POLICY SPOTLIGHT

How Medicare Part B's Physician Fee Schedule Drives Up Spending and Influences the Provision of Care

JOHN O'SHEA, ELISE AMEZ-DROZ, AND KOFI AMPAABENG | JUNE 2023

Medicare is the federal healthcare entitlement program for the elderly and certain younger people with disability status. Medicare Part B covers physician services and certain other services and reimburses providers on a fee-for-service basis through the Medicare Physician Fee Schedule (MPFS). Reimbursement rates in the MPFS are set by the Centers for Medicare and Medicaid Services (CMS) based on recommendations from a small group of physicians known as the Specialty Society Relative Value Scale Update Committee (RUC). However, this administrative pricing mechanism does not accurately capture the value of the services provided. In the short term, CMS should use more accurate data to set reimbursement rates. Ultimately, however, moving away from fee-for-service and adopting alternative payment models will be necessary to increase incentives for cost-cutting efforts and to promote value-based care.

SETTING THE REIMBURSEMENT RATE

Medicare assigns relative values based on resource costs for more than 10,000 services. It assigns to each service a current procedural terminology (CPT) code. The RUC meets three times a year to recommend updates to the relative value units (RVUs) of existing CPT codes to CMS. In making its recommendations, RUC members rely on surveys regarding physician work (PW), practice expense (PE), and professional liability insurance (PLI). Each value is adjusted for locality using Geographic Pricing Cost Indices (GPCIs). The sum of the three adjusted components is then multiplied by a conversion factor (in dollars) set by Congress every year.

The result, set out in the following formula, is the MPFS's reimbursement rate for the CPT code in a given locality.

$$[(\text{PW RVU} \times \text{PW GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{PLI RVU} \times \text{PLI GPCI})] \times \text{CF} = \text{MPFS payment}$$

PROBLEMS WITH THE CURRENT SYSTEM

Medicare Part B is subject to a budget-neutrality rule, meaning that if the RUC recommends rate increases for certain services, it must cut others. Over the years, this has resulted in cuts to relatively low-priced, high-volume services like physician visits and primary care services ("evaluation and management" [E/M] services), even though they may be of great value to

the patient, while high-priced, low-volume services like surgeries tend to be recommended for increases.

Complex services are overcompensated as a result. E/M services, on the other hand, are undercompensated. These rate differences create incentives for doctors and hospitals to overprovide services with high reimbursement rates and underprovide services with low rates.

The system discourages cost-cutting efforts. Successful cost cuts do not increase the profit margins of those who achieve them but risk resulting in revenue cuts instead.

The consequences are systemwide. Even though Medicare Part B covers only about 10 percent of the population, the MPFS drives up prices for physician services across the entire healthcare system, since most private insurers follow Medicare's lead in setting reimbursement rates. The problems caused by the MPFS within Medicare are thus replicated systemwide.

MAKING PRICES REFLECT THE TRUE VALUE OF CARE

Short-term solution: Improve the current system. Congress should give CMS the authority to (a) perform a budget-neutral rebalancing of the MPFS by increasing payment rates for E/M services and reducing rates for other services and (b) use more accurate data about the value of care to set rates.

Long-term solution: Move away from administrative pricing. Almost 50 percent of Medicare beneficiaries are already in Medicare Advantage (MA, or Part C), which pays private insurance plans a flat annual rate per enrollee that the plans then use to remunerate providers. This incentivizes the provision of high-value services. Congress therefore should change the default enrollment for new Medicare beneficiaries from traditional Medicare (Parts A and B) to MA. To limit spending growth in MA and encourage competition among insurers, Congress should also establish competitive bidding for the reimbursement benchmarks in the MA program.

FURTHER READING

John O'Shea, Elise Amez-Droz, and Kofi Ampaabeng, "The Medicare Physician Fee Schedule: Overview, Influence on Healthcare Spending, and Policy Options to Fix the Current Payment System." (Mercatus Policy Brief, Mercatus Center at George Mason University, Arlington, VA, May 24, 2023).

Roger Feldman, Bryan Dowd, and Robert Coulam, "Medicare's Role in Determining Prices Throughout the Health Care System" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, October 8, 2015).

Government Accountability Office, *Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy,* May 2015.

Brian J. Miller and Gail R. Wilensky, "The Next Step in Medicare Reform" (Backgrounder No. 3531, The Heritage Foundation, Washington, DC, September 16, 2020).

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