works against the professional responsibility and desires of clinicians and health care professionals who strive to improve patients' health and reduce health disparities.

The effects of these broken FFS payment incentives are amplified through physician payment across our entire health care system in two critical ways:

1. **Fee-for-service economics** are the basis for physician payment from one of the largest and most important payers in U.S. health care: Medicare, which predominantly pays physicians through the Medicare Physician Fee Schedule.
2. **The Medicare Physician Fee Schedule** is the model for most other health care payers' fee schedules.

The U.S. health care system incentivizes specific procedures and services that generate higher fees, without any real link to the quality of care or health outcomes.

As a result, FFS payment incentives predominate in all forms of health insurance, including Medicare Advantage, Medicaid managed care, private insurance and traditional Medicare and Medicaid, including the majority of current value-based payment models.

This means that Medicare payment policy — and specifically the Medicare Physician Fee Schedule (MPFS) is perhaps the most critical lever health advocates have to advance needed reforms. By addressing the problems inherent to MPFS and its misaligned incentives, we can move physician payment across the country away from FFS economics and toward a value-based payment system that drives whole-person health. Importantly, because MPFS is often a core component of value-based payment, it is critical for these efforts to be viewed as complimentary and advanced together.

The complexity of Medicare physician payment

To fully explore how Medicare payment can be leveraged to enact meaningful health care payment reform, it is important to ground any discussion about potential changes in an understanding of how Medicare payment works currently.

Medicare pays for physician and other professional medical services based on a list of health care services and their associated payment rates called the Medicare Physician Fee Schedule. This includes a broad range of services, such as office visits and surgical procedures that are delivered across a variety of care delivery sites: physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes.[10] Of the 1.3 million clinicians who bill Medicare, 55% are physicians.[11] The remaining 45% are nurse practitioners, physician assistants and other types of nonphysician practitioners, such as clinical social workers and certified nurse midwives.[12] These professionals either bill Medicare independently or provide services under physician supervision.

Physician services are paid for under Part B of the Medicare program along with hospital outpatient services, physician-administered drugs and other outpatient services. Importantly, spending on physician services and other Part B services now accounts for the largest share of total Medicare benefit spending, growing from 41% to 48% between 2011 and 2021.[13] As of 2023, physician services were the largest category of spending within Medicare Part B, accounting for more than $70 billion in spending annually.[14]

MORE THAN

$70 BILLION

is spent every year on physician services within Medicare Part B.

What is an RVU? Determining the "relative value" of a health care service

The Medicare Physician Fee Schedule sets the payment rate for each health care service by utilizing the resource-based relative value scale (RBRVS), which starts by setting the "relative value" of each of the almost 14,000 services reimbursed under the MPFS.[15] These relative value units attempt to account for the cost of the inputs used to provide a given medical service relative to all other services. By statute, the relative value of each coded service is calculated based on three components: physician work, practice expenses and professional liability insurance, considered together to arrive at the relative value unit (RVU) for each service:[16]

- **Physician work** accounts for the level of time, effort, skill and stress associated with providing each service.
- **Practice expenses** account for things like the cost of renting office space, buying supplies and equipment, and hiring administrative and clinical staff.
- **Professional liability** insurance accounts for the cost of a provider's professional liability insurance, including monthly or annual premiums.

Once the RVU for each service is calculated, it is multiplied by a conversion factor, which adjusts for geographic variation, to arrive at a dollar amount, or fee, for each service.[17] For billing purposes, each service is assigned a Healthcare Common Procedure Coding System (HCPCS) code. Notably absent from these statutory components are elements that reflect the value of the care provided to meet the needs of the Medicare population, and the statute does not require any consideration of workforce shortages in specific professional categories, such as geriatrics or primary care.[18]

What Happens Next? The Role of the RUC in Setting Physician Payment Rates

Critical to understanding how physician payment rates are set under the MPFS is knowing how specific RVU components, such as physician work and practice expenses, are calculated. The Centers for Medicare & Medicaid Services (CMS) relies on the health care industry itself to determine RVU components under the Physician Fee Schedule — specifically through the American Medical Association (AMA) and its Relative Value Scale Update Committee (RUC). The RUC is a panel of physicians that the AMA convenes to provide recommendations to CMS on how to value health care services.[19] The RUC has 31 members, the majority of whom are appointed by medical specialty societies.[20] While CMS is not required under federal law or regulation to adopt the RUC's recommendations, CMS adopts the vast majority of the RUC's recommendations with limited vetting or follow-up, since there is no alternative data source for how CMS should value physician services.[21,22]

The RUC develops its recommendations by partnering with medical specialty societies to collect survey data from physician practices to estimate practice expenses and physician work, and

The role of the RUC in setting Medicare payment rates for physician services results in payments that are in the best interests of specialty care providers rather than what is in the best interest of consumers and families.

those data are used to inform the RVUs for new and revised codes.[23] Specifically, physician specialty associations conduct these surveys with random samples of their own members to estimate the time, complexity and intensity, and the total work associated with a given service or services.[24] The heavy reliance on these surveys raises serious concerns that the survey data overrepresents specialty provider interests and directly undermines the accuracy of the RUC's RVU recommendations. Critically, this means that as a nation we are allowing entrenched specialty interests from the physician and health care professions to determine their own payment rates, clearly creating profound conflicts of interest in how Medicare prices are established.

Further, the nonpartisan experts at the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) have repeatedly expressed concerns that specialists sitting on the RUC have a financial interest to inflate their numbers, leading to biased estimates of RVUs and distorted fees.[25,26] It should not be surprising then that the evidence demonstrates that fees for procedures, imaging and tests are priced too high, and fees for time spent with patients, referred to as evaluation and management services and office-based services, are priced too low, creating a damaging distortion in the Medicare Physician Fee Schedule.[27] Research also confirms that changes to RVUs often keep payment rates for specialty services artificially high by not considering developments in technology and increased utilization of midlevel practitioners that would otherwise warrant decreases in payments for high-cost procedures, such as surgeries.[28,29] At the same time, RVU changes often do not account for increasing resource demands associated with providers' ability to deliver effective primary care, including the time-intensity required to meet patients' needs and critical thinking and judgement required to manage the health and well-being of an increasingly medically complex and aging population — factors that would otherwise warrant increases in primary care payments.[30,31] Simply put, the role of the RUC in setting Medicare payment rates for physician services results in payments that are in the best interests of specialty care providers rather than what is in the best interest of consumers and families.[32]

These payment distortions are not only blind to what consumers actually need, they often run *counter* to the interests of Medicare beneficiaries and families across the nation. This is particularly true for establishing payment rates for services that address social drivers of health. It is well-established that the social drivers of health (SDOH) are one of the most significant influences on an individual's health, yet the Medicare Physician Fee Schedule provides little to no payment for services that address social needs.[33] While CMS has taken steps to incentivize the delivery of equitable and whole-person care, such as creating new payments for SDOH risk assessments and community health integration services, there is considerably more work to do to ensure these payments are adequate to meet provider and patient needs.[34,35] As a result, the social needs that drive racial and economic disparities in health outcomes continue to go unmet while marginalized patients — specifically, Black, Hispanic, American Indian and Alaska Native communities — experience significantly worse health outcomes and shorter lifespans than their white counterparts.[36]

This flawed system of determining the value of services that are needed by patients, in turn, creates a perverse incentive in the Medicare Physician Fee Schedule, where physicians may provide a mix of services that often do not align with the needs and wishes of their patients. For example, patients want more time with their physicians, such as longer office visits, but instead often are sent off for more lucrative tests and procedures.[37] Importantly, because the MPFS serves as the benchmark for most other payers' fee schedules, many experts acknowledge that the majority of alternative payment models (which we will discuss in more detail below) will continue to be built on top of the MPFS, making it even more important to improve the accuracy of the MPFS so that policymakers do not unintentionally perpetuate these distortions in efforts to shift to value-based payments.[38]

One more complication: Budget neutrality

The health care industry's influence over the MPFS, including through the RUC, and the distortions it creates for physician payment are complicated even further by certain budgetary restrictions that CMS must follow when setting physician payment rates in the MPFS.

When CMS proposes changes to physician payment levels each year, they are subject to budget neutrality rules. By law, CMS cannot make any changes to RVUs and payment levels within the Physician Fee Schedule that are estimated to change total Medicare spending by more than $20 million per year.[39] This dollar amount is otherwise known as the budget neutrality threshold.[40] Importantly, budget neutrality serves as a critical tool to manage the growth in Medicare spending for physician services over time. As a result, if CMS increases payment rates for a subset of services or adds entirely new services that are expected to result in increases in total Medicare spending, CMS is required to offset the financial impact of those changes with decreased payments elsewhere in order to achieve budget neutrality. Alternatively, and most commonly, CMS would need to put in place across-the-board payment adjustments for all services through changes in the underlying conversation factor used to determine rates.[41,42]

Importantly, these budget neutrality rules essentially create a zero-sum game where medical specialties are in a constant battle for the largest share of Medicare payment increases every year — battles that almost always result in winners and losers. Since the RUC itself is biased toward increasing RVUs and payments for procedure-based services associated with specialty care as outlined above, increased payments for specialty services, combined with budget neutrality rules, lead to payments for services critical to the delivery of primary care being systematically undervalued and diluted over time (that is, their relative prices become too low because the prices for other services have become artificially high).[43] As a result, MedPAC has found that total RVUs for certain primary care services actually decreased over certain periods of time, contributing to drastic pay differences by specialty.[44] In 2021, compensation for specialty providers such as radiologists was 83% higher than for primary care.[45]

Even when CMS attempts to correct for longstanding disparities in Medicare payment through rulemaking, the required payment cuts to all other services lead to industry backlash and ultimately congressional intervention. For instance, when CMS proposed to increase payments to primary care through the creation of a new add-on HCPCS code (G2211) in its CY 2021 MPFS final rule, Congress — under heavy lobbying from the American Medical Association and specialty medical associations — intervened and barred implementation of the new code for at least three years, instead implementing an across-the-board payment increase of 3.75% to offset the budget neutrality payment cuts to certain specialists.[46,47] Despite a modest increase for primary care services, this intervention essentially protected the entrenched business interests of specialty providers, preserving the historical imbalances in payment between primary care physicians and specialists that CMS had attempted to correct.

Ultimately, budget neutrality rules, combined with the RUC's outsized industry influence, helps to lock in the misaligned payment incentives that drive the delivery of high-priced, low-value care at the expense of high-value primary care and behavioral health services that are critical to a high-functioning and high-quality health care system for our nation's families.

Progress or faux reform? A closer look at MACRA and the Quality Payment Program

Policymakers and academic experts have long been concerned about the role that fee-for-service economics plays in driving up health care spending with little accountability for the quality or efficiency of care delivery. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) aimed to address these challenges by repealing the Medicare Sustainable Growth Rate (SGR), a formula previously used by CMS to determine annual updates to the MPFS.[48] Medicare SGR triggered overall physician payment reductions if spending targets were not met, but physician groups repeatedly and successfully lobbied Congress to override and delay any payment reductions for well over a decade, resulting in a tumultuous and unsustainable approach to

physician payment. In repealing Medicare SGR, Congress created new financial incentives that aimed to shift physician payment toward value through the creation of the Quality Payment Program (QPP).

The QPP allowed CMS to reward clinicians who deliver high-value, high-quality care to Medicare beneficiaries with payment increases while also reducing payments to those clinicians who failed to meet performance standards.[49] Specifically, the QPP incentivizes health care providers to control costs and improve care quality in order to receive payments through one of two tracks: the Advanced Alternative Payment Model (AAPM) or the Merit-based Incentive Payment System (MIPS).[50] Beginning in 2019, clinicians participating in the AAPM track, including accountable care organizations (ACOs), received a bonus payment of 5% of their professional services payments. This bonus fell to 3.5% for 2023 and 1.88% for 2024.[51] The purpose of the AAPM bonus was to provide clinicians an added payment incentive to participate in value-based payment models that shift away from FFS payment incentives toward population-based payment incentives with accountability for health outcomes and cost.[i] But as that bonus payment dropped, so did the incentive for providers to participate.

Under MIPS, clinicians receive a MIPS score and either a positive payment, a payment penalty or no payment adjustments based on how well they performed across four performance domains: quality, improvement activities, promoting interoperability and cost.[52] The theory behind these payment adjustments was that they would motivate higher performance among clinicians, and over time as providers performed better under MIPS, they would eventually be ready to shift into payment models under the AAPM track. Essentially, MIPS would serve as on-ramp to participating in alternative payment models, allowing physician practices to became more experienced in meeting the care delivery, data and technology, and administrative requirements needed to be successful under payment models with greater accountability for cost and health outcomes.[53]

However, nearly a decade after implementation, there are significant concerns about whether the QPP — and MIPS in particular — are meeting the intended goals to drive toward high-value health care. One of the biggest criticisms of MIPS is that it allows providers to self-select many of the performance measures on which they will be evaluated.[54] This means that providers can skew their results by reporting on the measures for which they expect to perform the best on, resulting in a higher positive payment adjustment even if they exhibit little or no behavior change.[55] This makes it nearly impossible to use MIPS scores as a meaningful tool to compare clinician performance or motivate better outcomes as the program intended.[56] Another challenge of the MIPS program is

[i] Population-based payment models are based on paying one health care provider — typically a primary care organization or a health system — a single monthly payment that allows the organization or health system to pay for some or most health care costs for a whole population. Such payment arrangements are coupled with strong quality and outcome metrics to ensure that as providers' economics change, patients' health is thriving. In this way, providers are "at risk" for care that is wasteful and does not improve or protect patients' health.

One of the biggest criticisms of MIPS is that it allows providers to self-select many of the performance measures on which they will be evaluated.

that the payment adjustments continue to be rooted in FFS economics, meaning that under the MIPS program, the financial incentives still reward providers for higher care volume rather than higher care quality and improved health. Ultimately, MIPS largely fails to deliver on its promise to appropriately incentivize providers to shift into AAPMs that more effectively tie payment to quality.[57] Moreover, a robust evidence base has demonstrated that these types of payment bonus programs — often referred to as pay-for-performance (P4P) programs — do little to nothing to reorient financial incentives away from FFS and produce mixed results on improving care quality or affordability, despite claims about value.[58] In addition, several studies have shown that P4P approaches actually reduce access to care for socioeconomically disadvantaged populations because they incentivize providers to avoid treating low-income patients who may have unique, and more costly, barriers to achieving their best health.[59]

The pathway to true reform: Policy options to improve physician payment

Reforming and strengthening the way physicians are paid is foundational to efforts to move our health care system to one that delivers on the promise of affordable, equitable and high-quality health care for our nation's families. In the short term, policymakers should focus on policy solutions that address the underlying distortions in the Medicare Physician Fee Schedule while continuing to advance efforts that result in more health care providers participating in payment models with greater accountability for health outcomes and costs, including the following solutions:

- **Correct misvalued services** in the fee schedule to increase the estimated value and therefore the payment for services critical to meeting consumer needs, such as primary care and behavioral health.[60]
- **Reform the fee schedule payment setting process** by:[61]
    - Estimating relative resources using current, valid and reliable data.
    - Reducing code redundancy by consolidating the more than 14,000 payment codes into fewer payment codes.
    - Reducing CMS' overreliance on the RUC by establishing another advisory committee to serve as a secondary data source for determining the time and intensity of relative value units.

- **Make procedural changes in how CMS determines RVUs** by moving away from the existing RBRVS payment system and overreliance on the RUC and specialty societies toward a methodology based on empirical data that is routinely collected from physician practices and under different forms of medical practice ownership.[62]
- **Build alternative payment models into the MPFS** such as the primary care hybrid model or bundled payments for groups of services. Through legislation like the Pay PCPs Act, Congress can facilitate greater adoption of blended payment systems for primary care providers that support regular, fixed payments for high-volume, low-cost services while maintaining fees for irregular or high-cost services.[63]
- **Extend the original AAPM bonus of 5%** to incentivize more providers to move into alternative payment models.

All the while, policymakers should focus on creating new economic incentives in the health care sector that align the financial interests of the health care sector with the health and economic security of our nation's families. These efforts must focus on shifting away from broken FFS economics and moving toward a health care system that pays for whole-person health and is accountable for affordable, equitable, quality care and health for all.

In the short term, policymakers should focus on policy solutions that address the underlying distortions in the Medicare Physician Fee Schedule.

Conclusion

As key stakeholders and policymakers engage in discussion and negotiation about the ways to reform and improve physician payment, it is critical for consumer and patient advocates to be engaged and united in centering the needs and interests of patients and health care consumers in the fundamental design and economic incentives of health care payment. Interest groups representing clinicians have demonstrated time and time again that they will show up in force to influence those discussions, and the only way to ensure true person-centered health care reform is to make sure consumer advocates and allied stakeholders are right there with them. These efforts are paramount to ensure that the business interests of physicians and the health care sector more broadly are finally aligned with the health and financial security of our nation's families.

Endnotes

[1] Robert A. Berenson et al., *Addressing Health Care Market Consolidation and High Prices: The Role of the States* (Washington, DC: Urban Institute, January 2020), https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.

[2] Emily Sokol, "Healthcare Reimbursement Still Largely Fee-for-Service Driven," TechTarget, March 26, 2020, https://revcycleintelligence.com/news/healthcare-reimbursement-still-largely-fee-for-service-driven.

[3] "2023 Measurement Effort," Health Care Payment Learning & Action Network, October 30, 2023, https://hcp-lan.org/apm-measurement-effort/2023-apm/.

[4] Rachel Gifford, Eric Molleman, and Taco van der Vaart, "It's a Jungle Out There: Understanding Physician Payment and Its Role in Group Dynamics," Social Science & Medicine 350 (June 2024): 116945, https://www.sciencedirect.com/science/article/pii/S0277953624003897.

[5] Health Care Payment Learning & Action Network, *Alternative Payment Model: APM Framework* (MITRE Corporation, 2017), http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

[6] *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, DC: Medicare Payment Advisory Commission (MedPAC), June 2018), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf.

[7] MedPAC, *Report to the Congress*.

[8] Corinne Lewis et al., "Value-Based Care: What It Is, and Why It's Needed," The Commonwealth Fund, February 7, 2023, https://www.commonwealthfund.org/publications/explainer/2023/feb/value-based-care-what-it-is-why-its-needed.

[9] Sanne Magnan, "Social Determinants of Health 101 for Health Care: Five Plus Five," *NAM Perspectives*, Discussion Paper, National Academy of Medicine, October 9, 2017, https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/.

[10] Physician and Other Health Professional Payment System: Payment Basics Series. (Washington, DC: Medicare Payment Advisory Commission (MedPAC), November 2021), https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_physician_final_sec.pdf.

[11] MedPac, *physician and other health professional payment system.*

[12] MedPac, *physician and other health professional payment system.*

[13] Juliette Cubanski and Tricia Neuman, "What to Know About Medicare Spending and Financing," KFF, January 19, 2023, https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/.

[14] *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 2024), https://www.cms.gov/oact/tr/2024.

[15] Jim Hahn et al., *The Medicare Access and CHIP Reauthorization Act of 2015* (MACRA; P.L. 114-10) (Washington, DC: Congressional Research Service, updated November 10, 2015), https://crsreports.congress.gov/product/pdf/R/R43962; CMS-1807-F | CMS.

[16] "RBRVS Overview," American Medical Association (AMA), updated November 8, 2024, https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview.

[17] AMA, "RBRVS Overview."

[18] AMA, "RBRVS Overview."

[19] Maura Calsyn and Madeline Twomey, "Rethinking the RUC: Reforming How Medicare Pays for Doctors' Services," Center for American Progress, July 13, 2018, https://www.americanprogress.org/article/rethinking-the-ruc/.

[20] Calsyn and Twomey, "Rethinking the RUC."

[21] Calsyn and Twomey, "Rethinking the RUC."

[22] Calsyn and Twomey, "Rethinking the RUC."

[23] Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy, GAO-15-434 (Washington, DC: U.S. Government Accountability Office (GAO), May 2015), https://www.gao.gov/products/gao-15-434.

[24] "An Introduction to the RUC," American Medical Association (AMA), n.d., https://www.ama-assn.org/system/files/introduction-to-the-ruc.pdf.

[25] GAO, Medicare Physician Payment Rates.

[26] "Chapter 3: Rebalancing Medicare's Physician Fee Schedule Toward Ambulatory Evaluation and Management Services," *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, DC: Medicare Payment Advisory Commission (MedPAC), June 2018), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf.

[27] MedPAC, *Report to the Congress*.

[28] Paul B. Ginsburg and Robert A. Berenson, "Revising Medicare's Physician Fee Schedule — Much Activity, Little Change," *New England Journal of Medicine* 356, no. 12 (2007): 1201–1203, https://www.nejm.org/doi/abs/10.1056/NEJMp068272.

[29] Robert A. Berenson and Kevin J. Hayes, "The Road to Value Can't Be Paved With a Broken Medicare Physician Fee Schedule," *Health Affairs* 43, no. 7 (2024), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.00299.

[30] GAO, Medicare Physician Payment Rates; Robert A. Berenson and John D. Goodson, "Finding Value in Unexpected Places – Fixing the Medicare Physician Fee Schedule," *New England Journal of Medicine* 374, no. 14 (2016): 1306–1309,

[31] Berenson and Goodson, "Finding Value."

[32] Calsyn and Twomey, "Rethinking the RUC."

[33] Magnan, "Social Determinants of Health."

[34] U.S. Centers for Medicare & Medicaid Services (CMS), "Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule," news release, November 2, 2023, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule.

[35] Sarah Klein, "Paying Providers to Address Health-Related Social Needs: Lessons From Massachusetts and Minnesota," The Commonwealth Fund, October 2, 2024, https://www.commonwealthfund.org/publications/2024/oct/paying-providers-address-health-related-social-needs.

[36] Nambi Ndugga, Latoya Hill, and Samantha Artiga, "Key Data on Health and Health Care by Race and Ethnicity," KFF, June 11, 2024, https://www.kff.org/key-data-on-health-and-health-care-by-race-and-ethnicity/?entry=health-status-and-outcomes-life-expectancy.

[37] Hannah T. Neprash et al., "Association of Primary Care Visit Length With Potentially Inappropriate Prescribing," JAMA Health Forum 4, no. 3 (2023): e230052, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2802144; "2017 Patient Survey Report for The Physicians Foundation," Regina Corso Consulting, 2017, https://physiciansfoundation.org/wp-content/uploads/2017/12/Physicians_Foundation_2017_Patient_Survey_Report.pdf.

[38] *The Medicare Physician Fee Schedule Likely to Serve as Foundation for Alternative Payment Models* (USC-Brookings Schaeffer Initiative for Health Policy, 2017), https://www.brookings.edu/wp-content/uploads/2017/08/medicare-pfs-conference-brief-event-summary.pdf.

[39] Alex Cottrill, Juliette Cubanski, and Tricia Neuman, "What to Know About How Medicare Pays Physicians," KFF, March 6, 2024, https://www.kff.org/medicare/issue-brief/what-to-know-about-how-medicare-pays-physicians/#:~:text=Under%20current%20law%2C%20the%20projected,million%20in%20a%20given%20year.

[40] Jeffrey Davis, Kristen O'Brien, and Rachel Hollander, "The Budget Neutrality Paradox: Explaining the CY 2025 PFS Positive Budget Neutrality Adjustments," *Regs & Eggs* (blog), McDermott+, July 18, 2024, https://www.mcdermottplus.com/blog/regs-eggs/the-budget-neutrality-paradox-explaining-the-cy-2025-pfs-positive-budget-neutrality-adjustment/#:~:text=CMS%20is%20required%20by%20law,PFS%20conversion%20factor%20(CF).

[41] Davis et al, "The Budget Neutrality paradox."

[42] "History of Medicare Conversation Factors," American Medical Association (AMA), n.d., https://www.ama-assn.org/system/files/cf-history.pdf.

[43] MedPAC, Report to the Congress, "Chapter 3."

[44] MedPAC, Report to the Congress, "Chapter 3."

[45] "Appendix 4-A: Key Findings From the Commission's 2022 Access-to-Care Survey," *Report to the Congress: Medicare Payment Policy* (Washington, DC: Medicare Payment Advisory Commission (MedPAC), March 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Ch4_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

[46] Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS), Final Rule and Interim Final Rule, "Medicare Program; CY 2021 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; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19," Federal Register 85, no. 248 (December 28, 2020): 84472, https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part.

[47] U.S. Congress, H.R. 133, *Consolidated Appropriations Act* (CAA) of 2021. For more information, see https://www.congress.gov/bill/116th-congress/house-bill/133/text.

[48] J.A. Hirsch, "Sustainable Growth Rate Repealed, MACRA Revealed: Historical Context and Analysis of Recent Changes in Medicare Physician Payment Methodologies," *American Journal of Neuroradiology* 37, no. 2 (February 2016): 210–214, https://pmc.ncbi.nlm.nih.gov/articles/PMC7959940/.

[49] "Quality Payment Program Overview," Quality Payment Program, U.S. Centers for Medicare & Medicaid Services (CMS), n.d., https://qpp.cms.gov/about/qpp-overview.

[50] "MACRA," CMS.gov, U.S. Centers for Medicare & Medicaid Services (CMS), last modified September 10, 2024, https://www.cms.gov/medicare/quality/value-based-programs/chip-reauthorization-act.

[51] "Advanced APMs," Quality Payment Program, U.S. Centers for Medicare & Medicaid Services (CMS), n.d., https://qpp.cms.gov/apms/advanced-apms.

[52] "Merit-based Incentive Payment System (MIPS): 2024 MIPS Overview Quick Start Guide," Quality Payment Program, U.S. Centers for Medicare & Medicaid, n.d., https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2621/2024MIPSQuickStartGuide.pdf.

[53] "Chapter 15: Moving Beyond the Merit-based Incentive Payment System," *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, DC: Medicare Payment Advisory Commission (MedPAC), June 2018), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch15_sec.pdf.

[54] Matthew Fiedler et al., "Congress Should Replace Medicare's Merit-Based Incentive Payment System," University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics, February 27, 2018, https://healthpolicy.usc.edu/article/congress-should-replace-medicares-merit-based-incentive-payment-system/.

[55] Fiedler et al., "Congress Should Replace."

[56] Matthew Fiedler, "Matthew Fiedler's Testimony Before the House Committee on Energy and Commerce, Subcommittee on Health," Brookings Institution, October 19, 2023, https://www.brookings.edu/articles/matthew-fiedlers-testimony-before-the-house-committee-on-energy-and-commerce-subcommittee-on-health/.

[57] Jennifer R. Shapiro, Medicare Plan Payment Group, "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – Update," memorandum to all Medicare Advantage organizations, cost plans, PACE organizations, and demonstrations, July 10, 2020, https://www.hhs.gov/

guidance/sites/default/files/hhs-guidance-documents/2020%20mips%20hpms%20memo%207.10.2020.pdf.

[58] Aaron Mendelson et al., "The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care: A Systematic Review," *Annals of Internal Medicine* 166, no. 5 (January 2017): 341–353, https://www.acpjournals.org/doi/10.7326/M16-1881.

[59] Berenson and Hayes, "The Road to Value."

[60] Berenson and Hayes, "The Road to Value."

[61] Berenson and Hayes, "The Road to Value."

[62] Stephen Zuckerman et al., *Collecting Empirical Physician Time Data: Piloting an Approach for Validating Work Relative Value Units* (Washington, DC: Urban Institute, December 2016), https://www.urban.org/sites/default/files/publication/87771/2001123-collecting-empirical-physician-time-data-piloting-approach-for-validating-work-relative-value-units_0.pdf.

[63] Berenson and Hayes, "The Road to Value."

This publication was written by:
Sophia Tripoli, Senior Director, Health Policy, Families USA
Aaron Plotke, Senior Policy Analyst, Families USA
Alicia Camaliche, Senior Policy Analyst, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):
Nichole Edralin, Associate Director, Design and Publication
Lisa Holland, Senior Communications Manager
Sophia Ly, Website Content Manager
Lauren Rubenstein, Senior Communications Associate
Jen Taylor, Senior Director, Government Relations

1225 New York Avenue NW, Suite 800, Washington, DC 20005
202-628-3030 info@familiesusa.org FamiliesUSA.org facebook / FamiliesUSA twitter / @FamiliesUSA

VAL 2024-16