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Medicare Physician Fee Schedule Reform:

Structural Topics and Recommendations to Strengthen the System for the Future

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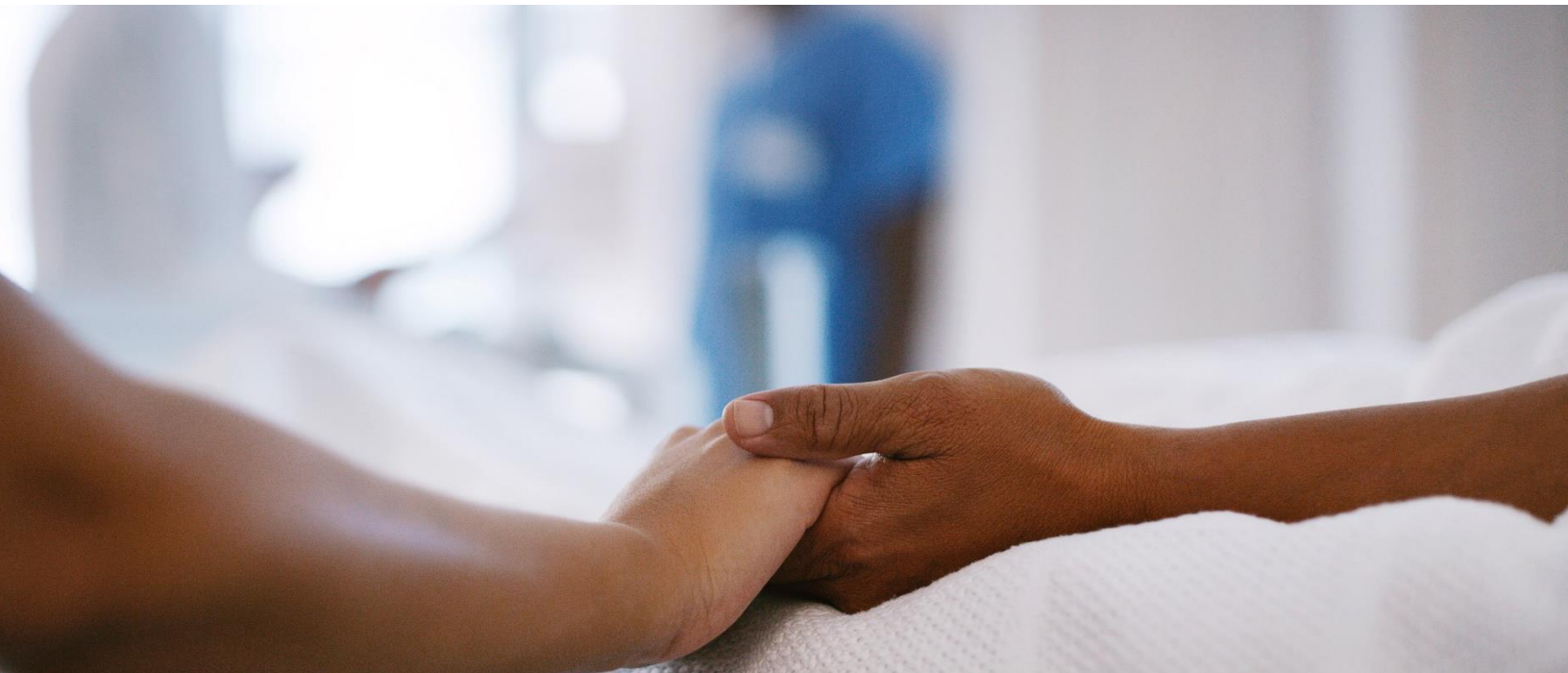


Table of Contents

EXECUTIVE SUMMARY

Recent years have witnessed a growing bipartisan call to reform how Medicare reimburses for physician and other health professional services. Stakeholders assert that the current system—the Medicare Physician Fee Schedule (PFS)—is misaligned to today's practice patterns and market dynamics. Many constituencies maintain that the current approach is insufficiently updated, embeds known pricing distortions, and does not appropriately effectuate value-based care principles, such as providing cost-conscious, high-quality care that prioritizes performance measurement and patient experience. Calls for reform are further prompted by increasing concern about the viability of independent physician practices, including the implications of consolidation and private equity acquisition of physician offices.[1] Finding a workable comprehensive solution to updating physician payments is an uphill battle stymied by the significant cost of doing so, competing stakeholder positions, and the complexities of restructuring payment.

The original design of the Medicare PFS, still in use today, is based on the resources typically needed to provide services to patients. First implemented in 1992, the PFS is a fee-for-service (FFS) system of payment premised on the idea that services should be separately valued in relation to each other. This requires information on the effort and costs incurred to perform those services and how those variables change over time. The Centers for Medicare & Medicaid Services' (CMS's) efforts to update data used to set rates in the required budget neutral manner often result in system instability and may take years to fully implement due to concerns about redistribution. These innate vulnerabilities have been compounded by three decades of policy decisions, statutory changes, and advancements in care delivery.

Key policy developments related to the PFS are outlined in this **E-Timeline** resource.

While established metrics suggest that physicians' participation in the Medicare program and beneficiary access is currently adequate, the Medicare Payment Advisory Commission (MedPAC) raises concerns that beneficiaries may experience more access to care barriers moving forward.[2] For the past two years, MedPAC has recommended physician payment updates based on changing economic conditions, as well as additional "safety net" payments to physicians treating low-income beneficiaries.[3] Reducing health disparities and improving the foundation of care is a top priority for many in this country, and payment reform within the PFS and more broadly that expands technology while also investing in person-centered, community-oriented care (especially for populations that are underserved and/or living with multiple chronic conditions) is central to that cause.

As robust policy discussions are taking place to explore these issues and identify solutions, Arnold Ventures engaged Health Management Associates, Inc. (HMA), to provide accessible background and context on the PFS for people who may be unfamiliar with the payment system, including a review of how the stakeholder community got to the point of needing to "fix" the fee schedule. Through a thorough assessment of the most pressing policy and payment concerns, we identified several key structural issues within the physician fee schedule that should be considered and balanced when making policy changes to the payment system. These include:

- Budgetary concerns and redistribution effects that benefit some specialties over others
- Opaque processes for setting and revising pricing for new and existing services

- Reliance on data that may be incomplete, perpetuate distortions, or allow physicians' services to become misvalued over time
- Insufficient support for primary care, care coordination, and behavioral health in a system often perceived as favoring episodic-based care
- The potential influx of emerging technology-based services that are not easily incorporated into the current system
- The critical need for affordable and accessible care for Medicare beneficiaries

We considered flexibilities that CMS may already have available to it to address some of these structural issues and better reflect the evolving practice of medicine. While CMS must work within statutory requirements to develop the values that are used as the basis of payment to physicians, the agency does have authority to implement changes that will improve processes, fee schedule pricing, and help strengthen the system for the future. Given prior CMS comment solicitations, many recommendations are in the public domain and are the basis of several of the suggestions outlined below. Overarching recommendations include:

- Provide further transparency and access to the interested public, through an online central repository, to the critical background information, data, and methods necessary to fully critique or supplement information used to develop physician payment values.
- Engage stakeholders by convening town hall meetings to evaluate potential reforms in physician work valuation as has occurred previously for the practice expense component of payment.
- Drive the agenda for valuation changes to existing services with a new CMS generated review to refresh criteria, determine if refinement is necessary, and update values more quickly.
- Move from granular accounting of resources and associated payment levels indicative of FFS towards greater aggregations within the PFS rate setting methodology, service level payments and measurement.
- Establish claims processing mechanisms to track where and how advanced practice providers such as nurse practitioners and physician assistants furnish care "incident to" a physician's service.
- Explore how to incentivize clinicians to deliver more care in the home or other community-based settings where beneficiaries feel most comfortable and are in the best position to manage their care before emergent or more intensive services are necessary.
- Provide additional flexibilities and different approaches to payment within Advanced Alternative Payment Models (AAPMs) to make practicing medicine easier, lessen administrative and regulatory requirements, and further incentivize participation in AAPMs.

We highlight areas that prioritize actionable steps, prompt idea generation, and encourage process improvement within the PFS. If CMS initiates further action on these issues, it will help to improve accuracy and potentially begin to shift the physician reimbursement mindset from service-by-service payment toward more accountable care. It is important to recognize that broader change, however, may require Congressional consideration of the PFS relationship to other Medicare payment systems and potentially how to shift funding across and within parts of the Medicare program to achieve change without incurring substantial cost to the government and taxpayers.

INTRODUCTION

Medicare and its beneficiaries spend nearly $100 billion per year on physician and other healthcare professional services. The payment structure is guided by the statutory requirements of the Medicare physician fee schedule (PFS),[4] which is comprised of more than 8,000 different services and reimburses more than one million medical professionals for the services they provide to approximately 34 million traditional Medicare beneficiaries (~52% of Medicare enrolled beneficiaries). The influence of the PFS extends beyond simply setting payment rates for providers in traditional Medicare, informing private payer contracting, providing the underlying architecture for alternative payment models (APMs), and playing a role in broader policy concerns (e.g., site neutral payments, quality and value, workforce challenges, consolidation, and provider wage gaps). Despite this broad reach and care delivery practice patterns that have dramatically evolved since its establishment 30 years ago, the underpinnings of the PFS have fundamentally remained the same.

The PFS was established in 1992 to curb growth in Medicare spending on physician services and eliminate variations in payments and other distortions in pricing that occurred under the previous reasonable charge-based system.[5] Though some of these objectives were achieved with the switch to PFS, many criticisms remain, and new ones have arisen over time. These criticisms include concerns about inequitable payment for primary care, systematic undervaluation of cognitive services, and inadequate capture of technologies and efficiencies in care delivery. In addition, the PFS lacks a mechanism for annual updates to payment rates that is similar to the market basket approaches used for hospitals and certain other Medicare providers. Though healthcare policymakers have made considerable progress in studying, revaluing, and rebalancing the PFS to tackle these challenges, many stakeholders still feel the PFS is “broken” and have called for Congress to “fix Medicare now.”[6]

Organized medicine (i.e., medical professional societies) is concerned that PFS reimbursement is inadequate to cover the cost of providing care and that fluctuations in payment levels cause instability that jeopardizes access to care and the viability of physician-owned practices. Many stakeholders, including organizations that represent accountable care organizations (ACOs), agree that a predictable update to the conversion factor is the first step toward providing physicians with the ability to maintain financially viable practices. To achieve value-based care as it was envisioned in the Medicare Access and CHIP Reauthorization Act (MACRA),[7] physicians must have predictable and stable payments. Physicians must also have confidence that the system is not weighted to incentivize furnishing certain services, whereas consumers want healthcare payment and delivery designed to reward high-quality, accessible, and affordable care.[8]

Momentum is building on Capitol Hill to examine Medicare payment for physician services and investigate long-term solutions.[9] When considering how to further modernize the PFS, it is important to remember that the underlying statutory basis of physician reimbursement is a relative scale where “value” is based on resource inputs (e.g., costs) to furnish care within a fixed pool system. Congress may choose to evaluate whether that is still an appropriate way to set rates and whether the current relative value scale methodology and associated processes will adequately address payment for evolving healthcare delivery models or market fluctuations.

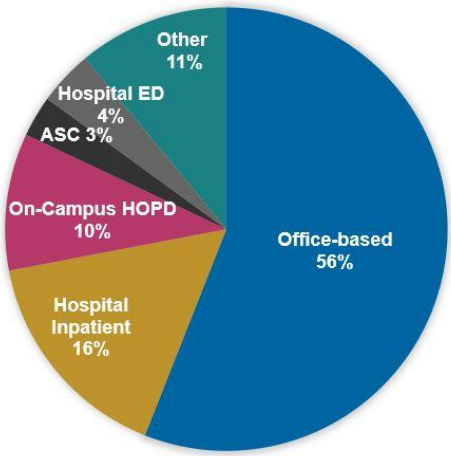
Arnold Ventures engaged Health Management Associates, Inc. (HMA) to provide accessible background information and context on the PFS for people who may be unfamiliar with the payment system, including a

review of how the stakeholder community got to the point of needing to “fix” the fee schedule. This report also includes a discussion of options available to the CMS that might position the PFS as a glidepath toward 100 percent accountable care by 2030.[10] Though each topic presented could warrant a comprehensive review on its own, the intention is to highlight structural aspects of the PFS that present challenges or opportunities for policy initiatives and to facilitate the development of process and policy solutions that CMS has the authority to implement.[11]

BACKGROUND: PROFESSIONALS AND SERVICES REIMBURSED UNDER THE PFS

PFS Pays for Professional Services across All Sites of Healthcare Delivery

FIGURE 1. PLACE OF SERVICE (POS) DISTRIBUTION OF ALLOWED CHARGES IN PFS CY 2022



Source: 2022 Physician/Supplier Procedure Summary (PSPS) data. See endnote 12 for details.

The PFS is the basis of payment to physicians who furnish care to traditional (i.e., fee for service) Medicare beneficiaries across all places of service. Spending on services furnished in the office setting comprises more than half (56%) of total PFS allowed charges (see Figure 1).[12] Reimbursement is intended to reflect the resources the physician typically uses to furnish a service, including their work, expenses incurred and professional liability insurance (PLI).

Physicians who practice in freestanding offices also may receive revenue from providing services covered through other Medicare benefit categories. When physicians incur the costs of other items and services not reimbursable under the PFS, such as for physician administered drugs (e.g., chemotherapy), clinical laboratory services, or durable medical equipment (DME), payment is made through another Part B Medicare program payment system.

Physicians, Other Clinicians, and Suppliers Are Paid under the PFS

Physicians and other qualified healthcare professionals who are authorized to independently bill Medicare for their services[13] and certain other types of suppliers receive reimbursement for services furnished under the PFS. The term physician(s) throughout this discussion is used to collectively refer to all clinicians and suppliers paid under the PFS. In 2022, reimbursement to primary care physicians (internal medicine, family practice, geriatrics, pediatrics, general practice) comprised approximately 16 percent of PFS reimbursement compared with 69 percent for all other specialties (see Figure 2).[14]

When physicians furnish a service, they typically receive 100 percent of the PFS payment level. Physician extenders or advanced practice providers (APPs), such as nurse practitioners (NPs) and physician assistants (PAs) can bill Medicare independently for their services and are paid at 85 percent of the PFS rate. For some services that an NP or PA provides, a physician supervising the advanced practitioner may bill for the service (instead of the NP or PA billing Medicare directly) and receive full (100%) payment. This approach is referred to as billing "incident to" a physician service.[15] Beginning this year (2024), marriage and family therapists (MFT) and mental health counselors (MHC) may bill Medicare independently for their services and receive reimbursement at 75 percent of what a clinical psychologist is paid (the full rate) under the PFS. The beneficiary is responsible for 20 percent coinsurance of PFS services rendered.

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

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

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

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

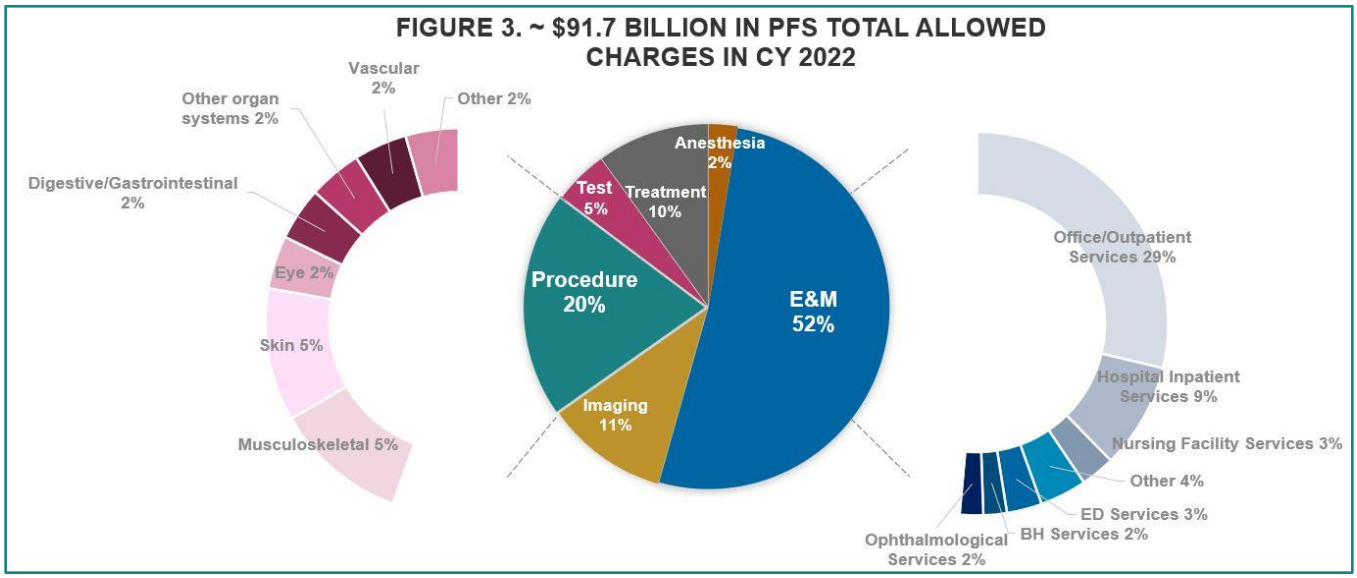
2%
Other suppliers
(22 specialties, 75,717 providers)

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

Notes: Data rounded to nearest percentage. See endnote 14 for details.
Source: 2022 Physician/Supplier Procedure Summary (PSPS) data; provider counts from 2022 100% Carrier Standard Analytic File (SAF)

The Majority of PFS Spending Is for E/M Services and Procedures

The physician fee schedule reimburses physicians for a range of services. Evaluation and management (E/M) services ("physician visits" in the physician office or other settings) and procedures comprise the bulk of PFS spending at more than half of total allowed charges (see Figure 3). Most physician specialties bill E/M services in varying proportions based on the mix of services an individual physician or specialty provides. **Appendix A** presents PFS spending by specialty including the share of E/M and procedures furnished by all clinicians designated as that specialty on bills to Medicare.



Source: 2022 Physician/Supplier Procedure Summary (PSPS) data, restricted to PFS services with status indicators A, C, R, T, and J per the PFS CY 2022 Final Rule Addendum B. Tolal allowed charges included Medicare and beneficiary portion of payment

BACKGROUND: HOW THE PFS SETS PAYMENT

A Billing Code Is Required to Receive Payment for a Service under the PFS

The Medicare PFS is a fee-for-service (FFS) payment system. Physicians report codes on healthcare claims that describe the service performed and are paid a fee for each service rendered, making coding and nomenclature a critical component of the physician reimbursement landscape. Physicians, technology manufacturers, and other interested parties seek new codes to facilitate service utilization tracking and research and ultimately to establish separate payment for services to promote uptake. As a guardrail, bodies that maintain code sets adhere to specific criteria and evidence requirements to limit unnecessary code expansion. The US Department of Health and Human Services (HHS) has designated the American Medical Association (AMA) Current Procedural Terminology® as the national coding system for professional providers.[16] The AMA releases new CPT codes annually and sometimes more frequently. CMS also issues billing codes through its Healthcare Common Procedure Coding System (HCPCS) process.[17]

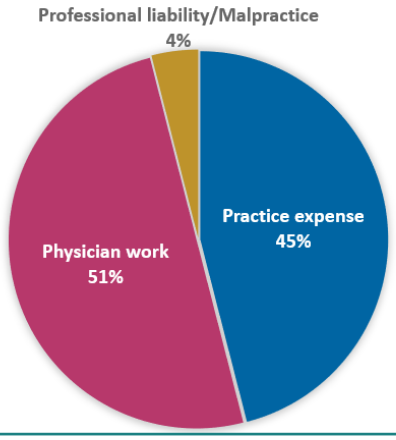
Resource-Based Relative Value Scale

The payment schedule uses a geographically adjusted resource-based relative value scale (RBRVS). Established in the early 1990s to replace reimbursement based on customary, prevailing, and reasonable charges,[18] the RBRVS was designed to be a payment system based on the relative resources typically needed to provide healthcare services. In theory, if the resources are accurate, the RBRVS should limit financial incentives to furnish one service rather than another.[19] The relative value scale (RVS) refers to the

ranking of services. A resource-based RVS is intended to value services relative to the resources consumed when furnishing care to a typical patient. Thus, a service that requires more resources (e.g., physician work, practice expenses) is valued higher than services that involve fewer resources. Value in this context does not signify value-based care (VBC) concepts such as quality, performance, patient experience or what an individual patient regards as most important.[20] Although VBC principles are not directly incorporated into the RBRVS, CMS and Congress have layered performance-based incentives on top of PFS reimbursement amounts through the Quality Payment Program (QPP) (see The Medicare Access and CHIP Reauthorization Act (MACRA) on page 13).

Relativity and Relative Value Units

FIGURE 4. OVERALL DISTRIBUTION OF PFS COMPONENTS

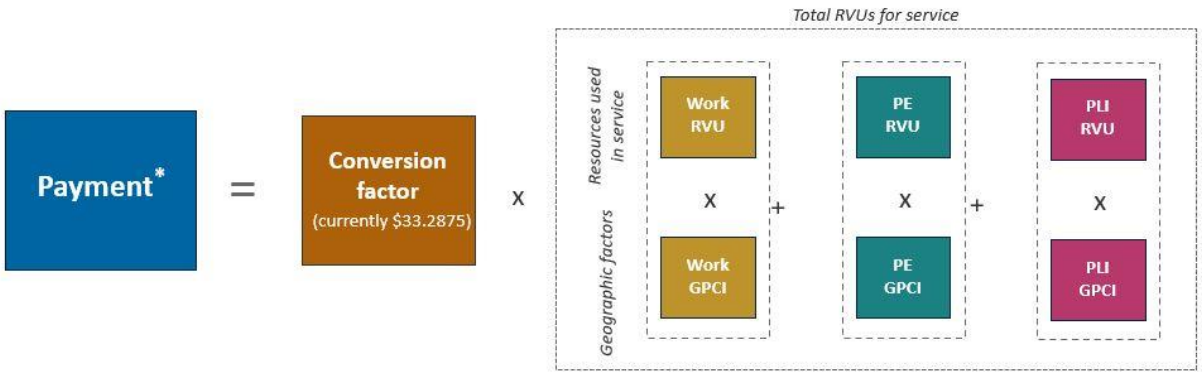


Source: PFS CY23 FR (87 FR 69404). Total RVUs in the system are proportioned to align with the Current 2006-based Medicare Economic Index (MEI) Cost Categories

The PFS establishes relative value units (RVUs), also referred to as relative weights. RVUs reflect the typical resources associated with each billing code. Resource input data on physician work, practice expense, and professional liability (commonly known as malpractice) are incorporated into multi-step formulas[21] to calculate RVUs for each component of a code's valuation. The physician **work** RVUs reflect physicians' time and intensity, **practice expense** RVUs account for direct and indirect costs incurred, and **professional liability** RVUs capture risk factors and costs imputed from professional liability insurance (PLI) premium data (see Figure 4).

RVU components are adjusted by geographic practice cost indices (GPCIs) calculated from similar data sources to account for cost variation across localities. A conversion factor is applied to translate RVUs to dollar payment amounts. Figure 4 shows how each individual RVU component contributes to the overall fee schedule and Figure 5 illustrates the most basic payment equation for services (a detailed payment equation is available at **Appendix C**).

FIGURE 5. BASIC PHYSICIAN FEE SCHEDULE PAYMENT EQUATION



Note that payment can be further adjusted by payment modifiers and applicable policy adjustments. See **Appendix C for more information.*
Source: MedPAC. Payment Basics: Physician and Other Health Professional Payment System. Revised October 2023. Available at: https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf

Practice Expense RVUs Differ by Place of Service

When a physician renders care in the office setting, the PFS reimbursement amount reflects the resource costs associated with work to provide care, direct care expenses (referred to as direct resource inputs or direct costs), indirect costs to operate an office, and a small portion to recognize PLI. This is referred to as the PFS non-facility rate and is paid when services are furnished in the office or any other setting outside a facility.

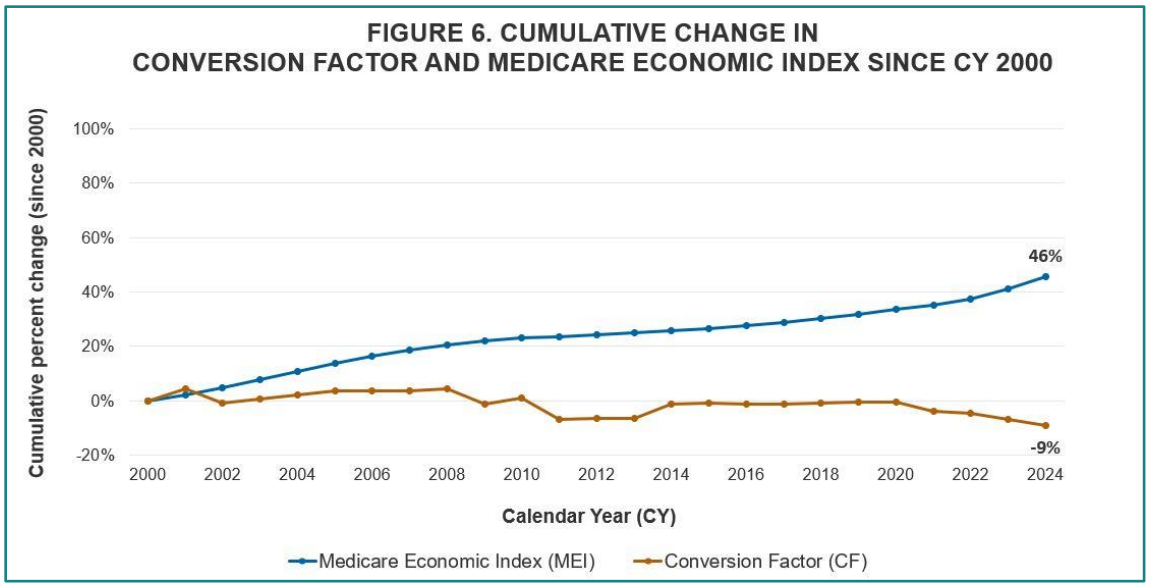
When physician encounters occur in a facility setting, such as a hospital or ambulatory surgical center (ASC), the PFS reimbursement to the physician is less than the level paid for office-based services because the clinician is not incurring direct costs to render care; however, they still receive a portion of reimbursement for the expense of operating a medical practice, referred to as the PFS facility rate.[22,23]

BACKGROUND: THE CONVERSION FACTOR FIX

The PFS Conversion Factor

The conversion factor (CF) has a fraught history and is again the focus of calls for reform that will require congressional intervention. CMS publishes a calculation of the CF in the PFS rulemaking cycle.[24] Though CMS makes utilization estimates that impact budget neutral adjustments to the CF, the update to the CF (currently based on a statutorily set percentage) and the dollar amount itself falls outside of CMS authority. Rising inflation contributes to organized medicine's concerns that PFS reimbursement fails to account for the

cost of providing care and budget neutrality requirements drive new rounds of reductions from prior levels. Figure 6 displays that difference, comparing the cumulative change in conversion factors since CY 2000 to the cumulative change in the Medicare Economic Index (MEI) (the fee schedule's metric for practice cost inflation). The calendar year 2024 CF ($33.29) is one of the lowest in the history of the PFS (see also **E-Timeline**),[25] despite Congress providing a 2.93 percent increase to partially offset reductions from the prior year level.[26]



Source: Health Management Associates analysis of CY 2000-CY 2024 Physician Fee Schedule final rules.

Note: The cumulative percent change in the conversion factor reflect the final the CF (set dollar amount) for that calendar year (finalized either via the fee schedule's final rule or through a Congressional "pay fix" enacted after the final rule). CF values include adjustments made under the fee schedule's budget neutrality requirement.

While the cumulative percent change in the CF dollar amount over the timeframe is negative, the cumulative percent change in PFS updates authorized by Congress over the same span is about 11%. The MEI values reflect the market basket increases published in the fee schedule's final rule each year. The conversion factor for CY 2024 includes the statutory increase enacted under the Consolidated Appropriations Act, 2024 (P.L. 118-42) ($33.29).

The CF History

The CF was established to ensure that the transition from the pre-1992 charge-based system to the RBRVS did not increase Medicare expenditures and was thus budget-neutral. The conversion factor also served as a mechanism to control the rate of growth in total physician services spending by adjusting payment rates through annual conversion factor updates using an aggregate expenditure target system. If total actual spending adjusted for medical input cost inflation exceeded target levels, the conversion factor update was negative, triggering an across-the-board cut in physician payments.

In the early 1990s, spending was benchmarked against an annual target level for different categories of services: primary care, surgical, and non-surgical services.[27,28,29] Each category had its own conversion factor ranging from a low of ~$31 to a high of almost $41.[30,31] This was replaced in 1998[32] by a multi-variable statutory formula to determine the update for a single conversion factor. This calculation was commonly referred to by a component of the formula, the sustainable growth rate (SGR).[33]

The SGR and the Annual "Doc Fix"

The SGR accounted for increases in fees, enrollment, changes resulting from laws and regulations, and economic growth (real per capita GDP) to set annual target levels and establish how much the system was allowed to grow. With the economic recession in the early 2000s, the formula produced cuts to physician payments annually for more than a decade because the link to growth in the US economy resulted in reductions when growth in physician services spending exceeded overall economic growth. This budget control was considered a flawed aspect of the system, creating payment volatility with no individual accountability for quality or cost of care. Every year, Congress overrode these cuts by legislating temporary reprieves, known as the annual "doc fix."[34]

To maneuver pay-as-you-go (PAYGO) rules that call for offsets to legislation that increase spending, "patches" were always short term. In some instances, Congress partially funded the annual fix through policies that hit specific services elsewhere and used creative budget maneuvers, such as pushing slated cuts forward a year to prevent cuts in the current year. These tactics limited the cost of the yearly fix to the federal government under Congressional Budget Office (CBO) "scoring" rules. Managing budget requirements in this manner created a "cliff" with impending cuts cumulating to more than 20 percent. For 12 years, legislative activity aimed at advancing Medicare payment policy for physician services was hampered by the near constant focus on the annual doc fix.

The Medicare Access and CHIP Reauthorization Act (MACRA)

MACRA was intended to stop this cycle of year-end legislative action to prevent physician fee cuts by repealing the SGR, mandating set updates, consolidating CMS's initial pay for performance programs into an overarching framework, and to incentivize the transition from FFS to value-based payment (VBP) models.[35] CMS implemented these requirements through the Quality Payment Program (QPP), establishing two tracks for professionals: the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Models (APM) track, each with different systems of financial rewards and penalties based on performance. CMS's value-based growth strategy within the PFS accordingly centers on the QPP and shifting physicians, other clinicians, and beneficiaries to accountable care[36] arrangements by 2030.[37]

The Medicare Payment Advisory Commission (MedPAC) has found that MIPS is falling short of its intended goals in part because the program is designed around individual performance using process measures that clinicians self-select and because many eligible clinicians are ultimately exempted for various reasons.[38] MedPAC has called for replacing MIPS with a new approach to reward quality care.[39] CMS is attempting to revamp MIPS through regulatory processes and move toward specialty or condition-specific value pathways.[40] Nonetheless, clinicians remain concerned about the administrative burden associated with participation and the disproportionate impact on small and rural practices.[41,42] Though meeting participation thresholds in Advanced APMs (AAPMs) can provide an exclusion from MIPS reporting, incentives to encourage physician participation in AAPMs will decrease from a 3.5 percent bonus in 2025 for qualifying

participants to a 1.88 percent bonus in 2026 (plus the higher CF update of 0.75% beginning in 2026, see **E-Timeline**). Physicians also have raised concerns about misaligned incentives between MIPS and AAPM participation, as the maximum possible upward increase under MIPS is 9 percent (though to date, MIPS positive incentives have yet to exceed 2.3%).

Renewed Focus on the Conversion Factor

As momentum builds on Capitol Hill to examine Medicare payment for physician services with continued emphasis on promoting value-based care as Congress intended in MACRA,[43] focus remains on the conversion factor. This is in part because MACRA's repeal of the SGR and inclusion of minimal CF update amounts were negated by budget neutral offsets to prevent policy and valuation changes in the PFS from increasing overall expenditures. Furthermore, the SGR took inflation into account, whereas the MACRA-specified CF levels do not. Cost pressures and recognition that most other Medicare systems of payment include an annual market-basket update led the MedPAC to recommend a PFS update based on half of the projected increase in the MEI.[44]

Bipartisan proposals have been released on the Hill to provide an annual PFS update tied to inflation,[45] and members of the House GOP Doctors Caucus circulated discussion draft legislation[46] to promote many of the AMA principles of reform, including changing budget neutrality requirements. More recently, senators formed a physician payment reform working group to investigate and propose solutions to ensure stable payments, update MACRA and investigate long-term reforms to the PFS.[47] The US Senate Committee on Finance also held a hearing on how to update physician reimbursement policies to bolster care delivery for beneficiaries living with chronic conditions.[48]

Culmination of Concerns

The provider community suggests that economic pressures and inadequate Medicare payment levels contribute to market consolidation and the shrinking of private practices (those that physicians fully own) to less than half of physician practice arrangements.[49,50] Leaders in the physician community cite productivity pressures, burnout, and concerns about budget neutrality in calls for broader physician payment reform. Some of these leaders also steadfastly support the underpinnings of the RBRVS and the process that the AMA/Specialty Society Relative Value Update Committee (RUC) uses to recommend values to CMS.[51]

Others raise significant concerns about the process and methodology used to develop RVUs and suggest that CMS's reliance on the AMA/Specialty RUC is an example of "agency capture" entrenching overvaluation of procedures and the undervaluation of cognitive care in the healthcare ecosystem.[52] The concern about misvalued services under the PFS extends broadly. MedPAC and others have suggested that chronically mispriced services can affect the career choices that medical students make and may ultimately contribute to workforce shortages that hinder beneficiary access.[53]

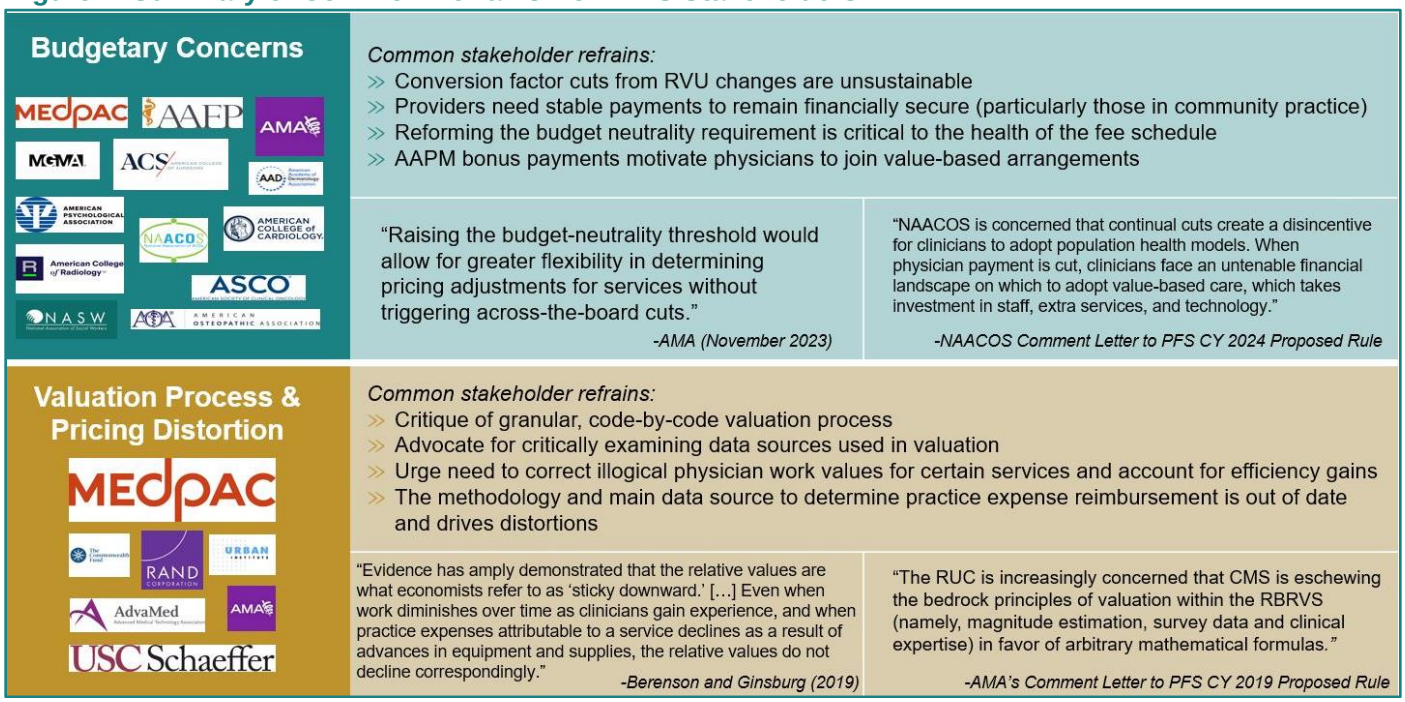
The complexity and challenges involved flow from the basic design of the fee schedule, which is premised on the idea that services should be valued and billed separately. Since valuation under the PFS is based on historic survey data (for physician work and indirect practice expense), it lacks a routine and automatic claims-based process to update reimbursement based on changes in resource inputs. For this reason, valuation under the PFS does not "self-correct" over time. Changes are made only when data updates occur

through CMS action, changes in coding, or established processes such as the potentially misvalued services initiative to identify and correct a service's valuation.

STAKEHOLDER PERSPECTIVES

Like all realms of public policy, a range of groups are interested in Medicare physician payment. Each perspective is informed by the stakeholder's background, expertise, and in some cases, vested financial interest. The AMA/Specialty Society RUC generally supports incremental updates to the current system's granular valuation of services.[54] Researchers and consumer groups, in contrast, typically recommend the use of new methodologies, new data sources, and in some instances, note the risk of unintentional bias when valuation is heavily influenced by the individuals who will receive the service payment.[55,56] In addition, the structure of the PFS system can also create the appearance of a divide between clinical specialties. Contrasting positions are notable, at times, between specialties that furnish cognitive services and longitudinal care (such as primary care) and those that provide procedural or episodic care. In fact, some stakeholders go as far as to equate the current system to "sick care" focused on slowing disease progression rather than proactive disease prevention.[57] Figure 7 briefly describes four common reform themes that often appear in stakeholder PFS messaging.[58]

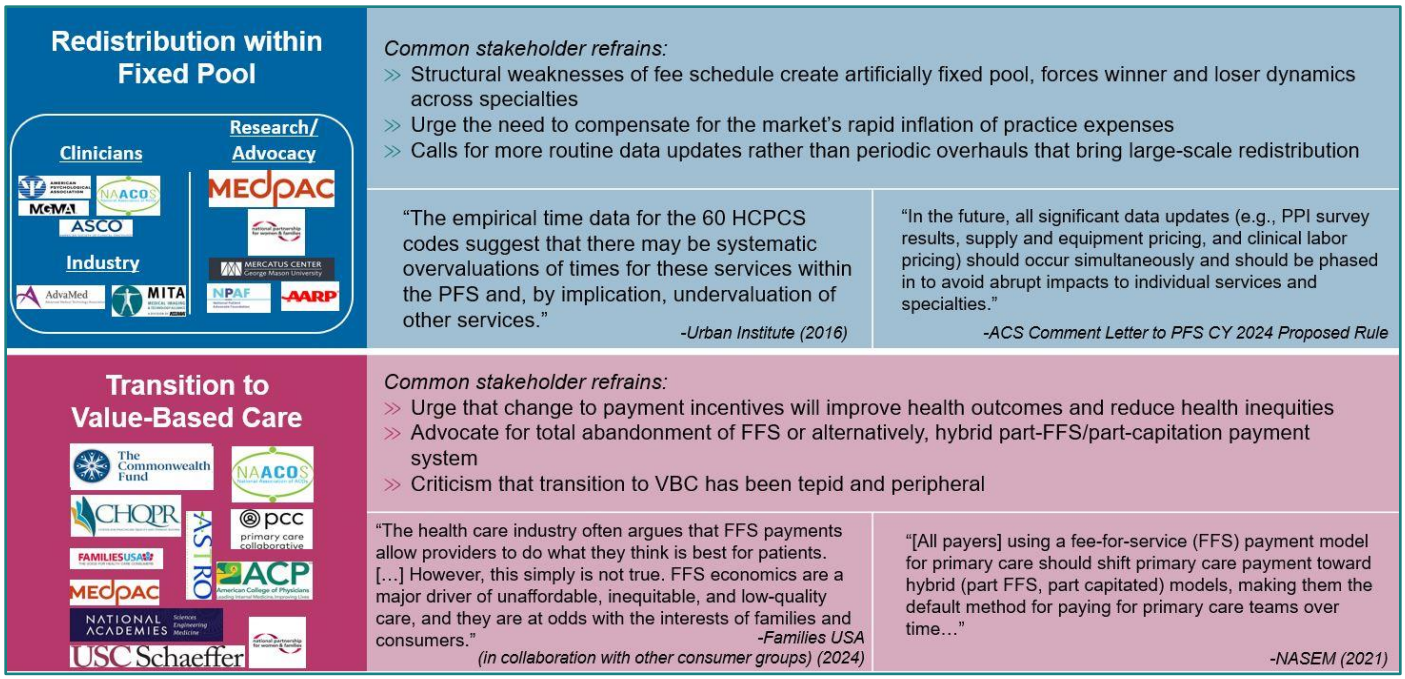
Figure 7. Summary of Common Refrains from PFS Stakeholders



Sources: See endnote 58 for details. Note: HMA's logo listing is for illustrative purposes only and does not reflect the organization's endorsement of the material presented.

AAPM = Advanced Alternative Payment Models, PMPM = Per Member Per Month, AMA = American Medical Association, NAACOS = National Association of Accountable Care Organizations, ACS=American College of Surgeons, NASEM = National Academy of Science, Engineering, and Medicine, ACP= American College of Physicians.

Figure 7. Summary of Common Refrains from PFS Stakeholders (cont.)



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STRUCTURAL ISSUES OF THE PFS

Some of the key issues driving the focus on PFS reform include:

- Budgetary concerns
- Pricing distortions in physician work and practice expenses
- Adequate support for primary care, care coordination, and behavioral health services
- Emerging technologies

Key policy developments related to these structural issues are outlined in this **E-Timeline** resource.

It is a challenge for CMS to balance these concerns. The agency has worked to refine the fee schedule to address and improve upon many of the issues discussed and continues to seek solutions within its authority.

Issue #1. Budgetary Concerns

Budget Neutrality Requirements from Changes in RVUs Driving Conversion Factor Cuts

In the past, the flawed SGR formula drove conversion factor reductions, whereas today's negative updates are driven primarily by the budget neutrality requirement. A divisive budget control mechanism, the budget neutrality (BN) requirement mandates CMS to offset RVU changes that cause fee schedule expenditures to increase or decrease by more than $20 million.[59] The $20 million threshold has not been updated since the law's original passage. In the context of today's PFS spending, roughly $100 billion annually, this threshold means that CMS is required by law to apply BN adjustments and offset any spending that exceeds 0.02 percent of current levels.[60]

In practice, the budget neutrality requirement means that large-scale valuation changes or the introduction of new procedures or services with anticipated high-volume utilization (based on CMS's assumptions) are usually accompanied by an offset to other areas of the fee schedule. Offsets can be made in either direction, lifting or dropping payment rates so that the update's net impact is budget neutral. CMS implements this offset by calculating a BN adjustment to the conversion factor and publishing its value in the proposed and final PFS rules through its rulemaking process. RVU budget neutral adjustments to the CF are driven by changes in physician work valuation,[61] whereas changes to other components of physician payment are "budget neutralized" within rate setting. The adjustment's impact on specific specialties or types of practitioners can vary substantially based on the volume and mix of services provided. Figure 8 identifies recent BN adjustments and the primary reason for their deployment.[62]

Figure 8. Recent Budget Neutrality Adjustments in the Physician Fee Schedule

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

Source: Health Management Associates analysis of CY 2020−CY 2024 Physician Fee Schedule Final Rules

Proponents view the fee schedule's budget neutrality requirement as an important budget control mechanism over the country's ballooning healthcare expenditures. According to the latest Medicare Board of Trustees Report, costs under Medicare Part B (the part of the program that covers physicians' services) have averaged an annual growth rate of 6.8 percent over the past five years. The national gross domestic product (GDP), in contrast, grew annually by an average of 5.5 percent over that same period. The Board of Trustees projects that this gap will widen over the next five years, with annual Part B cost growth averaging 9.7 percent and annual GDP growth averaging 4.3 percent.[63] Medicare Part B is funded through a combination of the government's general revenue (71%), beneficiary premiums (28%), and interest and miscellaneous sources (1%).[64] Under this funding structure, cost growth that is not contained by the fee schedule's budget neutrality requirement ultimately comes at the expense of other federal policy priorities that are left unfunded and at the expense of beneficiaries, who are asked to pay a higher monthly premium. Indeed, budgetary analysis suggests that the 2021−2024 annual congressional "doc fixes," which boosted fee schedule payments by only a few percentage points each year, have cost American taxpayers a total of roughly $7.9 billion over the 10-year budget window.[65]

On the other hand, opponents view the budget neutrality requirement as one of the most harmful features of today's fee schedule. AMA has previously asked that the threshold be increased to $100 million.[66] Other stakeholders have suggested that increases in physician service spending should instead be offset by cuts to other Medicare Part B programs.[67] In their view, the budget neutrality requirement artificially pits specialties against each other, as advancements for one specialty almost always are followed by losses for another.

Aside from a few policies that received a statutory exemption from Congress,[68] most substantive changes to the fee schedule have historically triggered a budget neutrality adjustment. For example, when E/M office visit codes were updated in 2021, the update was finalized with a 10.2 percent reduction in the conversion factor.[69,70] If a BN adjustment to the conversion factor had not been applied and a moratorium on a new billing code to report and receive reimbursement for a complex care add-on to an E/M office visit had not been set, overall fee schedule spending would have increased by more than $11 billion in 2021.[71] Though the change brought much-needed support to primary care, physicians furnishing E/M services did not realize the full benefit of the valuation increase because of the conversion factor reduction, and specialties that infrequently bill for E/M services experienced a payment cut.

Physician advocates have repeatedly argued that the budget neutrality requirement threatens access to care because doctors will eventually reach a breaking point over the declining fee schedule payments and refuse to accept Medicare beneficiaries. However, both MedPAC and other industry research note that access indicators are stable, with Medicare beneficiary access to physician services roughly equal to or better than the private insurance market[72] and only 1.1 percent of non-pediatric physicians formally opting out of the Medicare program as of June 2023.[73]

Contentious Redistribution from PE Changes Neutralized through Rate Setting

While changes in work valuation that exceed the $20 million threshold are made budget neutral through adjustments to the conversion factor, modifications in the practice expense or malpractice liability portion of PFS spending maintain budget neutrality through rate-setting calculations. This was most evident when

CMS updated the Bureau of Labor Statistics (BLS) wage rate data that are used as one variable in the determination of nonphysician labor costs (e.g., registered nurses, technicians, medical assistants) incurred to furnish physician services. These costs are a "direct resource input" in the calculation of practice expense RVUs and had not been updated for 20 years.[74] Updating clinical labor costs in the PFS methodology to more current levels would have resulted in an approximate $3.5 billion increase in expenditures, had budget neutrality not been maintained through rate setting.[75] Hence, physician specialties that incur more clinical labor expense (e.g., registered nurses) to furnish services in the office setting relative to other types of direct care costs experienced gains, whereas physician specialists with higher equipment and supply costs typically incurred losses. This type of shift is referred to as redistribution. As a result, lobbying and draft legislative efforts on Capitol Hill also focus on actions to mitigate redistributive and budget neutral effects of CMS data updates.[76]

Issue #2. Pricing Distortions

Potentially Misvalued Services Initiative

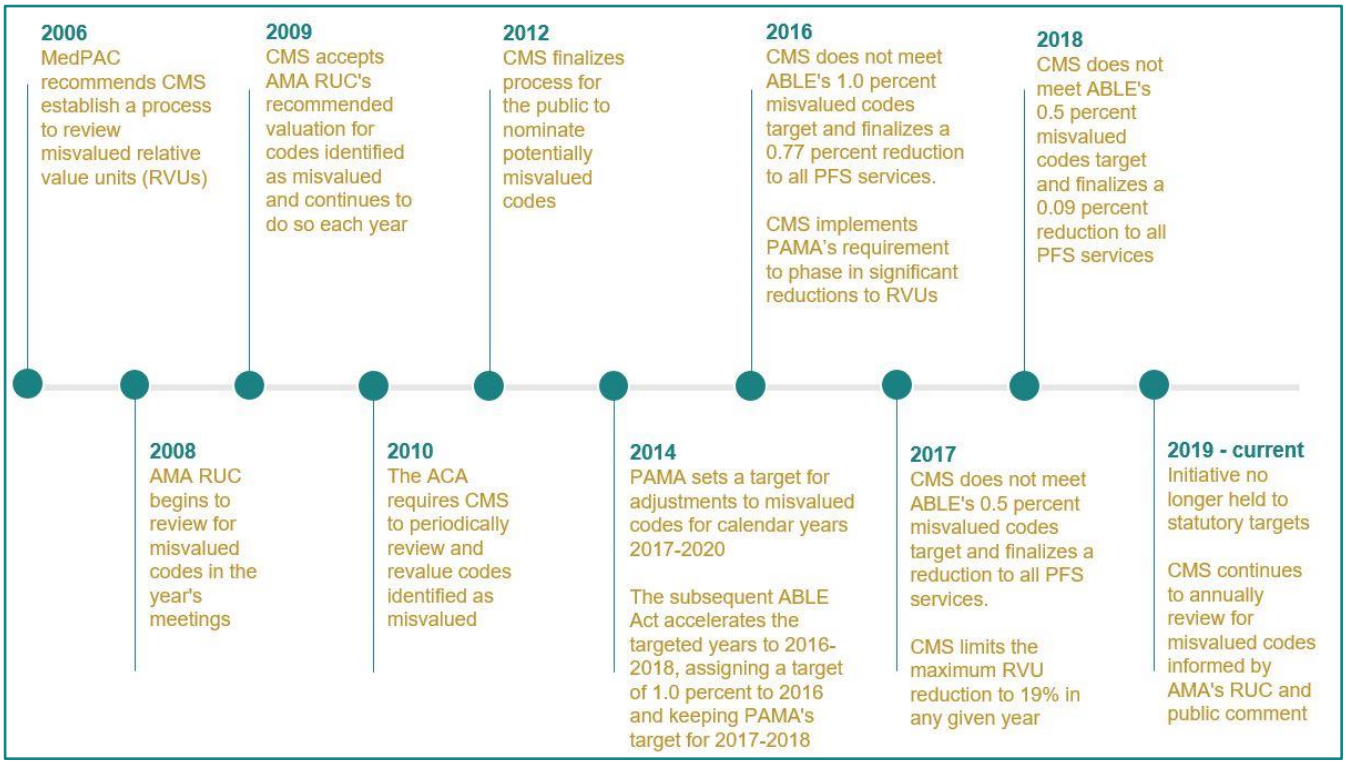
CMS has long grappled with how to ensure that PFS payment rates are based on accurate assumptions, using data that is auditable, comprehensive, routinely updated, and reflecting an array of providers. Ever-changing trends in the practice of medicine necessitate the regular review of service valuation, and over the years, CMS has reviewed the fee schedule through a variety of avenues. At the fee schedule's inception, the agency leaned heavily on its five-year review process, which is statutorily required by Congress.[77] Under the five-year review process, reviews focus on the individual components to a code's valuation (representing physician work, practice expense, and professional liability), and revisions are proposed and finalized via rulemaking. In the mid-2000s, some stakeholders began to call the five-year review process insufficient and urged CMS to develop a more rigorous review system. MedPAC was particularly vocal on this issue.

In its 2006 report to Congress, MedPAC warned lawmakers that structural components of the fee schedule allow physicians' services to become misvalued over time. As the commission pointed out, when the fee schedule adds a new service, it may be valued relatively high because of the associated time, skill, and clinical decision making. Over time, despite the decline in the required physician work resulting from efficiency gains from familiarity, the relative values of services "generally remain at their initial high levels."[78] Similarly, CMS has noted that services can become misvalued with substantial changes to the associated practice expense.

In response to MedPAC's report, the AMA/Specialty Society RUC began reviewing the fee schedule for inappropriate valuation. Although CMS accepted the valuation recommendations that came from the RUC's effort (and have continued to do so), Congress formalized the agency's role in the effort as part of the Patient Protection and Affordable Care Act (PPACA). Section 3134(a) of the ACA directed the Secretary of HHS to "periodically identify potentially misvalued services" and "make appropriate adjustments" to relative value units for services that are found to be misvalued.[79] Congress gave the Secretary several code categories to examine, including codes that have experienced the fastest growth or most substantial changes in practice expense, codes describing new technologies or services, and more. Thus began the "potentially misvalued services initiative," which CMS continues to operate today.

The initiative's process has morphed through the years and included a period during which CMS was statutorily held to a net expenditure impact target for code changes brought under the initiative (the targets were not met all three years). Today, CMS adjusts the relative value of codes deemed misvalued annually, informed by recommendations from AMA/Specialty Society's RUC and public comment. The agency estimates that it has reviewed more than 1,700 potentially misvalued codes or about 20 percent of all services on the fee schedule since 2009.[80] Examples of services that have been re-valued under the initiative include hip and knee replacements, mental health services, and gastrointestinal (GI) endoscopy services.[81] According to the RUC, the initiative has resulted in more than $5 billion in annual redistribution within the fee schedule from 2009 to 2023,[82] though it is unclear whether sufficient information is publicly available to validate that estimate. Figure 9 presents a brief timeline of the history of the misvalued services initiative, and Figure 10 offers example of HCPCS that were recently reviewed under the initiative.

Figure 9. Brief Timeline of the Misvalued Services Initiative



Source: Health Management Associates research and analysis.

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

Figure 10. Sample of HCPCS that CMS Recently Reviewed under the Misvalued Services Initiative

HCPCS	Short Description	Catalyst for Review	Old Work RVU before Review (CY 2020)	AMA/Specialty Society RUC-Recommended Work RVU	New Work RVU Finalized after Review (CY 2021)	% Change
27130	Total hip arthroplasty	Previously flagged under CMS's high expenditure procedural code screen; also nominated by Anthem in 2019	20.72	19.60	19.60	−5.4%
27447	Total knee arthroplasty	Previously flagged under CMS's high expenditure procedural code screen; also nominated by Anthem in 2019	20.72	19.60	19.60	−5.4%
28820	Amputation of toe	Flagged by RUC's site of service screen	5.82	4.10	3.51	−39.7%
28825	Partial amputation of toe	Flagged by RUC's site of service screen	5.37	4.00	3.41	−36.5%
45385	Colonoscopy with lesion removal	Nominated by Anthem in 2019	4.57	RUC recommended against revaluation	4.57	0.0%
70450	CT, head or brain; without contrast	Nominated by Anthem in 2019	0.85	RUC recommended against revaluation	0.85	0.0%
93000	Electrocardiogram complete	Nominated by Anthem in 2019	0.17	RUC recommended against revaluation	0.17	0.0%

Source: Physician Fee Schedule CY 2021 Final Rule (85 FR 84472) Pages 84609-846631

Pricing Distortions Remain in the Fee Schedule

Leading health policy researchers (including those at the Brookings Institution,[83] the Urban Institute,[84] and MedPAC[85]) warn that it is difficult to fix pricing distortions without broader change in the valuation process. These experts urge that CMS's reliance on the RUC is "hampered by the lack of current, accurate, and objective data on clinician and staff time."[86] Even the Government Accountability Office (GAO), the congressional watchdog group, found evidence of overarching conflicts of interest in the RUC process.[87] Many of the criticisms stem from concern about the underlying process and methods that the AMA/Specialty Society RUC uses to develop recommendations to CMS.

The AMA/Specialty Society RUC has long faced these criticisms as well as concerns about natural bias that leads to distortions in pricing.[88] Distortions transfer to all payers that rely on the PFS as a baseline and funnel into alternative payment model architecture and metrics. Further, beneficiaries share in the responsibility of the costs, and as new research suggests, this system also affects gender wage gaps.[89] Though the AMA/Specialty Society RUC has worked for years to review services identified as potentially misvalued, generated the coding and valuation recommendations to CMS that were ultimately implemented for office and outpatient E/M services, and has gradually made improvements to open its meetings to observers, further progress could be made. Nonetheless, AMA/Specialty Society RUC proceedings are beyond CMS's control.

Examples of pricing distortions have been in the public domain for several years and are summarized below with updates, in some instances to provide more recent context. As physician work and practice expense reflect most PFS service level payments, the work and PE components of reimbursement are the focus. Physician work and physician time are incorporated into CMS's calculation of practice expense RVUs. Accordingly, distortions in one component interact with calculations of the other component, creating a compounding distortionary effect. Though these topics are raised for purposes of context and illustration, it is important to remember that CMS's starting position is an "operating assumption" that existing values are valid and existing work times are accurate.[90] Further, adjusting work RVUs is far from a straightforward process[91] and assessing measures of intensity can be complicated, with different metrics for different types of services.

Pricing Distortions: Highlighted Critiques

- Patient vignettes used to value physicians' services exaggerate the typical patient's circumstances.
- Overly granular distinctions create false precision and false accuracy.
- Inflationary bias is inherent in the process to estimate physician time.
- Inflated time and subjective assessments of intensity lead to implausible values.
- Inaccurate physician time and physician work valuation contribute to inaccurate practice expense allocation.
- Efficiency gains over time are unaccounted for and result in passive devaluation of other services.
- The process to establish valuation recommendations is insufficiently transparent.

Source: Berenson, RA., Ginsburg PB., Hayes KJ, Kay T., Pham H., Terrell G. (9/2/2022) and Berenson, RA, Emanuel E., Ginsburg PB., Hayes KJ., Kay T., Pham H., Rudolf P., Shartzer A., Terrell GE., Zuckerman S (9/8/2023)

Distortions in Physician Work

Potentially Inflated Physician Time and Implicit Intensity

One sign of value distortion in the fee schedule is when a service is identified with possibly inflated estimates in total work time. At present, a code's work RVUs reflect both the intensity and typical time the clinician needs to furnish the service. The intensity value seeks to capture the technical skill, clinical decision making, and psychological stress associated with the encounter, whereas time estimates are based on surveys that specialty societies conduct for the AMA RUC's consideration. To measure a service's total time, the specialty surveys present a vignette describing the service's "typical" patient and ask respondents to choose a reference service that the clinician considers closest in terms of work to the service being provided. The survey then asks the respondent to estimate the amount of time required for each component, which ultimately combines to the service's total time estimate. After asking about time, the survey asks the respondent to estimate the total physician work.

In addition to concerns about low survey response rates for some specialties (the GAO found that 23 of the 231 surveys had fewer than 30 respondents in 2015[92]), several researchers have raised concerns that the specialty societies conducting the surveys are inherently biased given their financial interest in payment rates. HHS research in 2014 suggested that the time estimates for certain services are inflated,[93,94,95] and the RAND Corporation has suggested that the follow-up office visits that are built into valuation do not always occur.[96]

Similar inflation appears in the implicit intensity of some services, which is found by dividing a service's total work RVUs by the number of assigned work minutes. Research published in *The American Journal of Surgery* in 2019 looked at 473 surgical procedures and found 40-fold variations in implicit intensity values and little correlation between a service's fee schedule intensity value and its score across 26 measures of service risk in the American College of Surgeons National Surgical Quality Improvement Program. For example, the implicit intensity derived from work estimates were higher for colonoscopies than for hip and knee replacements.[97] We attempted to replicate the researchers' methodology using the work RVU values that were finalized in the CY 2024 update to the fee schedule. In doing so, we found the concern remains relevant—that musculoskeletal and skin procedures demonstrate the most drastic variation within their service subcategories, with intensity codes varying 52-fold and 34-fold, respectively (see **Appendix E**).

Negative IWPUT values

Another example of value distortion in the fee schedule is the presence of negative intraservice work per unit of time (IWPUT) values for certain codes. As a component of a code's total intensity value, the IWPUT values represent the intensity required for the physician to furnish the middle portion of the service. For surgical services, the intra-service period starts at the moment of skin incision and ends when the incision is closed (often referred to as "skin-to-skin" work). For nonsurgical services, the intra-service period captures the work performed in the face-to-face time that the physician has with the patient.[98]

A 2015 RAND study analyzed 2014 physician work RVUs and found that about 3 percent of IWPUT values were negative.[99] As previously stated, a service's intensity value seeks to capture the technical skill, clinical decision-making, and psychological stress associated with furnishing the service. A negative value for the intra-service work period is, as the RAND authors observe, purely "non-sensical" and implies an

overvaluation of pre-service time, immediate post-service time, and/or post-service E/M time. We replicated RAND's methodology using the work RVU values finalized in the CY 2024 update to the fee schedule and found that roughly 6.30 percent of IWPUT values were negative.[100] The issue is particularly concentrated in musculoskeletal procedure codes, as well as in 10- and 90-day global codes. **Appendix F** presents our findings in greater detail. It is important to note that more than 60 percent of the HCPCS we identified as having negative IWPUTs were low-volume services, which may be why the AMA/Specialty Society's RUC relativity assessment workgroup considers its review of negative IWPUT values complete.[101]

Overvaluation of Global Surgical Services

A final example of a pricing distortion in the fee schedule is the evidence of overvalued global surgical services. When a service is paid globally, it means CMS offers a single payment for a global package that includes the services typically furnished before, during, and after the procedure. Surgery is the most common type of global service, and codes are assigned to one of three categories based on the typical number of postoperative days: 0-day, 10-day, and 90-day global packages. The 0-day global codes include the surgical procedure and the preoperative and postoperative services furnished the day of the procedure. The 10-day global codes extend to include visits related to the procedure over the subsequent 10 days. The 90-day global codes include the preoperative services furnished one day before the operation, the surgical procedure and ancillary services furnished the day of surgery, and related visits that occur over the subsequent 90 days.

As CMS acknowledged in 2015, the global payment model for these surgical services was established several decades ago when surgical follow-up was "far more homogenous."[102] Researchers have noted that postoperative care today is most often provided by a hospitalist or nonphysician practitioner (NPP) rather than by the operating surgeon. Further, because hospitalists and NPPs separately bill Medicare for the postoperative care they provide, surgeons may ultimately be receiving payments for postoperative visits that another clinician provides.

A 2021 study by the RAND Corporation suggested only 4 percent of expected postoperative visits actually occur for procedures with 10-day global periods, and approximately 38 percent of expected postoperative visits occur for procedures with 90-day global periods.[103] It should be noted that organized medicine has publicly criticized the methodology RAND used in its 2021 study, which served as an update to the original 2019 study that RAND published under a MACRA mandate. The AMA has raised questions about the generalizability of both RAND studies, noting that the data comes only from practices with 10 or more practitioners in nine states.[104] Others argue that a small number of dermatological codes drove the findings, though RAND has since published a sensitivity analysis that excludes those codes and even under those conditions, the findings are similar to those under the original methodology.[105]

Distortions in Practice Expense

A well-documented concern is that outdated data sources are used in practice expense rate setting and aspects of the calculation contribute to misvalued services and potentially cause market distortions that can affect access to care.[106] It is also generally understood that new market dynamics are inadequately captured in the PFS practice expense methodology. Evolving care delivery models, changing business arrangements such as consolidation, physician employment, an expanding number of services, high-cost resource inputs,

and technologies used to furnish care in the community setting create challenges that were unanticipated when the methodology was designed almost two decades ago. Further, the notion that practice expenses might comprise a larger proportion of PFS payments over time was unforeseeable at the inception of the professional services payment system.

CMS has studied these issues and worked to make updates; however, major change appears to be on hold until new survey data collected by the AMA and specialty societies on physician practice costs are available for consideration.[107] Because the practice expense component comprises more than $40 billion of Medicare's payments to physicians, the emphasis now is on improving the system, prioritizing recurring data updates, and, once more recent data are available on physician practice costs, restructuring the methodology. Researchers have advised CMS that updating the data used to support practice expense rate setting should be a high priority;[108] however, experience points to the substantial redistribution implications of doing so and results in a system in near constant transition.[109] This scenario creates competing priorities, with a need to strike a balance between maintaining payment stability and predictability with responsiveness to market changes, while also addressing potentially inaccurate practice expense payments. This is a growing area of interest; particularly as practice expense reflects approximately 45 percent of physician fee schedule spending.

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

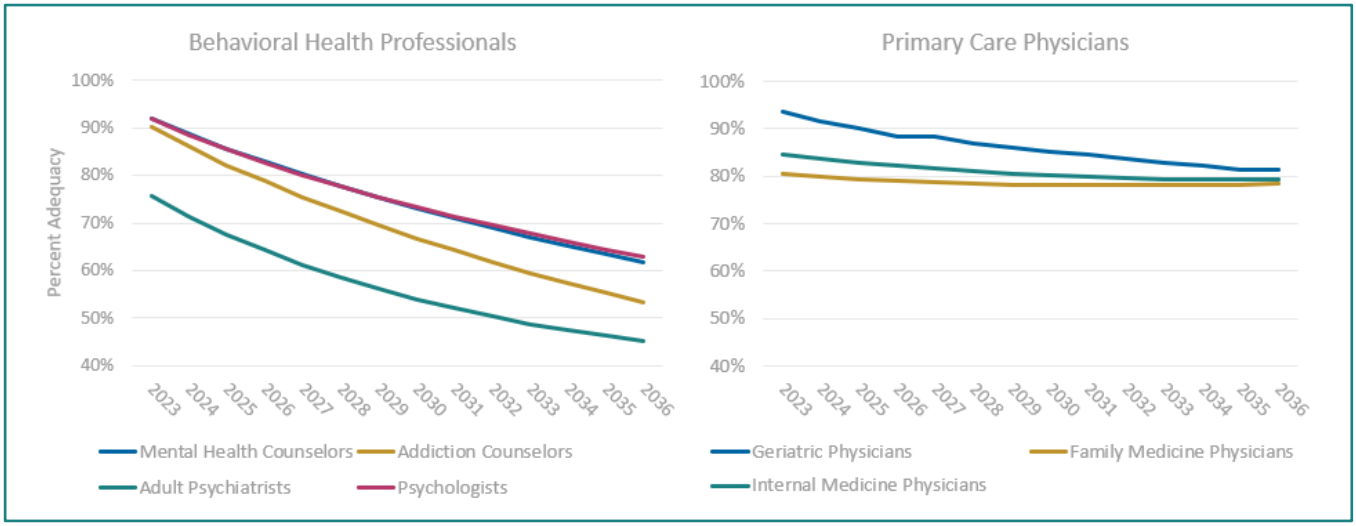
Payment for primary care and behavioral health services under the Medicare PFS have historically been undervalued, and over the long term, that deficit limits clinician investment in more coordinated and comprehensive care.[110,111] Inadequate valuation contributes to inequities in access to care, to income differentials between primary care and other specialties, and to the decline in the supply of primary care physicians and behavioral health professionals.[112,113] Workforce shortages are affecting all specialties and areas of healthcare, though primary care and behavioral health are facing particularly acute challenges.

According to MedPAC, the number of primary care physicians billing the fee schedule has declined from 2016 to 2021.[114] The issue is particularly concentrated in areas that the Health Resources & Services Administration (HRSA) has designated as medically underserved areas (MUAs). MUAs can be found in both rural and urban areas of the country and have been linked to poorer health outcomes, at least partially because of inadequate access to care. A recent Milbank analysis suggests that in 2020, the approximate ratio of primary care physicians to people living in MUAs was 55.8 per 100,000 versus 79.7 per 100,000 people in non-MUA areas.[115] Access to behavioral health services in this country tells a similar story. Only 40 to 50 percent of Medicare beneficiaries living with a mental illness receive treatment,[116] and a recent analysis from the HHS Office of the Inspector General found that on average, urban counties had three times more Medicare-participating behavioral health providers than rural counties.[117]

Without intervention, workforce shortages in primary care and behavioral health are projected to continue. According to HRSA workforce projections,[118] the "percent adequacy" for these professionals (how well supply is expected to meet demand) is projected to decline and/or remain inadequate over the coming decade, with behavioral health showing an especially steep decline (Figure 11). Though these challenges are multi-faceted, inadequate compensation is certainly one contributing factor.[119,120] Over the years, CMS has publicly acknowledged the need to increase support for primary and behavioral health services. An increasing focus is being placed on integrating primary and behavioral health care to treat mental health and substance use disorders (MH/SUD) in primary care settings,[121] an idea CMS incorporated into its 2022

Behavioral Health Strategy.[122] Moreover, the agency has made several changes to the fee schedule to improve valuation and promote care coordination, voicing concern that both the work and practice expense components are systematically undervalued for certain types of services.

Figure 11. Adequacy Projections for Behavioral Health and Primary Care



Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections. Available at https://bhw.hrsa.gov/data-research/review-health-workforce-research

Passive Devaluation of Primary and BH Services and Recent Efforts to Counteract

Passive devaluation affects the pricing of billing codes used to report services that do not experience efficiency gains over time. Efficiency gains can occur when advances in technology, techniques, and clinical practice allow physicians to furnish a service with less time and effort than required when the service first became available.[123] Services that involve physicians' time with patients, for example E/M and certain behavioral health services, are susceptible to passive devaluation because there are not opportunities to improve efficiency with experience (i.e., time spent with a patient is time spent with a patient). A budget-neutral payment system, with overestimates of physician time for some services that can become more efficient over time, left uncorrected can lead to passive devaluation of other services like E/M services that are physician time intensive.[124] For this reason, identifying mispriced services and adjusting valuation is critical to the integrity of the PFS.

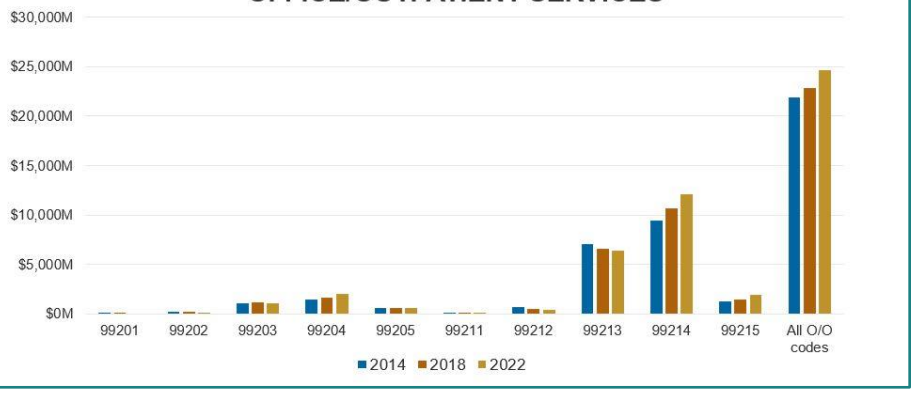
Improving Valuation for Office and Outpatient Visits

The longstanding concerns about undervaluation of cognitive and primary care services prompted recommendations to redistribute payments within the PFS away from higher valued services like procedures

and tests toward certain types of primary care services.[125,126] This change was most notable in CY 2021 when CMS implemented overall reimbursement increases of approximately 28 percent[127] for office and outpatient E/M services and streamlined documentation requirements. This spike, in turn, triggered a statutorily required budget neutral adjustment to the conversion factor. Though most physicians can attribute some portion of PFS reimbursement to E/M billing, for some specialties, such as primary care specialties like geriatrics, family practice, and internal medicine, E/M accounts for more than 90 percent of their PFS payments (**Appendix A**).

The bulk of office and outpatient E/M spending is centered on established patient visits, which require low to moderate level medical decision making (HCPCS 99213 and 99214 respectively); however, a snapshot of three points in time suggests a shift to more involved visits (99214) is occurring (see Figure 12). Though office and outpatient visits represent the largest share of E/M services, several categories of services fall under the E/M umbrella, with multiple codes in each category (**Appendix B**).

FIGURE 12. TOTAL ALLOWED CHARGES ($M) FOR OFFICE/OUTPATIENT SERVICES



Source: Physician/Supplier Procedure Summary (PSPS) Part B Data Files and Physician Fee Schedule Final Rule's Addendum B for 2014, 2018 and 2022

Improving Valuation for Psychotherapy and other BH Services

Consistent with the increase in the office patient visit codes, CMS increased the work valuations for psychiatric diagnostic evaluation and for psychotherapy services. CMS also took additional steps this year (2024) to further improve valuation of the psychotherapy code set with an upward adjustment of approximately 19 percent when fully implemented after a four-year phase in. AMA pushed back[128] against this change, noting that the calculation used to increase reimbursement for these services is not resource-based, violating the statute that requires relative values be based on resource costs.

CMS also previously identified anomalies in its rate-setting methodology for practice expense reimbursement that affects primary therapy and counseling services valuation. To correct this issue and improve payments for behavioral health services, CMS established a minimum value of expense reimbursement for these services and transitioned the change into the system over a four-year period, resulting in about a $40 million aggregate increase for behavioral health services once fully implemented in

CY 2021.[129] CMS continues to seek comment on whether further improvements to reimbursement for these services are warranted.

Boosting Primary Care and Access to BH Through the Creation of New Codes

Improved valuation of existing services under the PFS is one means of addressing concerns that low reimbursement for primary care contributes to access barriers to preventive services, necessary care, and care coordination. Another mechanism would be to establish new codes and payment for services that were not previously recognized for reimbursement. CMS generally looks to the CPT® Editorial Panel to determine when new billing codes should be introduced to reflect changes in medical practice. Over the past decade, the panel has developed new codes to report care coordination services, and CMS ultimately adopted its approach to revising the coding structure and documentation requirements for office and outpatient E/M services.

CMS also has latitude to establish new codes and exercised this authority to modernize and align the system with evolving care delivered in a comprehensive, coordinated, team-based approach.[130] For example, CMS now recognizes payment for activities provided by or under the supervision of the physician to communicate and coordinate with patients, families, caregivers, and/or other healthcare professionals as distinct physician services that previously were ineligible for reimbursement. This expansion began when the agency established separate payment for activities to assist patients as they transition from the facility setting to their home and has continued to include:

- Services to provide chronic care management over the course of a month
- Consultations between treating physicians and other professionals (e.g., collaborative care model)
- Other communication-based encounters and interactions
- Additional payment for visits that are inherently complex (e.g., G2211)
- Administration of social determinants of health (SDOH) risk assessments furnished during certain types of encounters
- Community health integration services to address SDOH
- Services to help patients navigate care when living with a high-risk or serious illness or healthcare condition,
- Cognitive care assessment and planning services
- Caregiver training services

Though these new codes are designed to improve the quality of care by paying for the types of services that were not previously reimbursable under FFS, uptake remains low (e.g., chronic care management and transitional care management,[131] collaborative care model[132]) or it is too soon to assess the impact (e.g., SDOH risk assessment, community health integration).

Calls for Broader Reform of Primary Care Payment

Though commendable, the primary care community remains concerned that these efforts are insufficient to address the significant challenges it is facing.[133,134] Primary care advocates suggest that FFS payment is the problem,[135] that a granular, incremental code-by-code approach is insufficient and may never fully account or appropriately pay for the spectrum of activities involved in the provision of primary care services.[136] These researchers and advocates are calling for comprehensive change and immediate payment reform to improve primary care and achieve person-centered, relationship-based, high-value care.[137]

A range of recommendations have been put forth including splitting the PFS in two, with one payment schedule for E/M services and the other for everything else. This approach would insulate primary care services from passive devaluation and budget neutral reductions driven by specialty care increases.[138]

The National Academies of Sciences, Engineering, and Medicine (NASEM) have recommended more fundamental reforms, calling for CMS to implement a hybrid payment model in the PFS for primary care services. The hybrid model would apply a combination of population-based payment (PBP)—which includes capitation, large bundles, or per member per month (PMPM) payment concepts—and FFS reimbursement to achieve primary care transformation and begin to address workforce shortages.[139] For example, some proponents of a hybrid system suggest services such as preventive care, chronic care management, and integrated behavioral health are well-suited for PMPM payment, whereas diagnostic testing and treatment of nonemergency acute events are best kept under a FFS model.[140]

Development of a hybrid system requires further evaluation including which services are paid under the PBP, what remains FFS, how to establish necessary safeguards to prevent underutilization of care under capitation, continued documentation of services provided on claims, and others; however, proponents are calling for immediate steps to implement a hybrid payment model.[141] Researchers, clinicians, and advocates suggest that CMS has the authority to implement these reforms in the Medicare Shared Savings Program (MSSP) and in the PFS through CMS rulemaking, but acknowledge that Congress needs to clarify ambiguities regarding CMS authority in statute or direct implementation of such a program in the PFS.

Issue #4. Emerging Technologies

Digital health technologies encompass numerous types of applications used in healthcare operations, revenue cycle management, and clinical care.[142] The topic is expansive and can range from health information technology (IT), prescription digital therapeutics (PDTs), software algorithms, remote patient monitoring (RPM), telehealth, and more (see text box).[143,144] Regulation and oversight of digital technology is outside of CMS's purview; however, coverage and payment for innovations used in direct patient care or to enable care management, coordination and communication is part of dialogue about modernizing Medicare and at the forefront of some stakeholder priorities.[145]

This turn of events is in part because availability of these types of services is transforming care delivery and moving patients from facility and traditional settings to their communities and home. The potential to scale physicians' services and help address workforce shortages and burnout, increase access, improve disparities, outcomes and possibly, reduced costs, for physical and behavioral health, is part of the perceived promise of digital health technology adoption.[146,147] Conversely, uptake can be hampered when the technology infrastructure is inadequate, or for certain technologies, reliable internet access is unavailable or too costly. This creates new barriers to consider and may contribute to the digital divide in rural areas and disconnected urban localities.[148,149]

CMS has stated its intent to establish separate payment for innovations that enable active management and ongoing care of beneficiaries.[150] Most notable, the use of telehealth increased more than 10-fold because of flexibilities afforded to ensure continuity of care during the COVID-19 public health emergency (PHE). This growth has been accompanied by expansion in the types of services available to be delivered via telehealth. Originally, under the Balanced Budget Act of 1997, only consultations were covered,[151] but as of 2024, 268 services with distinct billing codes may be furnished, either permanently or provisionally, as telehealth-eligible services.[152]

Examples of Digital Health Technologies

Telehealth: The use of electronic information and telecommunications technologies to furnish care when the clinician and patient are in different locations. Telehealth visits may involve live video, telephonic interaction, communications through online patient portals, and so on.

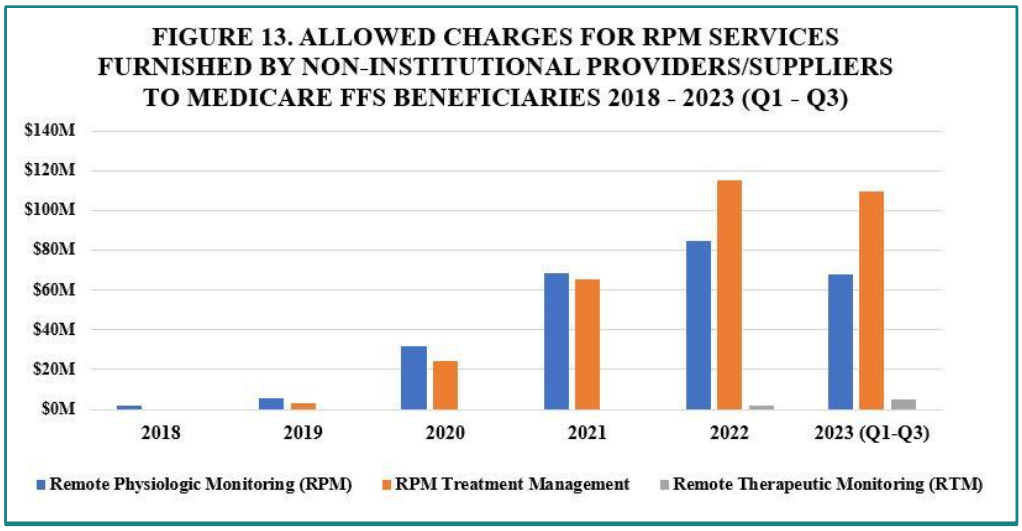
Remote Patient Monitoring (RPM): Services used to support the overall management of a beneficiary's acute or chronic condition. RPM devices and technologies connect physicians to their patients around the clock and facilitate identification of trends in patient health through physiologic data collection (remote physiologic monitoring), resulting in health alerts requiring escalation, care management and medical decision making. Remote therapeutic monitoring involves non-physiologic and patient-reported data to assess adherence and response to therapy for certain conditions.

Software as a Medical Service (SaaS): Technologies that rely on complex algorithms or statistical predictive modeling to aid in the diagnosis and treatment of a patient's condition. Services that CMS refers to as SaaS may involve artificial intelligence applications.

Artificial Intelligence (AI): Expert systems, machine learning and/or algorithm-based services with intended clinical use. Medical services and procedures are classified into three broad AI categories. Assistive AI detects clinically relevant data. Augmentative AI analyzes and/or quantifies data to yield clinically meaningful output. Autonomous AI interprets data and independently generates clinically meaningful conclusions with varying levels of physician involvement.

Sources: Definition of SaaS from 87 FR 44502. AMA CPT® AI taxonomy for medical services and procedures. The information presented here is simplified, see the full taxonomy for additional detail.

The use of remote patient monitoring and associated treatment management that involves communication with the patient or caregiver is also increasing (see Figure 13). Some types of RPM services have been available for several years, such as monitoring cardiovascular disease;[153] however, general remote physiologic monitoring and condition-specific remote therapeutic monitoring (RTM) are relatively new services with coding and payment established in 2019 and 2022, respectively. Infrastructure costs, data governance, patient safety, patient engagement and development of clinical protocols are necessary to set up and operate remote monitoring systems, thus requiring resource investments to implement remote patient monitoring.[154] CMS recognized the need to facilitate access by establishing payment policies for these services within the PFS and for certain safety net providers paid under different systems, including rural health clinics (RHCs) and federally qualified health centers (FQHCs). CMS also recognizes the necessity of program safeguards and has established minimum data collection and documentation requirements to report these services.



Source: 100% 2018-2023 (Q1-Q3) Carrier Standard Analytic File (SAF). HCPCS codes included in analysis: RPM: 99453, 99454, 99091, RPM TM: 99457, 99458 and RTM: 98975, 98976, 98977, 98978

For all these technologies, the appropriate level of reimbursement, how to best protect Medicare program integrity for services provided remotely (sometimes without patient interaction), and the best mechanisms to support continued access remain the subject of debate, particularly as certain flexibilities afforded during the COVID-19 PHE are set to expire (see **Appendix G**).[155] For other innovations, such as SaaS, CMS has either deferred pricing decisions to local Medicare Administrative Contractors (MACs) or employed an alternative approach to standard PFS rate setting methods to set payment amounts, as these services do not fit well within the current definitions and structure of the fee schedule.[156]

Appropriate coding and payment will be at the forefront of discussion as new innovations continue to emerge and expand, including whether each new application receives discrete payment, if a single payment level for a range of solutions and associated costs is appropriate, or if bundled payments are desirable. These considerations may be exacerbated in an FFS system such as the PFS. Because alternative payment models better align financial incentives with improvements in population health, these issues may be less pertinent as the provision of value-based care becomes more prevalent.[157]

Summary of PFS Structural issues

The PFS system of reimbursement is based on statutory requirements and is nuanced with several processes and complex methodologies used to set rates for clinicians' services. CMS and its partners have worked extensively for several years to update data sources and mechanisms to improve the accuracy and adequacy of reimbursement levels. Structural issues (some outside of CMS's authority) and key highlights are presented in Figure 14 below.

Figure 14. Summary of Structural Issues in the PFS

Budgetary Concerns	» System in near-constant state of transition. Lack of stability and inflationary update may incentivize vertical integration between practitioners and health systems. » Affordable and accessible care is critical to patients' health. » Stakeholders aligned on need for payment security and concern for prosperity of community practice. » Any update to budget neutrality requirement is outside CMS authority, only methodologies and redistribution via rate-setting within bounds.
Valuation Process & Pricing Distortion	» CMS presupposes services are valued correctly to maintain system integrity.[1] » Conflict of interest concerns with AMA's RUC (CMS's main collaborator in valuation). » Heavy reliance on physician survey data that is viewed as incomplete at best, inherently biased at worst. » Structural components of the PFS allow physicians' services to become misvalued over time. » Distorted work and/or practice expense values for certain services.
Adequately Supporting Primary Care, Care Coordination, and Behavioral Health	» Chronic undervaluation has led to inequities between cognitive/longitudinal vs. episodic-based care, amplified by current workforce crisis. » Fee schedule passively devalues services that do not experience efficiency gains from technology, techniques, and clinical practice (i.e., most codes in primary and behavioral health care). » While CMS has begun to address issue in recent years, some urge complete overhaul of payment system.
Emerging Technologies	» Potential influx of new technology-based services that are not easily incorporated into current system. » New technology may introduce questions on data governance, digital equity, safeguards to patient safety and Medicare program integrity, and appropriate payment policy. » Coding system incentivizes technology innovators to seek reimbursement for each individual item.

Source: Health Management Associates research and analysis.
Figure notes: 1) See page 78890 of Medicare Physician Fee Schedule CY 2024 Final Rule (88 FR 78818)

RECOMMENDATIONS FOR STRENGTHENING THE SYSTEM WITHIN CMS AUTHORITY

CMS has issued several requests for information on how the agency can improve its processes, methodology, and data collection to make more accurate payments that reflect the evolving practice of medicine.[158] The agency's most recent request in the CY 2024 rulemaking cycle reflects the culmination of concerns stakeholders have raised and the agency's efforts to balance competing demands for stability and accuracy.[159] Given these CMS comment solicitations, many recommendations are in the public domain and are the basis of several of the suggestions outlined below. These recommendations are presented to help prioritize actionable steps, prompt idea generation for change and process improvement. Overarching recommendations include:

- Immediate action to evaluate and address services where indicators suggest a pricing concern
- Further improve transparency and increase stakeholder engagement
- Employ greater aggregations in rate setting, measurement, and service level payments
- Incentivize the transition to AAPMs with additional flexibilities not afforded under the PFS

Immediate Action to Evaluate Services Where Indicators Suggest Review Is Warranted

Drive the Review of Potentially Misvalued Services with an Initiative "Refresh"

CMS initially drove the misvalued services agenda by, for example, analyzing data and providing lists of codes in rulemaking for immediate review by the RUC.[160,161] In more recent years, CMS has deferred to the RUC for codes to review and has not aggressively pursued review of misvalued codes. CMS should again set the agenda and expectations of what changes it wants to emerge from the misvalued code review while continuing to accept public nominations and services identified by the AMA/Specialty Society RUC. As part of a misvalued services refresh, CMS should assess current and previously used criteria and refresh with a new CMS generated review. CMS also should consider variations or new criteria under its authority to identify other codes.

Identify Services with Notable Growth in Allowed Charges

As an illustration, Figure 15 presents services with more than $10 million in total allowed charges in CY 2022 (the most recently complete year of data) that also experienced more than 10 percent growth in allowed charges for three consecutive years (like CMS's fastest growing and high expenditure screens). While some of these services may have been reviewed previously, if more than five years has elapsed, the services should be newly identified. Notable growth screens could serve as early warning signals and identify services that warrant further consideration as has been done in prior years. As noted in subsequent recommendations, CMS could facilitate improved access to this type of information on a misvalued services section of the CMS website. While notable, it is important to recognize that spending is only one metric, and there may be clinically or policy appropriate and desirable reasons for growth, including improved access and uptake of an emerging technology.

Figure 15. High Expenditure PFS Services with More than 10 Percent Growth in Allowed Charges for Three Consecutive Years, 2018-2022 (excluding 2020 due to the PHE)

HCPCS	Short Description	2022 Allowed Charges ($M)	Annual Growth in Allowed Services (2018-2019)	Annual Growth in Allowed Services (2019-2021)	Annual Growth in Allowed Services (2021-2022)	Growth in Allowed Services (2018-2022)
97530	Therapeutic activities	$1,015.37	25%	13%	22%	72%
97112	Neuromuscular reeducation	$760.96	22%	16%	15%	63%
97116	Gait training therapy	$97.24	17%	28%	15%	70%
36465	Njx noncmpnd sclrsnt 1 vein	$94.83	143%	85%	12%	403%
97535	Self care mngment training	$87.74	19%	28%	19%	81%
93656	Compre ep eval abltj atr fib	$77.34	14%	13%	10%	43%
72197	MRI pelvis w/o & w/dye	$61.22	14%	11%	12%	41%
92507	Speech/hearing therapy	$41.88	23%	19%	26%	86%
99358	Prolong service w/o contact	$37.16	69%	42%	13%	171%
97610	Low frequency non-thermal us	$34.90	233%	481%	135%	4445%
G6001	Echo guidance radiotherapy	$33.18	164%	133%	56%	856%
33340	Perq clsr tcat l atr apndge	$31.45	40%	60%	35%	202%
93298	Rem interrog dev eval scrms	$28.60	26%	20%	16%	76%
G0277	Hbot, full body chamber, 30m	$28.18	70%	71%	20%	250%
65820	Relieve inner eye pressure	$27.68	53%	24%	64%	212%
99483	Assmt & care pln pt cog imp	$26.08	50%	100%	21%	263%
37243	Vasc embolize/occlude organ	$25.49	13%	59%	25%	123%
75574	Ct angio hrt w/3d image	$21.72	15%	17%	20%	60%
95251	Cont gluc mntr analysis i&r	$18.95	75%	72%	25%	276%
92526	Oral function therapy	$17.85	19%	20%	25%	77%
52287	Cystoscopy chemodenervation	$17.50	22%	17%	14%	64%
95800	Slp stdy unattended	$16.65	13%	112%	128%	447%
93297	Rem interrog dev eval icpms	$16.05	15%	16%	11%	48%
96574	Dbrdmt prmlg les w/pdt	$15.86	66%	12%	15%	114%
97166	Ot eval mod complex 45 min	$14.62	15%	22%	24%	73%
61624	Transcath occlusion cns	$11.66	17%	14%	13%	50%
77401	Radiation treatment delivery	$11.51	24%	84%	17%	167%

Source: 2018-2022 Physician/Supplier Procedure Summary (PSPS) data. Data from 2020 not included in the above illustration because of the PHE effect on service use. Only includes PFS codes defined by status indicator A, C, R, T, and J for each year and HCPCS codes in 2018, 2019, and 2021 that were still available in 2022.

*Note: **Appendix D** presents the same information for services with more than $1 million in total 2022 allowed charges.*

Refer Services for Review to the Public through Sub Regulatory Processes

A CMS-driven agenda for a misvalued services refresh should coincide with a push for interested party engagement through an open call for review. Historically, CMS has referred services identified as potentially misvalued to the AMA/Specialty Society RUC. Though this committee has worked extensively for decades to

provide CMS with data on how physician work and practice expenses have changed over time, the process is time consuming, sometimes extending for years. CMS can signal its intent to address specific codes through an online posting. CMS also could consider proposing new values for services within a specified, reasonable timeframe to help refine values more quickly, even if AMA/Specialty Society RUC or interested party review is incomplete. An open call for review through sub-regulatory processes, combined with the central repository recommendation below, will open an additional avenue for stakeholder response and participation.

Improve Transparency and Increase Stakeholder Engagement

Create a Central Repository on Physician Work Data and Methods on the PFS Section of the CMS Website

Some people who are familiar with the PFS have referred to rate setting as an "insiders" game,"[162] and reporters have raised concern about disclosure restrictions and delayed access to minutes from AMA/Specialty Society RUC meetings.[163] Though concerns about inappropriate release of proprietary information are valid, the control of information related to services reviewed, how recommendations to CMS are developed, and the timing of available information place the interested public at a disadvantage. CMS should rectify this situation to the maximum extent within agency purview.

CMS provides background and rationale for proposals in PFS notices of proposed rulemaking (NPRMs), has previously published AMA/Specialty Society RUC standards[164] for public consideration, and posts public use files on its website; however, full access to understand physician work data and methods involves mining these and other data sources.[165] CMS could improve transparency and better facilitate the public's access to and understanding of the critical background information necessary to fully critique or supplement information used to develop work RVUs.

For example, a central repository of the guidelines, standards, and methods the CMS requires and that the AMA/Specialty Society RUC follows to generate its recommendations is not readily apparent. Lists of services the AMA/Specialty Society RUC maintains, periodically reviews, and forwards to CMS, do not appear to be in fully accessible and searchable formats (for example the 828 services on the new technology services list or those codes with work RVUs based on the original Harvard[166] values).[167] Interested parties may submit a request (with a stated reason) to attend a RUC meeting, but may not have access to the background materials, methods, and results under discussion.

Minutes are ultimately published but with significant delay. The most current AMA/Specialty Society RUC recommendations accessible to the public are from the January 2023 meeting[168] and contain recommendations discussed in the CY 2024 PFS NPRM. Since then, the RUC has met three times to discuss codes and recommendations pertaining to the CY 2025 PFS. Though proprietary concerns may underlie restricted access to timely information, including reasons related to publication of the annual CPT coding manual[169] and concerns about the possibility of insider trading, serious consideration should be given to how CMS can further improve transparency through a centralized and accessible repository of information on physician work data and methods.

Establish a Misvalued Service Refresh Section of the Central Repository with Extended Timeframes.

Improving transparency includes establishing a potentially misvalued services refresh section in the central repository. This section should contain a complete list of PFS services, including the date of last review. This section also should include newly generated lists of services for potential future review. A CMS posting of services that meet specific criteria will increase awareness, stakeholder engagement, and potentially generate a clinical rationale for the service's identification or serve as an early warning system, particularly if other indicators also raise the potential need to correct the valuation.

Convene a Series of Town Halls to Evaluate Potential Reforms in Physician Work Valuation

CMS used a town hall process in 2006,[170] 2021,[171] and 2023[172] to clarify agency practice expense-related proposals, gain additional stakeholder input, and discuss methodology, improvements, or intended changes in payment. CMS should convene a similar series of town hall meetings on potential future reforms to the physician work component of payment.

Reconsider Stakeholder Requests for a PFS Panel or Committee

Stakeholders with seemingly opposite positions on PFS reform call for establishment of a PFS advisory committee or panel to further deliberate, evaluate or discuss contentious issues, concerns, or new approaches. Though parties calling for an additional avenue for CMS to receive input and advice have different reasons for doing so (for example, some want an appeals process,[173] while others want a single Federal Advisory Committee Act-compliant expert advisory panel [EAP][174] to complement CMS's reliance on the AMA/Specialty Society RUC), the desire for an additional forum for discussion is apparent. A panel or committee to assist agency staff in its deliberations of PFS policy might increase capacity, transparency, and stakeholder engagement if scoped to focus on new business, policy, and methods rather than dispute resolution.[175]

Of note, Congress previously directed the establishment of physician payment advisory commissions[176] or councils[177] (since decommissioned) and established a technical advisory committee to provide recommendations to the HHS Secretary regarding alternative physician-focused payment models. Other advisory panels assist the agency in its consideration of payment policy for other systems. If Congress were to direct the formation of a new physician advisory commission, consideration should be given to how effective previous or other payment panels have been in advising CMS.

Employ Aggregations in Rate Setting, Measurement, and Service Level Payments

Moving from granular accounting of resources and associated payment levels toward greater aggregation within the PFS could help shift the physician reimbursement mindset from developing RVUs and separate reimbursement for each item and service toward value-based payment and total cost of care constructs. Other CMS payment systems (notably the Outpatient Prospective Payment System) have used service groupings and cost bands. Similar concepts could be incorporated into the PFS.

Greater Aggregations in Rate Setting Methodology

Researchers and experts studying the physician work and practice expense components of physician reimbursement have identified where valuation methodologies might move from a granular approach to larger groupings.

Within physician work, suggestions to establish intensity bands for service valuation is one such innovation. Under this approach, a service is still individually reimbursed, but rather than developing underlying estimates of intensity for each billing code, an intensity grouping could be selected and used to value the service.[178,179] For families of services, this process might include identifying an "anchor" code that is highly utilized with a generally agreed upon intensity metric. All services within the family could be assigned the same intensity measure and a similar work RVU absent compelling evidence to the contrary. CMS initiated a discussion of gradations for intensity of services in the request for comment contained in the CY 2024 PFS proposed rule[180] and could continue to move toward change through work rate setting town hall discussions as mentioned previously.

With regard to the practice expense component, researchers at RAND have suggested clustering specialties that provide similar services or that maintain similar cost structures for purposes of calculating indirect practice expense RVUs rather than maintaining unique data points for more than 50 different specialties.

Greater Aggregations of Codes and Payment

The idea of clustering could also be used to identify families of billing codes that might be appropriate to collapse into a smaller set of services. For example, CMS could look at the distribution of volume for services within a family of codes and determine whether most claims are clustered within a few specific services. That might serve as a criterion for further consideration. If several codes within a family are used infrequently, it might serve as a prompt for further consideration to determine whether separate reporting with separate measures of work and practice expense are necessary or if potential bundling into fewer billing codes is appropriate. Though all codes in a family could be maintained for coding and nomenclature specificity, CMS could require demonstrated differences in work or practice expense to justify different valuation for a specific service in the family.

When services are accurately valued, MedPAC generally supports efforts to move Medicare toward bundled payments (a single payment for multiple items or services).[181] The AMA CPT Editorial Panel and the AMA/Specialty Society's RUC relativity assessment workgroup have worked with CMS to identify services commonly furnished and reported on claims together to consider when services should be bundled rather than separately reported and paid. CMS could pursue additional code bundling options within the PFS.

Greater Aggregations in Measurement

Whether separately reported or increasingly bundled, the ability to track service provision is critical to a well-functioning system. Services must be reported on claims to facilitate research on the Medicare population, the care beneficiaries receive, and the quality and outcomes of that care. Tracking service level utilization is important and part of several criteria to identify potentially misvalued services. CMS could also consider analyses to monitor overall trends as part of its efforts to assess and maintain payment accuracy within the PFS. For example, assessing growth in payments or volume at the specialty or service category level over a 10, 5, or 3-year period might identify trends in service provision sooner and allow CMS to assess and respond earlier if a trend warrants further investigation or expansion.

For example, as workforce constraints and changes in state scope of practice laws prompt greater reliance on advanced practice providers, further research to understand where and how nurse practitioners and physician assistants are practicing will help CMS and Congress consider appropriate payment policies or improvements. When these professionals independently bill for their services, claims data are available;

however, the NP's or PA's specialty is omitted. When advanced practice nurses and PAs furnish care "incident to" a physician's service, the physician bills the claim and the provision of care by the NP or PA is not visible to Medicare in claims data; thus, CMS cannot determine that the service was furnished by the advanced practitioner.

CMS could facilitate better tracking of care that advanced practice nurses and PAs provide in two ways. First, require NPs and PAs to list a second specialty on claims to designate the clinical area in which they furnish care (e.g., a primary care related specialty designation or a specific specialty). Second, for care furnished incident to a physician's service, Medicare could institute a modifier or other mechanism to identify this on claims. Doing so would facilitate further study of the increased use of advanced practice professionals who furnish care to Medicare beneficiaries. It would also be useful in assessing MedPAC's prior recommendation to eliminate incident to billing (paid at 100% of the PFS rate) and instead require NPs and PAs to directly bill all their services (paid at 85% of the PFS rate).[182]

Incentivize the Transition to AAPMs with Additional Flexibilities and Different Approaches to Payment

CMS would like to have all Traditional Medicare beneficiaries enrolled in accountable care arrangements by 2030. To that end the agency is exploring new model designs and other incentives to attract provider participants into these models. The recently announced ACO Primary Care Flex Model will assess how prospective payments and increased funding for primary care in ACOs will impact health outcomes, quality, and costs. This new approach to primary care holds great promise. CMS should also explore how to incentivize providers to deliver more care in the home or other community-based settings where beneficiaries feel most comfortable and are in the best position to manage their care. Further, opportunities to deliver in-home services may prevent trips to the emergency department and hospitalizations. If a patient does have an acute need, familiarity with home-based care may make them more comfortable with more intense home-based services, such as Hospital at Home or other rehabilitation services. The ACO REACH (Realizing Equity, Access, and Community Health) model has built a foundation for this type of payment with incentives to take care of the sickest patients in alternative sites of service. CMS should find ways to continue ACO REACH or, if that is not legally possible, then take key lessons learned from that model and design a new model that incentivizes state of the art care using current technology and best practices.

In addition to alternative payment approaches, CMS should use the Innovation Center waiver authority to give physicians and practitioners more flexibility to deliver care. CMS operates under the assumption that the incentives in risk-based APMs will ensure that physicians and ACOs will effectively manage their patient populations, and if they overutilize resources or deliver inappropriate services, the quality and financial requirements of the model will hold them accountable for these poor decisions. Therefore, CMS should conduct more systemic reviews of existing payment policies that may be creating the inappropriate incentives for specific total cost of care models. The exact waivers will need to vary by model, but more flexibility in incident to requirements, services provided in the home or post-acute setting, or greater use of alternative provider types could encourage physicians to participate in APMs. These flexibilities can make practicing medicine easier, removing certain administrative and regulatory burdens that often frustrate providers.

CONCLUSION

The Medicare PFS is the basis of payment for services furnished by professionals (physicians, other clinicians, and certain other suppliers) to FFS beneficiaries, and other payers use it to set reimbursement rates. Since the PFS was implemented in 1992, the Medicare program has changed dramatically, including an increase in the number of beneficiaries, the addition of new benefits, and rapid growth in Medicare Advantage, all in the broader context of overall healthcare reform in the United States. The healthcare delivery landscape has shifted considerably over the past three decades, with the movement to value-based care, focus on the balance between primary and specialty care, consolidation of physician practices, the introduction of new technologies, and much more. Although CMS has implemented a considerable number of changes in the PFS over the years to address the need for payment updates, relative value refinements, and other specific issues, the PFS has never been subject to a major statutory overhaul that would comprehensively address pressing issues or better align the system with changing practice structures.

Congress is now grappling with the question of how to reform the PFS in the context of this evolving ecosystem, with potential solutions including providing an automatic payment update similar to the market basket updates hospitals and other providers receive, incentivizing participation in APMs, extending neutrality of payments between physician offices and hospital outpatient departments, dealing with workforce issues, and promoting high-quality, comprehensive, and coordinated care for beneficiaries with chronic conditions. While these efforts are under way, CMS can take steps to strengthen the PFS using its authority and facilitate change through regulatory and sub-regulatory processes.

For example, CMS could lead a refresh of efforts to identify misvalued services to drive the agenda on payment reform within the PFS, further opening the process to determine and update relative values to the interested public, employing greater aggregations in rate setting, and providing more flexibility to promote APM participation. CMS should evaluate how to better leverage its authority under the Protecting Access to Medicare Act (PAMA) section 220(a)[183] to use any mechanism the HHS Secretary deems appropriate to improve the valuation of services under the PFS. Doing so will help address distortions and position the PFS as a glide path to achieve CMS's accountable care goal by 2030.

Appendices

APPENDIX A. PFS SPENDING FOR TOP 10 BILLING SPECIALTIES IN CY 2022

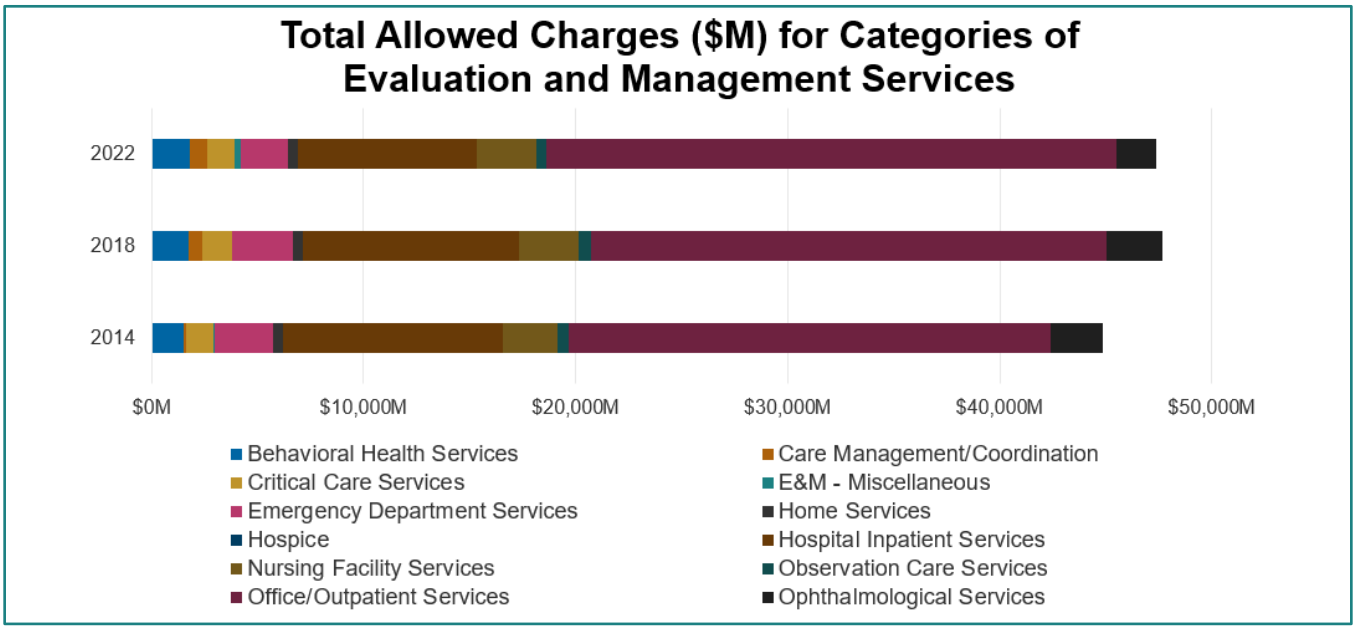
For online viewing of the complete table, please click here.
To download a sortable Excel file of the complete table, please click here.

CMS Specialty	No. of Practitioners	2022 Allowed Charges ($M)	% From E/M	% From Procedures	2022 Top Billed Service ($)	2022 Top Billed Service ($) Description
Internal Medicine	110,655	$8,553	92.75%	2.05%	99214	Office o/p est mod 30-39 min
Family Practice	95,997	$5,587	92.49%	3.73%	99214	Office o/p est mod 30-39 min
Nurse Practitioner	215,499	$5,450	90.69%	6.05%	99214	Office o/p est mod 30-39 min
Diagnostic Radiology	33,616	$5,026	0.37%	7.77%	77067	Scr mammo bi incl cad
Ophthalmology	18,428	$4,854	42.88%	42.72%	92014	Eye exam&tx estab pt 1/>vst
Cardiology	23,981	$4,848	47.12%	11.11%	99214	Office o/p est mod 30-39 min
Physical Therapist in Private Practice	82,992	$4,210	0.06%	1.39%	97110	Therapeutic exercises
Dermatology	13,242	$3,629	27.88%	63.98%	99213	Office o/p est low 20-29 min
Orthopedic Surgery	23,993	$3,513	30.14%	60.80%	27447	Total knee arthroplasty
Physician Assistant	116,278	$2,935	73.81%	22.43%	99214	Office o/p est mod 30-39 min

Sources: 2018 and 2022 PSPS Data Files, 2018 and 2022 Physician Fee Schedule Final Rule Addendum B, 100% 2022 Carrier Standard Analytical files from VRDC, 2023 Restructured BETOS Classification System data file.

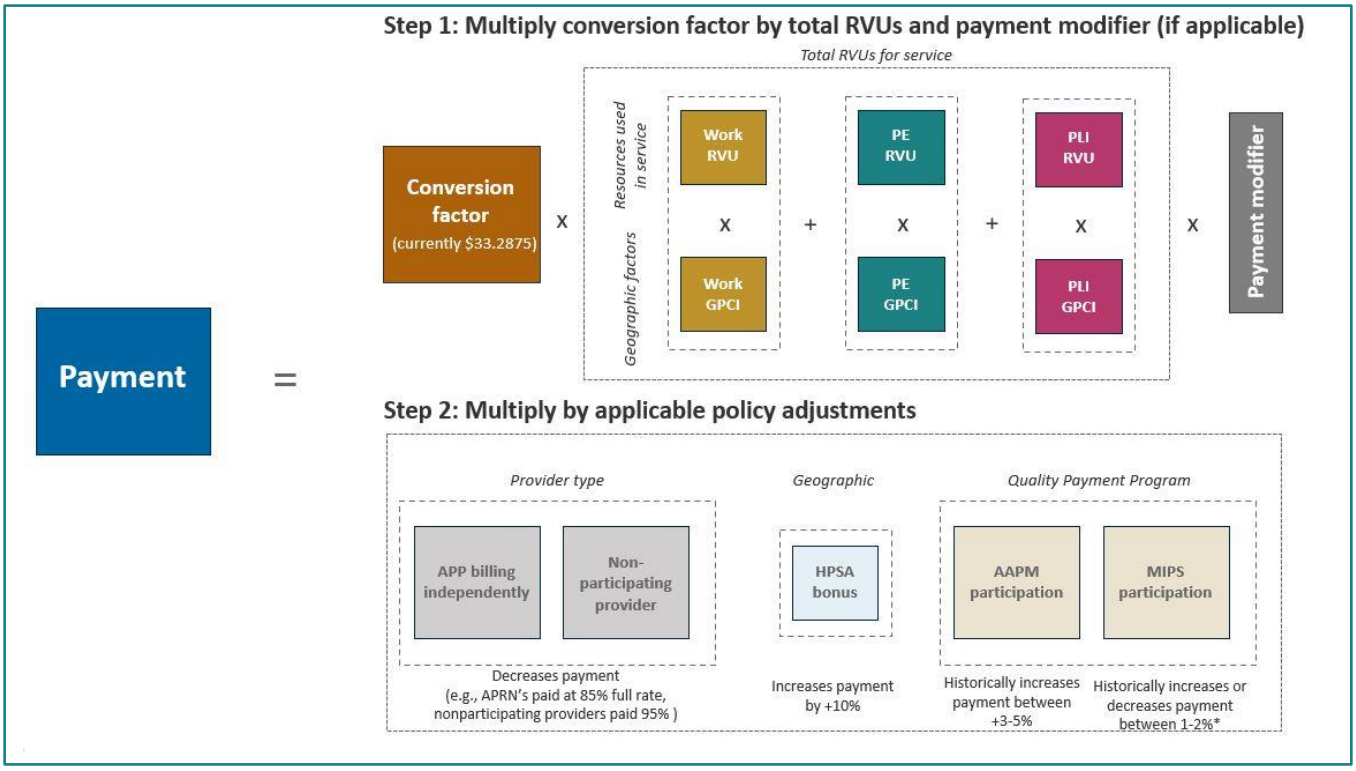
Notes: Only top ten billing specialties under PFS CY 2022. Only includes PFS codes defined by status indicators A, C, R, T, and J. Includes codes that are included in the PSPS Part B data file and Addendum B for that year. Data are sorted by 2022 total allowed charges (both non-facility and facility charges). CMS data use agreements require that cells containing between one and ten observations or those from which that range of data could be identified, be blinded. Blinded values are indicated with an asterisk (*).

APPENDIX B. PFS ALLOWED CHARGES BY E/M CATEGORY, 2022



Source: 2014, 2018, 2022 PSPS Part B Data Files, 2014, 2018, 2022 Physician Fee Schedule Final Rule Addendum B, 2023 Restructured BETOS Classification System Data File. Behavioral health services include psychotherapy services as per RBETOS classifications.

APPENDIX C: DETAILED PFS PAYMENT EQUATION



Source: MedPAC. Payment Basics: Physician and Other Health Professional Payment System. Revised October 2023. Available at: https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf

APPENDIX D. HIGH EXPENDITURE PFS SERVICES WITH ALLOWED CHARGES OVER $1 MILLION IN CY 2022 AND THREE CONSECUTIVE YEARS OF 10 PERCENT OR MORE CONSECUTIVE GROWTH

For online viewing, please click here.
To download a sortable Excel file, please click here.

HCPCS	Short Description	2022 Allowed Charges ($M)	Annual Growth in Allowed Charges (2018-2019)	Annual Growth in Allowed Charges (2019-2021)	Annual Growth in Allowed Charges (2021-2022)	Growth in Allowed Charges (2018-2022)
97530	Therapeutic activities	$1,015.37	25%	13%	22%	72%
97112	Neuromuscular	$760.96	22%	16%	15%	63%
97116	Gait training therapy	$97.24	17%	28%	15%	70%
36465	Njx noncmpnd sclrsnt 1	$94.83	143%	85%	12%	403%
97535	Self care mngment	$87.74	19%	28%	19%	81%
93656	Compre ep eval abltj atr	$77.34	14%	13%	10%	43%
72197	MRI pelvis w/o & w/dye	$61.22	14%	11%	12%	41%
92507	Speech/hearing therapy	$41.88	23%	19%	26%	86%
99358	Prolong service w/o	$37.16	69%	42%	13%	171%
97610	Low frequency non-	$34.90	233%	481%	135%	4445%
G6001	Echo guidance	$33.18	164%	133%	56%	856%
33340	Perq clsr tcat l atr apndge	$31.45	40%	60%	35%	202%
93298	Rem interrog dev eval	$28.60	26%	20%	16%	76%
G0277	Hbot, full body chamber,	$28.18	70%	71%	20%	250%
65820	Relieve inner eye	$27.68	53%	24%	64%	212%
99483	Assmt & care pln pt cog	$26.08	50%	100%	21%	263%
37243	Vasc embolize/occlude	$25.49	13%	59%	25%	123%
75574	Ct angio hrt w/3d image	$21.72	15%	17%	20%	60%
95251	Cont gluc mntr analysis	$18.95	75%	72%	25%	276%
92526	Oral function therapy	$17.85	19%	20%	25%	77%
52287	Cystoscopy	$17.50	22%	17%	14%	64%
95800	Slp stdy unattended	$16.65	13%	112%	128%	447%
93297	Rem interrog dev eval	$16.05	15%	16%	11%	48%
96574	Dbrdmt prmlg les w/pdt	$15.86	66%	12%	15%	114%
97166	Ot eval mod complex 45	$14.62	15%	22%	24%	73%
61624	Transcath occlusion cns	$11.66	17%	14%	13%	50%

77401	Radiation treatment	$11.51	24%	84%	17%	167%
20985	Cptr-asst dir ms px	$9.11	24%	24%	24%	90%
0275T	Perq lamot/lam lumbar	$8.89	76%	134%	56%	541%
88381	Microdissection manual	$8.83	92%	105%	33%	422%
99484	Care mgmt svc bhvl hlth	$8.57	140%	186%	21%	727%
G0446	Intens behave ther cardio	$8.28	17%	13%	12%	47%
92978	Endoluminl ivus oct c 1st	$7.79	27%	18%	14%	70%
92523	Speech sound lang	$7.08	36%	40%	24%	136%
99493	Sbsq psyc collab care	$7.05	175%	147%	48%	904%
75561	Cardiac mri for morph	$6.70	17%	21%	13%	60%
27279	Arthrodesis sacroiliac joint	$6.32	28%	110%	13%	204%
61783	Scan proc spinal	$6.22	23%	17%	16%	66%
52649	Prostate laser enucleation	$5.94	15%	25%	23%	77%
93355	Echo transesophageal	$5.86	23%	22%	12%	68%
64555	Implant neuroelectrodes	$5.80	56%	174%	14%	389%
77600	Hyperthermia treatment	$5.17	17%	64%	39%	166%
75571	Ct hrt w/o dye w/ca test	$4.64	52%	52%	34%	208%
75572	Ct hrt w/3d image	$4.50	18%	21%	16%	65%
01925	Anes ther interven rad	$4.37	28%	11%	15%	63%
44146	Partial removal of colon	$4.08	14%	27%	13%	64%
20604	Drain/inj joint/bursa w/us	$3.76	18%	13%	11%	49%
97533	Sensory integration	$3.30	140%	121%	76%	833%
G0425	Inpt/ed teleconsult30	$3.21	63%	85%	12%	238%
31574	Largsc w/njx	$2.88	26%	14%	15%	66%
0055T	Bone srgry cmptr ct/mri	$2.81	75%	1321%	89%	4586%
78814	Pet image w/ct lmtd	$2.73	71%	11%	21%	129%
97542	Wheelchair mngment	$2.62	21%	35%	18%	92%
11308	Shave skin lesion >2.0 cm	$2.52	12%	12%	18%	48%
55899	Genital surgery procedure	$2.45	68%	117%	36%	395%
92524	Behavral qualit analys	$2.21	21%	20%	13%	64%
G0508	Crit care telehea consult	$2.19	148%	149%	26%	680%
0238T	Trluml perip athrc iliac art	$2.14	106%	99786%	29%	265526%
99357	Prolng svc i/p/obs ea addl	$2.06	15%	28%	12%	65%
90901	Biofeedback train any	$2.04	40%	51%	67%	253%
0501T	Cor ffr derived cor cta	$1.83	488%	1296%	538%	52227%
01160	Anesth pelvis procedure	$1.68	15%	12%	13%	45%
96405	Chemo intralesional up to	$1.66	38%	56%	26%	172%

97607	Neg press wnd tx <=50 sq	$1.62	18%	553%	39%	970%
55706	Prostate saturation	$1.32	42%	13%	32%	113%
34848	Visc & infraren abd 4+	$1.23	33%	29%	31%	124%
0483T	Tmvi percutaneous	$1.20	86%	109%	29%	401%
92979	Endoluminl ivus oct c ea	$1.15	27%	19%	16%	75%
75563	Card mri w/stress img &	$1.01	17%	17%	17%	60%
84182	Protein western blot test	$1.00	34%	49%	40%	179%

Source: 2018-2022 Physician/Supplier Procedure Summary (PSPS) data and 2018-2022 PFS Final Rule Addendum B.

Note: Includes codes that are in the PSPS Part B data file and Addendum B for that year. Only includes PFS codes defined by status indicators A, C, R, T, and J for each year. Only includes HCPCS codes in 2018, 2019, and 2021 that were still active in 2022. Only includes HCPCS codes that have more than $1 million in total allowed charges in 2022. HCPCS codes that have missing total allowed charges values are excluded from the percent change formula. Only includes HCPCS codes that have more than 10% growth in 3 consecutive years (2018, 2019, and 2021). 2020 data are not used due to the PHE impact on volume. Data are sorted by 2022 total allowed charges.

APPENDIX E. ADDITIONAL DETAIL ON POTENTIALLY INFLATED PHYSICIAN TIME AND IMPLICIT INTENSITY

We attempted to replicate the methodology researchers previously applied as discussed in the above sections using the work RVU values finalized in the CY 2024 update to the fee schedule. In doing so, we found additional instances of potentially inflated implicit intensity values. For example, the implicit intensity for an MRI of the jaw joint (HCPCS 70336) appears to be larger than the implicit intensity for surgery of complex brain aneurysm (HCPCS 61698). As earlier research indicates, we also found significant variation in implicit intensity values (see the table below). Musculoskeletal and skin codes demonstrate the most drastic variation within their Restructured Berenson-Eggers Type of Service (RBETOS) subcategories, with intensity codes varying 49- and 34-fold, respectively.

Variation in Implicit Intensity Values by RBETOS Category

RBETOS Subcategory	Maximum Implicit Intensity (wRVU/minute)	Minimum Implicit Intensity (wRVU/minute)	Fold Difference
Musculoskeletal	0.443	0.009	49
Skin	0.138	0.004	34
Pulmonary	0.055	0.005	11
Office/Outpatient Services	0.125	0.012	10
Behavioral Health Services	0.057	0.006	10
E/M - Miscellaneous	0.072	0.008	9
Physical, Occupational, and Speech Therapy	0.029	0.004	7

Ophthalmological Services	0.055	0.008	7
Eye	0.157	0.022	7
CT scan	0.068	0.012	6
Anesthesia	0.083	0.017	5
Chemotherapy	0.046	0.010	5
Breast	0.075	0.021	4
Dialysis	0.075	0.024	3
Injections and Infusions (nononcologic)	0.036	0.012	3
Emergency Department Services	0.069	0.025	3
Care Management/Coordination	0.051	0.019	3
Hospital Inpatient Services	0.047	0.018	3
Vision, Hearing, and Speech Services	0.038	0.017	2
Critical Care Services	0.080	0.040	2
Hematology	0.037	0.019	2
Molecular Testing	0.034	0.022	2
Home Services	0.037	0.026	1
Spinal Manipulation	0.043	0.031	1
Imaging - Miscellaneous	0.041	0.030	1
Nursing Facility Services	0.050	0.038	1
Observation Care Services	0.044	0.040	1
Hospice	0.030	0.030	1

Note: Several RBETOS categories were excluded due to implicit intensity values of 0.
Source: Health Management Associates modeling of the PFS CY 2024 Final Rule data

APPENDIX F. ADDITIONAL DETAIL ON NEGATIVE IWPUT VALUES

The two tables below detail findings from our replication of RAND's 2015 study of IWPUT values, presented by RBETOS and global period. Our analysis is based on the work RVU values that were finalized in the CY 2024 update, as well as the CY 2022 utilization presented in the CY 2024 update. As previously noted, negative IWPUT values are particularly concentrated in musculoskeletal procedure codes, as well as in 10- and 90-day global codes. For 10-day and 90-day global codes, a negative IWPUT likely implies an overvaluation of the postoperative E/M time. For the few 0-day global and non-global codes with negative IWPUTs, the value likely implies an overvaluation of pre-service and/or immediate post-service time. Of note, more than 60 percent of the HCPCS we identified as having negative IWPUTs were low-volume services in CY 2022 (meaning less than 10,000 PFS billed services), per the CY 2022 utilization data presented in the fee schedule's CY 2024 update.

Number of HCPCS Codes with Negative IWPUT Values by RBETOS Subcategory

RBETOS Category	RBETOS Subcategory	No. of HCPCS with Negative IWPUTs	% of HCPCS in RBETOS Subcategory	Allowed Charges Associated with Subcategory in PFS CY 2022
Procedure	Musculoskeletal	181	9.6%	7.1%
Procedure	Other Organ Systems	94	6.1%	2.4%
Procedure	Digestive/Gastrointestinal	61	9.3%	2.6%
Procedure	Cardiovascular	32	8.6%	1.3%
Procedure	Skin	29	8.1%	5.0%
Procedure	Eye	14	5.2%	4.0%
Procedure	Vascular	13	3.5%	2.1%
Procedure	Breast	1	6.2%	0.6%
Test	Neurologic	6	6.2%	0.2%
Test	Test - Miscellaneous	4	1.0%	2.6%
Test	Pulmonary	1	0.9%	1.6%
Imaging	Standard X-ray	2	1.8%	0.2%
Imaging	Nuclear	1	4.8%	0.1%
Treatment	Radiation Oncology	1	2.2%	1.8%

Source: Health Management Associates modeling of the PFS CY 2024 Final Rule data

Number of HCPCS Codes with Negative IWPUT Value by Global Period

Global code	Global code description	No. of HCPCS with negative IWPUTs
090	90-day global period	370
010	10-day global period	51
XXX	Global concept does not apply	13
000	0-day global period	9

Source: Health Management Associates modeling of the PFS CY 2024 Final Rule data

APPENDIX G. TELEHEALTH BACKGROUND

Although CMS has reimbursed telehealth services since the Balanced Budget Act of 1997 first opened the doors to doing so, the use of telehealth only accelerated meaningfully during the COVID-19 PHE as new waivers removed limitations based on location, provider type, and modality.[184] Many of the PHE provisions have been extended or made permanent,[185] as shown in the figure below.

The use of telehealth increased more than 10-fold as a result—rising from roughly 5 million visits in a nine-month period in 2019 to 53 million in the same period the following year after the onset of the PHE.[186] Though telehealth use has since declined from the highs of 2020, it remains elevated above pre-pandemic levels.[187] This growth has been accompanied by a rise in the types of services available to be delivered via

telehealth. Originally, under the Balanced Budget Act of 1997, only consultations were covered,[188] but as of 2024, 268 HCPCS codes are covered either permanently or provisionally.[189] Congress continues to consider and advocates continue to push for making the remaining telehealth flexibilities permanent.[190]

Status COVID-19 PHE Telehealth Flexibilities

Provision	Status
Federally qualified health centers (FQHCs) and rural health clinics (RHCs) can serve as a distant site provider for behavioral/mental telehealth services.	Made permanent
FQHCs and RHCs can serve as a distant site provider for **non**-behavioral/mental telehealth services.	Expires December 31, 2024
Medicare patients can receive telehealth services for behavioral/mental health care in their home.	Made permanent
Medicare patients can receive telehealth services in their home.	Expires December 31, 2024
There are no geographic restrictions for originating site for behavioral/mental telehealth services.	Made permanent
There are no geographic restrictions for originating site for **non**-behavioral/mental telehealth services.	Expires December 31, 2024
Behavioral/mental telehealth services can be delivered using audio-only communication platforms.	Made permanent
Some **non**-behavioral/mental telehealth services can be delivered using audio-only communication platforms.	Expires December 31, 2024
Rural emergency hospitals (REHs) are eligible originating sites for telehealth.	Made permanent
An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required.	Expires December 31, 2024
Telehealth services can be provided by all eligible Medicare providers.	Expires December 31, 2024
Direct supervision permitted using remote, real-time, interactive audio-video technology.	Expired December 31, 2023

Source: See endnote 189 for details.

Though the expanded use of telehealth has been a boon for access, CMS is grappling with how to appropriately reimburse for these services. Before the PHE, CMS reimbursed telehealth services at the facility PFS rate, which was lower than the non-facility rate. A June 2023 report from MedPAC recommends

that CMS resume paying the lower facility rate "as soon as practicable after the PHE." [191] However, the CY 2024 PFS final rule[192] extended the policy of paying the higher non-facility rate. Stakeholders like the Medical Group Management Association[193] have called for the continued higher levels of reimbursement.

Some tension arises when balancing the goals of accurately reimbursing for services and increasing payment to primary care and behavioral health providers; 98 percent of telehealth services are for E/M services, 68 percent of which are for office/outpatient visits, whereas 23 percent are for behavioral health services, the latter of which accounts for an increasing share of Medicare FFS telehealth spending.***Error! Bookmark not defined.*** Paying the higher non-facility rate is one way to increase overall reimbursement for these providers, the potential of technology to improve the efficiency of delivering services, possibly with lower costs after startup, also should be factored into consideration. For example, although telehealth services were typically shorter than in-person visits, the distribution of E/M service level billing for in-person and telehealth visit was equivalent.**Error! Bookmark not defined.**

GLOSSARY OF TERMS

Note: For a more comprehensive glossary of the many acronyms and technical terms used in health policy, see CMS's online glossary at https://www.cms.gov/glossary.

Term	Definition
AAPM	Advanced alternative payment model.
ABLE	Achieving a Better Life Experience (ABLE) Act of 2014, signed into law as part of the Tax Increase Prevention Act of 2014 (Public Law 113-295).
ACA	The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), Section 3134(a) requires the HHS Secretary to periodically identify potentially misvalued services using certain criteria.
Accountable care	CMS defines accountable care as when a person-centered care team takes responsibility for improving quality of care, care coordination, and health outcomes for a defined group of people to reduce care fragmentation and avoid unnecessary costs.[194]
ACO	An accountable care organization is composed of hospitals, clinicians, and other providers that work together on behalf of a defined population to deliver accountable care.
AI	In healthcare, artificial intelligence could refer to technology that is assistive (detects clinically relevant data), augmentative (analyzes and/or quantifies data to yield clinically meaningful outputs), or autonomous (interprets data and independently generates clinically meaningful conclusions).
AMA	American Medical Association.
APM	Alternative payment model.
APP	Advanced practice providers.
ASC	Ambulatory surgical center.

ATRA	American Taxpayer Relief Act (Public Law 112-240).
AUC	Appropriate use criteria for advanced diagnostic imaging services.
BBA	Balanced Budget Act of 1997 (Public Law 105-33), Authorized PFS telehealth service with narrow statutory and regulatory parameters.
BBA of 2018	The Bipartisan Budget Act of 2018 (Public Law 115-123), which expanded telehealth coverage and payment.
BCA of 2011	Budget Control Act of 2011 (Public Law 112-25).
BH	Behavioral health (often used interchangeably with mental health).
BN	Budget neutrality.
CAA, 2023	The Consolidated Appropriations Act, 2023 (Public Law 117-328).
Care coordination	The coordination between two or more participants (e.g., providers) involved in a patient's care.
CARES Act	The Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136).
CF	Conversion factor.
CLFS	Clinical laboratory fee schedule
CMMI	The CMS Innovation Center, established by Congress to identify ways to improve healthcare quality and reduce costs
CPT® Editorial Panel	An internal committee of the American Medical Association (AMA) that oversees the development and updating of the Current Procedure Terminology (CPT®), which is composed of representatives of various specialty societies and manages an annual process through which codes for new services are added and obsolete codes are deleted
CY	Calendar year.

Digital health	Broadly refers to numerous types of applications used in healthcare operations, workflow, triage, revenue cycle management, and in clinical care. Term includes health information technology (IT), mobile health (mHealth), prescription digital therapeutics (PDTs), devices with software algorithms, digital features and connectivity, telehealth and more.
DMEPOS	Durable medical equipment, prosthetics/orthotics & supplies, paid on a separate fee schedule to Medicare-enrolled DME suppliers.
E/M	Evaluation and management.
EHR	Electronic health record.
ESRD	End stage renal disease.
E-visits	Online digital E/M services.
FFS	Fee-for-service refers to a payment methodology that issues reimbursement for each line item of care.
FQHC	Federally qualified health center.
GAO	Government Accountability Office.
Global periods	Codes with 10- and 90-day global periods account for the number of visits post-surgery during the 10-day and 90-day timeframe in surgical code valuation.
GPCI	Geographic practice cost indices.
HCPCS	The Healthcare Common Procedure Coding System is the code set that the US Department of Health and Human Services has designated as the national coding system for professional providers, based on the AMA CPT® coding system
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

HITECH	Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) to promote adoption and meaningful use of health information technology.
HPSA	Health professional shortage area. Section 5501 (b) of the ACA revised section 1833 of the Act provides a 10 percent incentive payment for major surgical procedures furnished in a geographic HPSA.
HRSA	Health Resources and Services Administration.
IMPACT Act	Improving Post-Acute Care Transformation Act of 2014 (Public Law 113-185).
Intra-service	The care activities that occur after pre-service (before the service or procedure starts) but before post-service (after the service or procedure is complete). In the physician office setting, intra-service often refers to the patient encounter time. In the surgery, this often refers to the time from the initial incision to the closure of the incision (i.e., “skin-to-skin” time).
IOM	Institute of Medicine.
IWPUT	Intra-service work per unit of time.
MAC	Medicare Administrative Contractor.
MACRA	The Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114-10).
MedPAC	Medicare Payment Advisory Commission.
MEI	Medicare Economic Index.
MFTs	Marriage and family therapists.
MH	Mental health (often used interchangeably with behavioral health).
MHCs	Mental health counselors.

MHPAEA	Mental Health Parity and Addiction Act (Public Law 110-343).
MIPPA	Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275).
MIPS	Merit-based Incentive Payment System.
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173).
MPPR	Multiple Procedure Reduction Policy. Therapy MPPR applies to occupational, physical, speech language. Imaging MPPR applies to the technical component with lesser discount to the professional component. Diagnostic cardiology and ophthalmology MPPR apply to the technical component.
MSSP	Medicare Shared Savings Program.
MUA	Medically Underserved Area.
NCD	National Coverage Determination.
NPPs	Non-physician practitioner.
OPPS	Outpatient Prospective Payment System.
Organized medicine	Medical societies comprised of primary and specialty care professionals.
OTP	Opioid treatment program.
OUD	Opioid use disorder.
PAMA	Protecting Access to Medicare Act of 2014 (Public Law 113-93).
PCIP	Primary care incentive payment. Section 1833(x)(2)(A) (as added by section 5501(a) of the ACA) defines a primary care practitioner by specialty designation, for whom primary care services account for at least 60 percent of allowed charges for the practitioner under the PFS (2011 FR provides calculation of primary are percentage) for

	eligible primary care codes. 10 percent incentive payment, not subject to budget neutrality.
PE	Practice expense
PFS updates	Refers to the annual update to the conversion factor and, where applicable, the formula used to calculate the update.
PFS	Physician fee schedule.
PHE	Public health emergency
PPIS	Physician practice expense information survey.
PLI	Professional liability insurance.
PPS	Prospective payment system in which reimbursement is based on a predetermined, fixed amount.
PQRI	Physician Quality Reporting Initiative.
PQRS	Physician Quality Reporting System.
QPP	Quality Payment Program.
RBRVS	Resource Based Relative Value Scale (RBRVS) created in section 6102 of Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), the relative value scale is based on resource costs.
Recovery Act	American Recovery and Reinvestment Act of 2009 (Public Law 111-5).
Remote patient monitoring (RPM), remote therapeutic monitoring (RTM), or remote physiologic monitoring	Technology that connects physicians to their patients and facilitates identification of trends in patient data, health alerts requiring escalation, care management, medical decision making and population health.
RHC	Rural health clinic
RUC	AMA/Specialty Society Relative Value Update Committee (RUC) formed the Relativity Assessment Workgroup.

RVUs	Relative value units.
SaaS	Software as a medical Service.
SDOH	Social determinants of health.
SGR	Sustainable growth rate.
VBC	Value-based care.
VBP	Value-based payment.

REFERENCES AND ENDNOTES

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[2] Medicare Payment Advisory Commission's transcript of the April 11, 2024 public meeting, page 128. Available at: https://www.medpac.gov/wp-content/uploads/2023/10/April-2024-meeting-transcript.pdf. Accessed April 2024.

[3] See the Medicare Payment Advisory Commission's March 2023 and March 2024 recommendations for physician and other health professional services, available at: https://www.medpac.gov/recommendation/?topic_filter=physicians-and-other-health-professionals. Accessed April 2024.

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[10] Centers for Medicare & Medicaid Services. Innovation Center Strategy Refresh. Available at: https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper. Accessed March 2024.

[11] Changes in healthcare delivery and practice structures also call for evaluation and consideration of the code of federal regulation for payment for services of teaching physicians, services, and supplies incident to a physician's professional services and for physician or treating practitioner authorizations are not discussed. Likewise, the CMS Quality Payment Program (QPP) is not part of this review.

[12] Figure 1. Source: 2022 Physician/Supplier Procedure Summary (PSPS). Notes: Only includes PFS codes defined by status indicators A, C, R, T, and J. Includes codes that are included in the PSPS Part B data file and Addendum B for that year. Includes place of services that account for more than 2% of the total allowed charges. All other POS are grouped under the "All Others" category. HOPD = Hospital Outpatient Department, ASC = Ambulatory Surgical Center, and ED = Emergency Department

[13] Qualified health practitioners are mid-level clinicians, such as advance practice nurses and physician assistants, also referred to as advanced practice providers, who are eligible to bill Medicare under their own National Provider Identifiers (NPIs).

[14] Figure 2. Source: Allowed charge data from 2022 physician/supplier procedure summary (PSPS) data and provider count data from the 2022 100% standard analytic file (SAF). Primary care is defined as internal medicine, preventive medicine, family medicine, geriatrics, pediatrics, and general medicine. Behavioral health is defined as psychiatry, geriatric psychiatry, clinical psychology, and clinical social work. Advanced practice providers (APPs) include physician assistants, nurse practitioners, nurse anesthetists, anesthetist assistants, and other certified clinical nurse specialist. Other suppliers are defined as entities that bill for the following services: ambulance transportation, centralized flu, home infusion therapy, independent laboratory/testing, individual orthotic personnel certified by an accrediting organization, individual prosthetic personnel, mass immunization roster billing, medical supplies, Medicare diabetes prevention program, opioid treatment program, optician, pharmacy, public health or welfare agencies (federal, state, and local), and other or unknown services. Provider counts only include NPIs with at least 11 claims for Medicare FFS in 2022, per CMS data use agreements.

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[16] CPT® is a registered trademark of the American Medical Association. All rights reserved. CPT edition 4 (CPT-4) is designated by HIPPA as the protected code set.

[17] Professional services billing codes fall under the Healthcare Common Procedure Coding System (HCPCS). CPT® codes are Level I HCPCS. Level II HCPCS codes are alphanumeric codes that are not represented in Level I CPT codes.

[18] Usual, customary, and reasonable payment is made when the amount billed is compared with the most frequent charge made by that physician for that service and when the amount billed is less or above the usual amount.

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[21] For detailed information on the methodology used to calculate PE RVUs see the CMS website on practice expense data & methods available at: https://www.cms.gov/medicare/payment/fee-schedules/physician/practice-expense-data-methods

[22] When care is furnished in a facility setting, physicians receive reimbursement for their professional service based on the PFS facility rate, which reflects a lesser amount for physician practice expenses. The facility receives reimbursement for the provision of services through other Medicare payment systems (such as the hospital Inpatient Prospective Payment System under Part A of the Medicare program or the Hospital Outpatient Prospective Payment System, Medicare Part B). For this reason, when a beneficiary receives a service in the facility setting, two bills are generated, one for the professional service and one for the facility fee.

[23] Some services, such as certain cardiac or neurosurgery services, among others, do not have a non-facility rate because they are never performed in non-facility settings. In those cases, payment to the physician is the same regardless of where the service is furnished.

[24] To calculate the conversation factor, CMS starts with the current conversion factor (CF) without any one-time percentage payment increase afforded by Congress. The agency then multiples the CF by the proposed or finalized RVU budget neutrality adjustment. CMS calculates the budget neutrality adjustment necessary to comply with the statutory requirements that changes in RVUs not cause the amount of Medicare Part B expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of those changes. If the $20 million threshold is exceeded, CMS applies an adjustment to the CF to preserve budget neutrality. These estimates are based on CMS assumptions about the anticipated utilization of services.

[25] In CY 2011, the CF was $33.9764, an almost 8 percent reduction from the prior year; however, this cut was a result of CMS rebasing and revising the Medicare economic index. Practice expense and professional liability insurance RVUs were adjusted up and the conversion factor was adjusted down to maintain budget neutrality.

[26] In CY 2023, the CF was $33.8872, which includes a 2.5 percent one-time increase. In 2024, before any congressional relief, the CF was $32.34. Prior to March 9, 2024, Congress provided a 1.25 percent increase, resulting in a conversion factor of $32.74. This reflected an approximately 3.4 percent reduction from the 2023 level. Beginning March 9, 2024, Congress provided an additional 1.68 percent increase for a total 2.93 percent increase to the CF for the remainder of the year. The 2024 CF is accordingly $33.29.

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[60] Medicare Physician Fee Schedule CY 2022 Final Rule (86 FR 64996), page 65027.

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