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CENTER FOR HEALTH AND WELFARE POLICY

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This paper, in its entirety, can be found at **https://report.heritage.org/sr302**

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Medicare Physician Payment: The Case for Market-Based Reforms

Caleb Keng and Robert E. Moffit, PhD

Almost annually, physicians face the prospect of Medicare payment cuts unless Congress intervenes to block or modify them. Without congressional intervention, such cuts would affect patients directly in the form of less access to care and services. The current system of physicians' reimbursements has been a source of ongoing concern for doctors and other health care providers and is ripe for reform. Physicians who serve Medicare patients practice under a payment system that is the product of decades of government price controls, a history of fixes and starts, and piecemeal and patchwork adjustments to flawed administrative pricing arrangements. Congressional leaders should re-examine the shortcomings of previous payment reform efforts and craft a new path forward. It is past time for bold solutions that will properly realign incentives and ensure that older Americans have access to the best care that physicians can provide at a sustainable cost.

American doctors are facing yet another Medicare pay cut. The Centers for Medicare and Medicaid Services (CMS), the agency that runs the Medicare program, recently finalized its Medicare physician payment rule for 2025.[1] This year, the CMS is proposing yet another reduction in Medicare physician payment by cutting the "conversion factor"—the basic physician payment benchmark—by 2.8 percent.[2] Each year, based on the previous year's benchmark, the CMS re-calculates the "conversion factor" and adjusts it to ensure that the total physician payment is "budget neutral" across the medical specialties.

The threat of annual physician payment cuts has almost become routine. For example, at the start of 2024, the CMS proposed a 3.37 percent cut to physician payments.[3] However, with the passage of the Consolidated Appropriations Act in March 2024, Congress partially reduced the extent of the 3.37 percent cut, resulting in a 1.77 percent cut instead, for services

provided from March 9, 2024, through the end of the year.[4] Although this reduction was less severe than the CMS had initially proposed, it still represented a decrease from the 2023 rate. While this short-term fix provided some temporary stability for physician reimbursement until the end of 2024, it failed to address the underlying structural issues with the Medicare physician fee schedule (PFS) and the distorted incentives that undermine the patient–doctor relationship.

To be clear: Unless checked, this downward trajectory of Medicare physician payment will contribute to a future crisis in terms of patient access to quality care. As Bruce Scott, MD, president of the American Medical Association (AMA), remarked, "With CMS estimating a fifth consecutive year of Medicare payment reductions—this time by 2.8 percent—it's evident that Congress must solve this problem."[5]

Dr. Scott is correct. The program is ripe for reform. The yearly battle to prevent projected cuts in Medicare physician payment serves as another reminder that mere Band-Aid solutions are inadequate. Rather than trying to recalibrate the program's complex administrative pricing systems, Congress should consider market-based reforms that would simultaneously establish a more efficient payment system while ensuring patient access to quality care.

Washington policymakers must recognize that without meaningful reforms to align payment incentives with the efficient delivery of high-quality care, valuable time and resources will continue to be wasted on short-term fixes. The decades-long history of incomplete reforms and ongoing congressional delays in addressing this issue once again underscores the need for a definitive long-term solution.

The Need for Physician Payment Reform

According to the Office of the Actuary at the U.S. Department of Health and Human Services (HHS), as of 2021, Medicare physician payment had fallen to just 75 percent of private rates.[6] With decades of failed fixes, Medicare physician payments, products of complex administrative pricing, remain plagued by perverse incentives. Meanwhile, doctors are threatened with even tighter future price controls and a continuation of Band-Aid fixes to cope with Medicare's explosive spending growth.

Policymakers have struggled to strike the right balance between cost containment and fairness for medical professionals and patients. Despite previous legislative efforts, the underlying fee-for-service (FFS) reimbursement system still drives up the volume of medical services, and the

bureaucratic price-setting process prevents anything resembling the efficiency of market competition. Consequently, the fee schedule not only harms Medicare's fiscal health but remains a stumbling block to achieving a higher quality of care at a lower cost.

Physicians who serve Medicare patients practice under a payment system that is the product of decades of governmental price controls, a history of fixes and starts, and piecemeal and patchwork adjustments to flawed administrative pricing arrangements. Congressional leaders should re-examine the shortcomings of previous payment reform efforts and craft a new path forward. It is past time for Congress to pursue market-based solutions that will properly realign incentives and ensure that senior citizens have access to the best care that American physicians can provide in a fiscally responsible fashion.[7]

The Long-Term Goal. Congress can resolve many of Medicare's problems by transitioning the entire program into a defined contribution ("premium support") system of financing, where the government makes a direct contribution to the plan of a Medicare beneficiary's choice, including the choice of an updated FFS Medicare plan. Most physicians could then be compensated through competitive private contracts, rather than through a government price control model, that reflects the real forces of supply and demand, in a new market in which both health care prices and provider performance in delivering quality care would be fully transparent.

Congress can initiate that comprehensive transition by fixing what is broken and building on the best features of the Medicare Advantage (MA) program, a system of competing private health plans that provides most beneficiaries with a richer package of benefits at affordable cost.[8] Powered by consumer choice, with both prices and provider performance fully transparent, both health plans and medical professionals would face intense competition. According to former Director of the Congressional Budget Office (CBO) Douglas Holtz-Eakin, such a fully competitive (defined-contribution) program would yield savings of $2.2 trillion over 10 years for beneficiaries and taxpayers alike, while securing real value for their dollars in the form of higher quality care at lower cost.[9]

Meanwhile, with a view toward achieving a more sustainable and efficient Medicare program, lawmakers should advance specific reforms to the Medicare physician payment system. These reforms should be compatible with a comprehensive Medicare reform agenda, serving as a bridge between the current payment system and a future competitive program, while fostering greater competition and transparency in price and provider performance.

A New Policy. Such a reform agenda would have three key objectives:

1. **Provide doctors immediate relief** by halting Medicare FFS pay cuts, put in place a temporary payment update, and direct the Medicare Payment Advisory Commission (MedPAC) to add more precise data to its annual report to accurately assess the value of Medicare Part B physician services.

2. **Enhance physician integration with MA** by streamlining participation in MA and alternative payment models, leveling the playing field with site-neutral payments, adopting competitive pricing for certain services, and accelerating broader applications of episodic bundled payments.

3. **Restore the doctor–patient relationship** by removing restrictions on private contracting, reconsider restrictions on balanced billing between patients and doctors, expand access to direct primary care, and institute price transparency for all medical procedures.

By harnessing market forces and restoring the doctor–patient relationship, policymakers can transform this set of short-term and long-term reforms into a catalyst for value, ensuring Medicare's long-term sustainability and improving care for millions of Medicare patients by moving away from the governmental administrative pricing regime to a more competitive market-based payment model.

How Traditional Medicare Pays Doctors Today

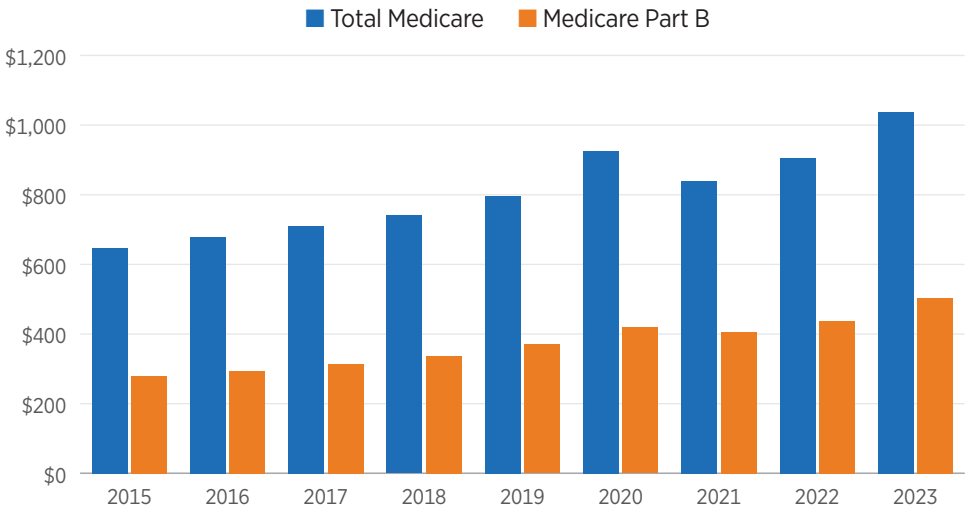
Medicare is divided into four parts (A, B, C, and D), each of which has implications for physician reimbursement. Part A provides predetermined per-day rates for inpatient services, while Part B covers outpatient provider services, diagnostic tests, and physician-prescribed drugs administered in outpatient settings. Together, Parts A and B form traditional FFS Medicare. Part C (MA) allows private health insurance plans to contract with Medicare to offer the benefits provided under Parts A and B, as well as additional benefit coverage, including catastrophic protection. Lastly, Part D offers an outpatient prescription drug benefit through private plans, either as a standalone offering or integrated with MA plans.

Medicare physician payment legislation emerged in large part as a means to control Medicare Part B costs, given the rapid growth in the demand

CHART 1

Total Medicare and Medicare Part B Expenditures

IN BILLIONS OF DOLLARS



SOURCE: *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance;* and Federal Supplementary Medical Insurance Trust Funds, Communication from the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, pp. 89 and 177, Table III.C4 and Table V.B1, transmitted May 6, 2024, https://www.cms.gov/oact/tr/2024 (accessed September 18, 2024).

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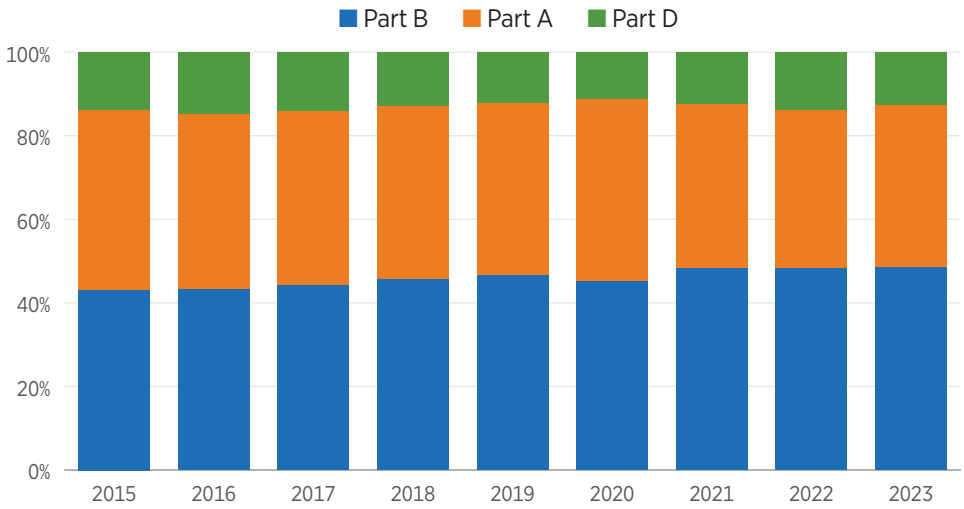
for services among an ever-larger population of beneficiaries.[10] Based on the Medicare Trustees' most recent report, policymakers are right to be concerned with Medicare's accelerating spending. As shown in Chart 1, by 2023, total spending amounted to $1.04 trillion, with Part B, the part of the program that pays physicians and other health care providers, reaching $502.9 billion—almost 50 percent of total Medicare spending.[11]

Trends in total Medicare spending, especially the rapid growth in Part B, impose strong financial pressures that push Washington policymakers to make changes to physician payment rates to slow spending down. The Trustees predict that Medicare's total expenditures will grow faster than the nation's future earnings and economic growth. Among Medicare's components, Part B spending has been growing faster than spending in Part A (hospitalization) and Part D (prescription drugs) in recent years, making it the primary driver of this aggregate spending trend.[12] (See Chart 2.)

The Current Physician Payment System. Under Part B, physicians are reimbursed based on billing for services using Current Procedural

CHART 2

Medicare Parts, A, B, and D as Percentage of Total Expenditures



SOURCE: *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance*; and Federal Supplementary Medical Insurance Trust Funds, Communication from the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, pp. 56, 89, and 108, Table III.B4, Table III.C4, and Table III.D3, transmitted May 6, 2024, https://www.cms.gov/oact/tr/2024 (accessed September 18, 2024).

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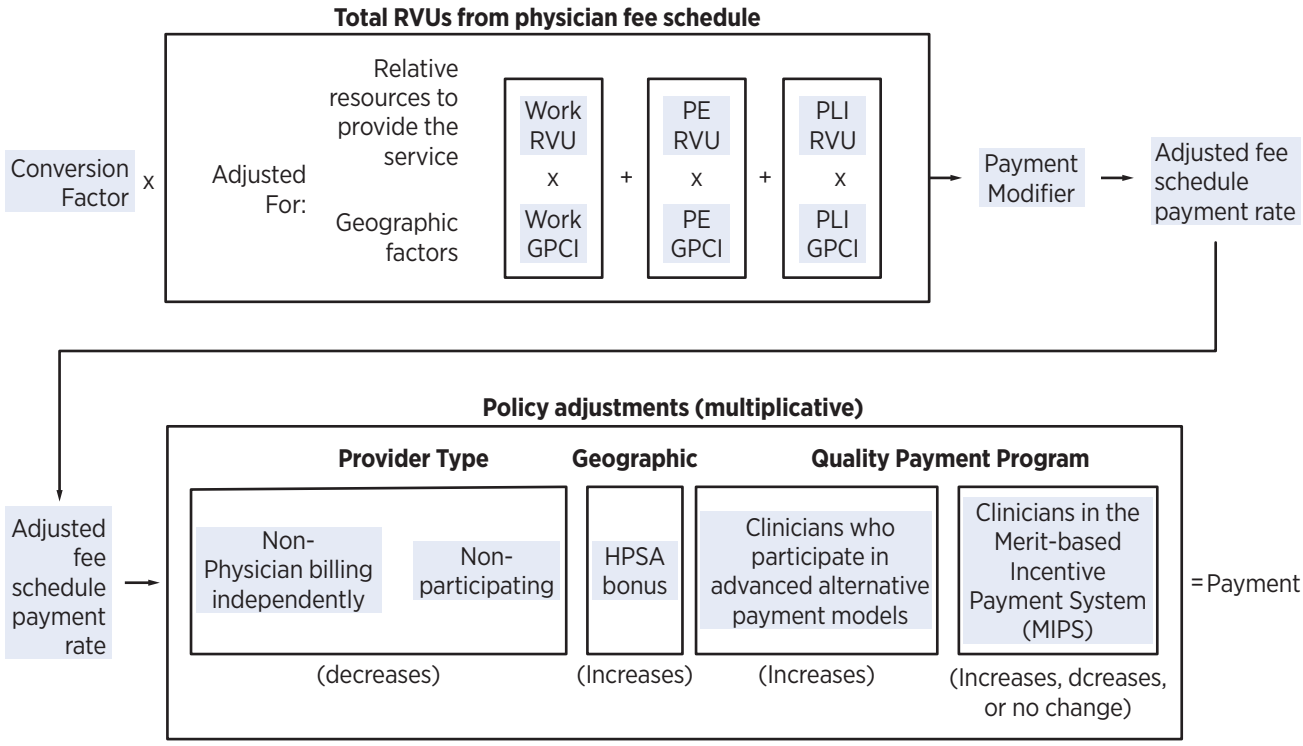
Terminology (CPT) codes. Each code represents a health care service and is assigned a set of relative value units (RVUs) by the Centers for Medicare and Medicaid Services (CMS). The RVUs are determined using the resource-based relative value scale (RBRVS), which considers three factors: physician work, practice expenses, and professional liability insurance (PLI).[13] These RVUs are then adjusted using geographic practice cost indices (GPCIs) to account for local market prices. Procedures or services that would require more resources, according to the scale, are assigned a higher number of RVUs, resulting in a higher payout from Medicare.

Under current law, Medicare payment to physicians is thus governed by this complex formula. Each year, the adjusted RVUs are translated into dollar amounts for the specific medical services or procedures by multiplying the sum of the adjusted weights by a fixed dollar amount called the conversion factor. Any decrease in the conversion factor will lower payments across all services for physicians.

FIGURE 1

An Overview of Calculating Payments



RVU—Relative Value Unit GPCI—Geographic Practice Cost Index PE—Practice Expense
PLI—Professional Liability Insurance HPSA—Health Professional Shortage Area
SOURCE: Medicare Payment Advisory Commission (MedPAC), "Physician and Other Health Professional Payment System," last updated October 2023, https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf (accessed September 18, 2024).

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For example, as of January 2024, the CMS set the Medicare conversion factor at $32.74 per RVU. This represented a 3.4 percent reduction from the 2023 conversion factor of $33.89 per RVU, effectively resulting in a 3.4 percent pay cut for physicians at the beginning of 2024. As noted, however, in March 2024, Congress intervened, forcing the CMS to increase the conversion factor from $32.74 to $33.29 per RVU, which partially mitigated the agency's earlier proposed pay cut.[14]

To determine a physician's payout, the RVUs for a specific service are factored into the formula, and the sum is multiplied by the conversion factor. This formula considers the three components of the RBRVS—physician work, practice expenses, and the PLI—and their respective GPCI to arrive at the final dollar amount.[15] For example, a common diagnostic colonoscopy

is assigned CPT code 45378. In calculating the Medicare reimbursement for this and any other covered treatment or procedure, the CMS must adjust the RVUs for this procedure (the relative value units for the work) according to the GPCI and the PLI. The CMS then multiplies the total adjusted RVUs by the conversion factor for the given year to determine the dollar amount.

For 2024, the CMS has determined that that final payment for a physician performing a diagnostic colonoscopy (CPT code 45378) would be $474.11. If the colonoscopy required the removal of a lesion (CPT code 45385), however, the payment would be $612.16.[16] This Medicare payment would be further adjusted depending on additional factors that will be discussed further in this paper. (See Figure 1.)

Yearly, the CMS reviews the RVUs for new, revised, and some potentially "misvalued" services, making periodic changes. With more than 11,000 codes under the payment system, prices of services, as determined in traditional Medicare, are set administratively based on the RVUs assigned to each service and the fixed conversion factor that the CMS updates annually.[17]

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 made significant changes to Medicare physician payments. It froze updates to the conversion factor from 2020 to 2025 and capped it for future years. Nevertheless, Congress has repeatedly intervened to override MACRA's payment updates.

Beyond this service code specificity, physicians must cope with another layer of Medicare payment adjustments enacted under MACRA. On top of the underlying FFS system, MACRA instituted two pathways to link physician compensation to "value" metrics: Merit-based Incentive Payment System (MIPS) and "advanced" Alternative Payment Methods (APMs).

MIPS adjusts the basic FFS payments (payments determined by the RVUs and the conversion factor) based on clinicians' reporting of additional quality and cost metrics, rewarding high performers on quality and cost markers with bonuses while penalizing low performers.

Advanced APMs are a specific type of model within the broader category of APMs.[18] Advanced APMs require clinicians to take on more financial responsibility for their patients' health outcomes than other APMs. Participating clinicians agree to be held accountable for the quality and cost of the care they provide. If they can improve patient outcomes while keeping costs down, they could earn higher payments. However, if costs exceed expectations or patient outcomes suffer, clinicians may earn less or even lose money. By tying greater financial rewards and penalties to patient outcomes, advanced APMs aim to drive meaningful improvements in the way health care is delivered.

The Evolution of the Medicare Physician Payment Policy

When Medicare was signed into law in 1965, physician reimbursement operated on a customary, prevailing, and reasonable (CPR) model. This model, designed by physicians in the 1930s and 1940s to obtain favorable rates from insurers, allowed doctors to have significant control over their rates. This model was used in the initial years of Medicare to ensure physician participation and ease their transition into the program. Compensation reflected the lowest of either the physicians' billed charge for the service, the customary charge of a service, or the prevailing charge for that service in the geographic community.[19]

In response to the rise in spending, Congress established the Medicare Economic Index (MEI) in 1975 to track physician practice costs and earnings. This was primarily used as a reporting metric to track the rise in medical costs and Part B expenditures, rather than as a direct cost control measure. The congressional intent was to enable federal officials to base payment rates on objective economic indicators (related to medical practice) rather than on what physicians chose to charge based on the CPR.[20] The index was a "guideline"—a metric for consultation—for policymakers in setting annual reimbursement updates. Back in the 1970s, any charge increases exceeding the MEI were subject to government review and revision before reimbursement. While the MEI prompted policymakers to limit the rate at which physicians could raise their fees for services, it failed to regulate the number of services a physician could bill when providing care for his or her patients. These volume increases stimulated new congressional efforts to contain costs.[21]

The Resource-Based Relative Value Scale (RBRVS). In response, Congress enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989, a major change in Medicare physicians' reimbursement. It created the existing Medicare Physician Fee Schedule (PFS) and required physicians' fees to be based on the novel RBRVS.[22] The RBRVS was then a new formula designed to determine the "true" value of physician services based on a "social science" measurement and weighting of the resource costs required to perform them. Among the factors, or "inputs," to be measured are a physician's time, effort, skill, practice costs, and opportunity costs.[23]

The PFS provided a formal price catalog by translating RVUs, using the aforementioned conversion factor, into dollar payment amounts for each service. To ensure the validity of the RVU assignments, the CMS for decades has relied on the AMA's RVS Update Committee (RUC), a panel of physicians and advisors who provide annual recommendations for rate setting.[24]

The RBRVS, though designed to control the growth of physician fees for individual medical services, did not deal with the problem of physicians' incentives to increase the volume of their services to secure higher revenues from Medicare. This was a central congressional concern for the rapid rise of Part B spending since the creation of the MEI.[25] So, to control the growth in the volume of medical services and thus Part B spending, Congress also enacted, as part of OBRA, the volume performance standard (VPS), which tied annual payment updates to spending trends relative to historical volume targets.[26]

The purpose of the VPS was to rein in Medicare spending growth by setting yearly expenditure targets for physicians' services. If the actual physician Part B spending exceeded those targets, the law provided that future fee schedule rates would be adjusted downward through changes in the conversion factor.[27]

The VPS system failed. Despite slowing down spending growth slightly, it failed to motivate individual physicians to reduce their service volume, and thus failed to meet Medicare's annual budgeting challenges.[28] In fact, since the VPS was tied to payment updates for all physicians, it created a perverse incentive for individual physicians to actually increase their volume in order to offset the anticipated negative impact on their own pay, ultimately leading to larger downward adjustments for the entire profession. Because of the complexity of the PFS metrics and its year-to-year variability, Medicare physicians faced unstable and unpredictable payment updates; indeed, annual PFS updates between 1992 and 1998 ranged from 0.6 percent to 7.5 percent.[29]

In response to these statutory shortcomings, Congress passed the Balanced Budget Act (BBA) of 1997. This major law replaced the unworkable VPS with a new physician payment update formula, the sustainable growth rate (SGR).[30] The congressional authors of the SGR decided to align Medicare physician reimbursement with broader economic growth indicators, such as the growth of the gross domestic product (GDP), thus intending for reasonable payment increases while simultaneously controlling spending. If spending exceeded the growth in GDP in any given year, it would result in a proportional, automatic cut in Medicare physician reimbursement the following year. However, the economy's fluctuations often had little correlation with the cost of providing health care.[31]

Following the introduction of the SGR system, actual expenditures initially aligned with targets, and the physician fee schedule updates were close to the MEI. However, as Medicare physician spending continued to rise and the economy slowed down, expenditures started to exceed the allowed

targets in 2002, prompting the SGR to call for a 4.8 percent pay cut for that year. Discrepancies between expenditures and targets continued to grow, calling for progressively harsher pay cuts in the years thereafter.[32] These proposed cuts created a backlash among professional medical organizations, prompting Congress to repeatedly override these reductions through temporary year-after-year "doc fixes." Consequently, this widened the gaps between the statutory benchmark and actual Medicare Part B spending in subsequent years.[33]

The Medicare Access and CHIP Reauthorization Act (MACRA). By 2015, it was clear that the Medicare physician payment provisions of the BBA were also unworkable, particularly the SGR formula for updating physician payments. By that year the accumulated cost overruns resulting from repeated annual overrides of Medicare's SGR would have necessitated an enormous 20 percent pay cut to recoup expenditures.[34]

Because pending physician payment cuts of this magnitude were intolerable, when Congress enacted MACRA in 2015, lawmakers abolished the SGR and created the Quality Payment Program (QPP), thus establishing the APMs and MIPS. The law was designed to encourage medical professionals to deliver value-based care by linking their reimbursement to performance indicators for delivering quality care or participation in advanced APMs. Congress enacted these provisions to incentivize the delivery of quality care in a cost-efficient fashion. It was designed, in other words, to reward doctors for quality and cost efficiency rather than reimburse them simply on the volume of their medical services, which had been a major defect of the traditional Medicare FFS system.[35]

Since the enactment of MACRA, the CMS has continually modified the QPP to provide clinicians with more flexibility and support. These changes have included increasing payment updates, adjusting MIPS participation requirements, and developing MIPS Value Pathways to improve quality measures and reduce reporting burdens.[36] Additionally, the CMS has tested numerous advanced APMs. Among these, the Medicare Shared Savings Program was the largest of them, allowing participants to create accountable care organizations (ACOs). The CMS set a goal of moving all traditional Medicare beneficiaries into ACO-like arrangements by 2030, while offering financial incentives to physicians to encourage their participation.[37]

Flawed Payment Reforms. The congressional enactment of MACRA in 2015 was supposed to resolve multiple Medicare physician payment problems. New payment and delivery reforms were supposed to deliver program savings with higher-quality care. The record, thus far, is unimpressive. The Medicare Trustees have expressed doubts about whether recent

delivery reforms can generate savings of the magnitude needed to align with MACRA's statutory price updates, which were intended to stay frozen, resulting in a failure to account for economic factors that affect medical practice costs and inflation.

MACRA, as noted, created MIPS. Instead of making medical practice easier, however, MIPS has created substantial administrative burdens for practices, exacerbated by frequent programmatic changes and the inclusion of quality measures that are often irrelevant to certain specialties, particularly those outside of primary care.[38] Even within the scope of primary care, MIPS has been criticized for its methodology. A 2022 *JAMA* study of more than 80,000 primary care practices revealed that MIPS scores were inconsistent on performance, process, and outcome measures, concluding that physicians treating patients with medically complex issues often received lower MIPS scores despite providing high-quality care.[39] Additionally, the MIPs financial incentives are often viewed as insufficient for complying with the program's requirements, with many medical practices reporting that they participate primarily to avoid financial penalties for not participating rather than to earn rewards.[40]

MACRA also encouraged the adoption of advanced APMs. The dual objective was to enhance the delivery of quality care while securing program savings. In achieving savings, however, overall APM performance has been less than stellar, with only six of more than 50 APMs (not limited to the advanced models incentivized in MACRA) tested by the CMS Innovation Center resulting in statistically significant savings from 2010 to 2020.[41] In addition, the voluntary nature of ACOs, along with the ability for providers to selectively participate or drop out and the presence of conflicting incentives from overlapping models, may have also contributed to mixed results in savings and quality improvement.[42]

Nevertheless, there is still potential for ACOs to generate savings according to the CBO. Specifically, ACOs led by independent physician groups and those with a larger proportion of primary care providers were found to be associated with increased cost savings.[43] This finding underscores the critical role that medical professionals play in coordinating patient care within the ACO framework and why they should be compensated for such coordination.

In any event, MACRA has not significantly improved overall service quality. The law has emphasized compliance with federal metrics over patients' personal experiences, and its reporting requirements and payment models have increased medical practice burdens without delivering substantial improvements or savings.[44]

Moreover, certain program policies, particularly with respect to ACOs, have "discouraged partnership with certain types of providers with higher-revenue volume, such as hospitals and specialists," according to a white paper published by the Senate Finance Committee.[45] The result: Some ACOs have chosen to remove hospitals or specialists from their participation lists based on factors that are not directly related to the quality of care provided.[46] This lack of specialty-focused APMs and the challenges associated with current APM participation have also contributed to the difficulties with the widespread adoption of "value-based" care models.

The Status Quo and Its Consequences

The multiple problems of Medicare physician payment are rooted in an ideological assumption that government officials, rather than free-market forces, can somehow best determine the "right price" for medical treatments and procedures. This was apparent in the creation of the RBRVS, the basic formula for setting physician payment in the Medicare FFS system.

The leadership of the House Ways and Means Committee, with the support of the George H. W. Bush Administration, originally sold the RBRVS formula to lawmakers in 1989 as a "scientific" approach to setting a "fair and rational" price for physicians' services. It was and is no such thing. In 1991, following the congressional debate on the RBRVS, Professor H. E. Frech, University of California economist, observed:

> The RBRVS is tremendously arbitrary. There are judgment calls from the very beginning, from writing vignettes of care linking unrelated specialties. But for those on the outside—which means the congressmen and their staffs—it is a scientific black box, like a computer. To them it seems scientific and objective and mechanical. It seems devoid of human judgment or values… An important part of the support for the RBRVS comes from its appearance of scientific objectiveness.[47]

Since the 1990s, the RBRVS façade of "scientific" objectivity has faded.

At the same time, this administrative payment system continued to incentivize physicians to prioritize the volume of services over the quality of services delivered, and it stimulated extensive lobbying efforts on behalf of medical organizations to increase the dollar value of the conversion factors, which renders the final payment a product of special interest politics.[48]

Special Interest Power. As noted, the AMA's RUC makes recommendations on the relative values of the variables that comprise the RBRVS

formula. The CMS routinely accepts more than 90 percent of the RUC's recommendations.[49] However, the Government Accountability Office, among others, has criticized the RUC data and the CMS' process for establishing relative values, calling for more robust data collection and methodological improvements.[50] Mispriced services that do not accurately reflect market dynamics of supply and demand have, for example, incentivized high volumes of potentially ineffective or harmful services, contributing to increased and unnecessary health care spending.[51]

Moreover, the RUC's recommendations and the CMS' process for reviewing potentially "misvalued" services have been criticized for failing to correct distortions in the PFS that favor procedures and certain specialties over ambulatory evaluation and management (E&M) services.[52] These distortions, caused by flawed RVU calculations, have led to the underpricing of E&M services, potentially negatively affecting access to primary care and exacerbating shortages of primary care physicians.[53]

When the Medicare PFS was enacted into law in 1989, there existed just over 7,000 physician service codes for treatments and procedures reimbursed by the Medicare program. Today, there are more than 11,000. The RBRVS formula was, as noted, designed to provide a scientifically "objective" value for the resources, such as the time, effort, and practice costs, that go into providing each of these services. Even at the time of its enactment, it was clear, however, that the basic formula had glaring weaknesses, such as its failure to accurately reflect differences in physician skill or expertise, while ignoring the role of consumer demand, service quality, the value to the patient, and the real market prices in determining Medicare rates.[54]

In their implementation, payment updates in the Medicare PFS are supposed to follow a budget-neutrality rule, requiring that any changes to the PFS resulting in an increase or decrease in Medicare Part B spending exceeding $20 million must be offset by automatic adjustments elsewhere in the fee schedule.[55] As a result, when the RUC recommends payment increases for certain health care services, it must also recommend corresponding payment cuts for other services to maintain budget neutrality. As a result, when the CMS regularly accepts the RUC's recommendations, increases in total RVUs for some services must be counterbalanced by decreases in RVUs for other services within the fee schedule.[56] This pits one specialty group against another in a special interest lobbying contest. None of this, of course, creates value for the patients.

Therefore, despite MACRA's intent to freeze updates to the conversion factor, the budget neutrality requirement has led to a decrease in the conversion factor every year from 2021 to 2024. This requirement, imposed

to establish fiscal rectitude, nonetheless contributed to the distortion of Medicare physician rates away from the aggregate preferences of consumers that would otherwise be expressed through real market prices.[57]

Market Distortions. Given the program's sheer size, the impact of Medicare's pricing policies goes well beyond the program itself. The government's policies influence private-sector and commercial pricing, such as benchmarking private insurer rates to Medicare prices. This has impeded the efficient allocation of resources that would otherwise be obtained in a normal market.[58]

Regardless of the real conditions of supply and demand, Medicare physicians are limited in their ability to price their services or provide alternative options, such as independent medical contracting for medical services with Medicare patients. For example, under OBRA, Congress imposed unprecedented controls on physicians that restricted them from "balance billing"[59] Medicare patients more than a specified percentage above the Medicare-approved payment amount for Medicare-covered services. In short, price control.

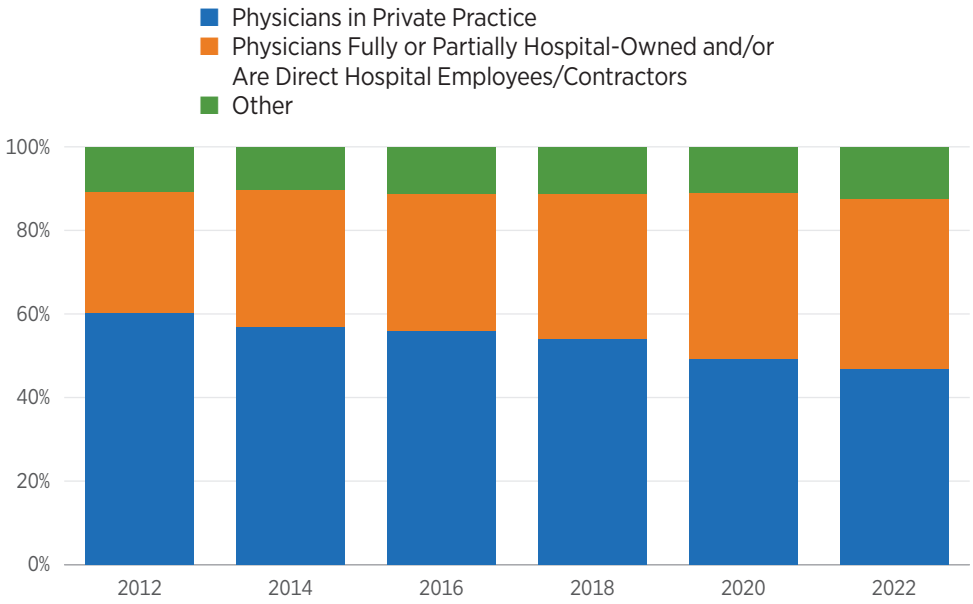
Compounding physicians' problems, the nation's hospital markets have become increasingly concentrated and less competitive, and they are exercising enormous market power at the expense of independent medical practices. Meanwhile, Medicare policy has exacerbated this imbalance between independent physicians and ever-larger hospital systems. Under Medicare payment policy, hospitals can secure higher reimbursement for a medical treatment or procedure than physicians can receive for the delivery of the same treatment or procedure. This policy aggravates the pricing disparities between hospital outpatient departments and independent physician practices. Meanwhile, hospitals are financially motivated to acquire independent physician practices and convert them into outpatient departments, allowing them to charge higher Medicare rates for outpatient services.

Consequently, taxpayers are compelled to pay significantly more for services provided in hospital outpatient settings compared to independent offices, and thus bear the burden of increased program spending.[60] Not surprisingly, there has been a steady decline in independent physician practices, with the share of physicians in private practices dropping from 60.1 percent in 2012 to 46.7 percent in 2022.[61] Future physician payment cuts, already baked into current Medicare law, would only further exacerbate these problems for doctors, patients, and taxpayers. (See Chart 3.)

Most critics of the Medicare status quo support the delivery of value-based medical care. In truth, real value-based care has the potential to improve patient experiences and outcomes beyond the outdated Medicare

CHART 3

Distribution of Physicians by Practice Ownership Structure



NOTE: Figures are based off data from the 2022 AMA Physician Practice Benchmark Surveys.
SOURCE: Carol Kane, "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022," American Medical Association, last updated November 16, 2023, https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf (accessed September 18, 2024).

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FFS system of price controls, reams of regulations, and skewed incentives. Value-based care, however, must be of value to patients; it should mean that they have higher-quality care at lower cost, and that goal can be best achieved by harnessing market forces to incentivize physicians to provide the best care possible to their patients at an affordable cost. The current Medicare payment system is structurally defective in achieving those goals. Inconsistency in rules and incentives across Medicare payment models, as MedPAC reported 10 years ago, remains a significant barrier to optimal and efficient care delivery.[62]

How the Physician Payment Affects Medicare, Patients, and Physicians

The Medicare physician payment system is an iconic example of the modern administrative state in action, replete with detailed central

planning and complex price control policies. While government price setting initially appears to decrease the visible costs of the controlled goods and services to consumers, it routinely shifts costs to uncontrolled sectors of the economy, hiking prices while creating shortages in the controlled sector. So, there is always a hidden cost to price control policy that compromises overall economic efficiency.[63]

When prices are regulated or capped, certain suppliers of goods or services may be forced out of the market if government-set prices guarantee their financial losses, thus contributing, again, to a greater concentration of market power among those who can and do remain. In the health care sector of the economy, the reduced competition not only limits patient access to a broader range of clinical alternatives, but also discourages innovation in care delivery that can improve the quality of patient care.[64]

Under current law, key MACRA provisions are set to expire, thus worsening the Medicare physicians' reimbursement problems. Bonuses for participation in advanced APMs are set to end after 2025, and the $500 million in exceptional performance bonus payments for physicians in the MIPS program are slated to expire after 2024.[65]

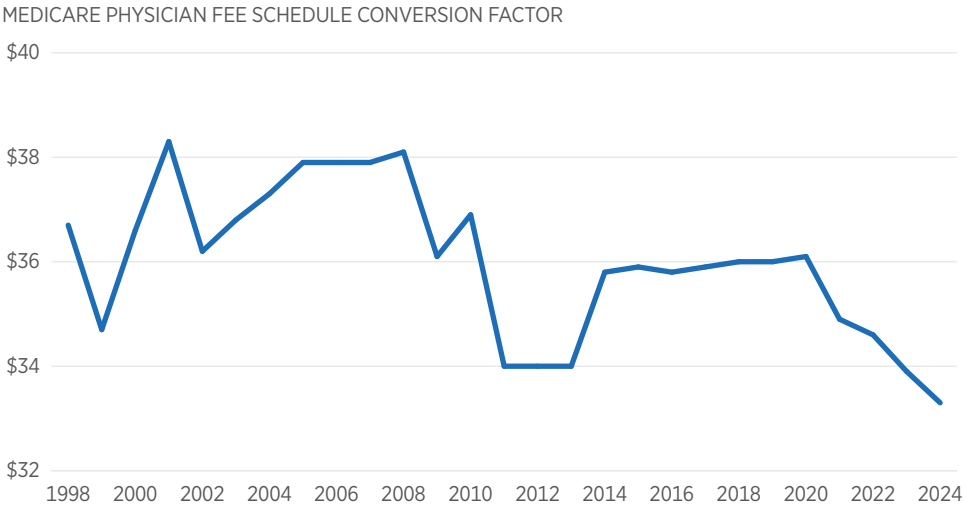
These impending changes underscore the urgency of measures to at least stabilize Medicare physician payments for the short term. For the long term, Congress needs to adopt comprehensive reforms to rescue Medicare itself from the threat of fiscal insolvency. Meanwhile, analysts with the CMS Office of Actuaries warn, "While there are mounting concerns in the near-term regarding Medicare physician payment rates, we expect that access to Medicare-participating physicians will become a significant issue in the long term as these concerns continue to grow, absent a change in the delivery system or level of update by subsequent legislation."[66] If Congress fails to take a proactive approach to addressing these payment issues, that failure could jeopardize access to quality medical care for millions of Americans.

Patient and Physician Impact. Part B costs are accelerating rapidly. Under current law, Part B beneficiaries will bear higher costs because Part B premiums reflect higher total program spending.[67] Older Americans on fixed incomes, many of whom suffer from costly chronic illnesses, will thus face heavier financial burdens.

So, the dynamics of the Medicare status quo are paradoxical: Part B costs and spending are rapidly rising, but physician payments, adjusted for inflation, are steadily declining. Inadequate reimbursement under the existing FFS system can contribute to higher Part B costs as physicians seek to increase their volume of services, especially in the form of additional testing and screenings, to secure higher Medicare revenues. This problem

CHART 4

Change in the Medicare Physician Fee Schedule Conversion Factor Reflect Lagging Physician Payments



SOURCE: American Medical Association, "History of Medicare Conversion Factors," https://www.ama-assn.org/system/files/cf-history.pdf (accessed September 18, 2024).

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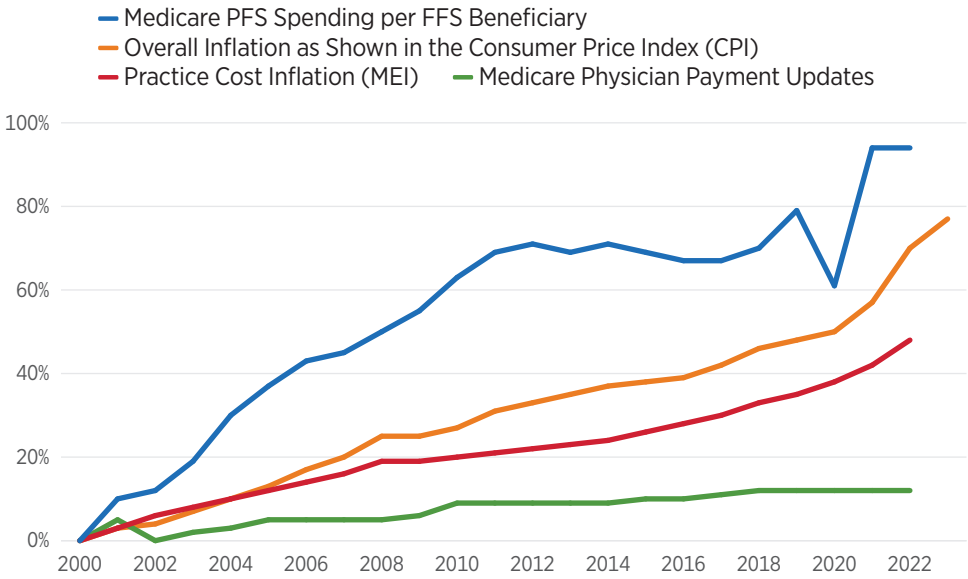
of "overtreatment" exists in traditional Medicare as well as private insurance.[68] In any case, the dual consequences are bigger taxpayer burdens and potentially serious negative consequences for patients trying to receive quality care and secure better overall health and well-being.

The trend lines for physician payment are, as noted, bending downward. Chart 4 highlights how, since 1998, the PFS conversion factor nominally declined by almost 8 percent.[69] When adjusted for inflation, Medicare physician payments have effectively declined by 29 percent from 2001 to 2024, according to the AMA.[70]

This decline in real payments has strained medical practices financially. As MedPAC reports, the costs of running a practice have increased by 48 percent from 2000 to 2022, while physician Medicare payment updates lagged far behind, at a 12 percent increase during the same period.[71] Therefore, the combination of declining reimbursements and rising practice costs has made it increasingly difficult for physicians to maintain the financial viability of their practices, potentially leading to reduced access to care for patients.

CHART 5

Medicare PFS Spending per Beneficiary and CPI Grew Faster than MEI and Medicare PFS Payment Updates



SOURCES: Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare Payment Policy," March 2024, p. 112, Figure 4-5, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf (accessed September 18, 2024), and US Inflation Calculator, "Consumer Price Index Data from 1913 to 2024," https://www.usinflationcalculator.com/inflation/consumer-price-index-and-annual-percent-changes-from-1913-to-2008/ (accessed September 18, 2024).

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If this trend continues, access to physicians who participate in FFS Medicare will become a serious problem for Medicare patients. Keeping up with declining reimbursements, physicians have continued to try to drive up the volume of their services. As MedPAC also noted, "updates to fee schedule payments have grown more slowly than clinicians' input cost growth but increases in the volume and intensity of services furnished by clinicians have resulted in higher physician fee schedule spending per FFS beneficiary."[72] (See Chart 5.)

In response to such financial pressures, doctors and physician groups may be more inclined to limit accepting *new* Medicare patients and rely more on commercially insured patients to secure higher reimbursements. Independent practices often require a certain "case mix" of Medicaid, Medicare, and commercially insured patients to remain financially viable or just break even.

It is not surprising that the Medicare Trustees anticipate that access to Medicare-participating physicians will become a "significant issue" without proper legislation to address the flawed payment reforms enacted in the past.[73] Ensuring sustainable Medicare reimbursement rates is thus crucial for maintaining patient access to care and ensuring the long-term viability of medical practices.

Physician Burnout. Not surprisingly, burnout among physicians has also been on the rise. According to a 2019 survey, 79 percent of primary care physicians and 57 percent of specialists reported burnout.[74] Regulatory and reporting requirements also take a toll on practicing physicians. According to a major 2016 study in *Health Affairs*, researchers reported that physicians spent 15 hours on average per week dealing with non-clinical requirements, such as compliance with external quality measures, at an estimated annual cost of $40,069 per physician or $15.4 billion combined for internists, family physicians, cardiologists, and orthopedists in the United States. The researchers also reported that only 27 percent of the physicians believe that current measures required for their reporting are moderately or very representative of the quality of care.[75] In other words, administrative burdens on physicians may not be effectively capturing the true quality of care provided, thus defeating the purpose of physician reimbursement based on the government bureaucracy's determination of "value."[76] The burnout factor only makes the access concerns for Medicare beneficiaries even more acute.

What Congress Should Do

The current Medicare physician payment policies are plagued with misaligned incentives, including incentives to ramp up service volume, that have contributed to escalating Medicare expenditures and a misrepresentation of value in health care services. This flawed administrative pricing system extends its influence beyond the Medicare program, permeating the private market and the entire health care system. However, moving to a new payment system will not be quick nor easy. Congress should focus on three key objectives: (1) adopt measures to provide doctors immediate relief; (2) transition to a more competitive, market-based payment system, including facilitating physicians' participation in "alternative payment models" and bonuses within MA; and (3) restore the traditional doctor–patient relationship.

1. Measures to Provide Doctors Immediate Relief. In the short term, reform of the current payment system should help to pave the way for

long-term changes that would transform Medicare into a comprehensive, patient-centered, value-driven, market-based, defined contribution system. Given the bipartisan recognition of the need to address these pressing issues, there is a real opportunity for lawmakers to come together and enact meaningful, lasting Medicare payment reforms.

Congress should:

Halt Medicare FFS Rate Reductions on the Condition that They Be Replaced with a Temporary Update Based on the Chained Consumer Price Index (C-CPI). Future payment updates should be based on an inflation index to ensure some measure of predictability. Congress should try to achieve this goal while maintaining some level of fiscal responsibility in a large and growing program that urgently requires it. There are three leading options: The Medicare Economic Index (MEI), the Consumer Price Index (CPI), and the C-CPI.

The MEI, as noted, measures physician practice cost inflation and is projected to increase by 3.6 percent next year. Not surprisingly, professional medical organizations favor MEI as the index for annual physician payment updates.[77] However, by using the MEI as the basis for annual updates, Congress would be accommodating, rather than restraining, the rapidly increasing Part B spending growth, which is fueling large annual deficits and contributing to the growth of a dangerous national debt. As the Medicare Trustees repeatedly warned, Congress, for the financial health and stability of the program, has a serious obligation to slow down the growth of Medicare spending. In any case, since 1992, especially with the enactment of the BBA and MACRA, the role of the MEI has been weakened as a guide for physician payment updates.[78]

The CPI is the most common measure of inflation. Over the 12-month period (ending in May 2024), the CPI increase for all goods and services registered 3.0 percent and for medical services 3.3 percent.[79] While the CPI is the most common measure of inflation, it is not the most accurate.

The C-CPI is a more accurate measurement. As the CBO reports, C-CPI is superior because it accounts for changes in consumer preferences month to month, capturing the dynamism of consumers' substitution of goods and services in response to pricing pressures.[80] While medical professional organizations are lamenting the projected 2.8 percent Medicare payment cut next year, it is noteworthy that the C-CPI increased by 2.8 percent over the 12 month period (also ending in May 2024).[81] Therefore, physicians would be better off than they are under today's dysfunctional status quo.

Though it is more accurate than the traditional CPI,[82] C-CPI is still not an ideal index as it is not focused specifically on health care transactions.

Replacing the proposed annual cuts with a C-CPI update would nonetheless provide some temporary stability and predictability for the many physicians serving Medicare beneficiaries as Congress wrestles with more comprehensive reforms. It would also serve as a practical compromise that ensures physician compensation is fair, holding off future CMS-proposed pay cuts and congressional overrides that foster uncertainty, while bringing some consistency to the health care market. Physicians and independent practices should know with at least some degree of certainty that they can invest in care delivery innovations that could help more patients without fear that the amount they were going to spend will be cut in the following year. Adopting a temporary C-CPI update would also allow Congress sufficient time to develop the necessary long-term payment and spending reforms while ensuring that, in the interim, physician reimbursements will bring much-needed stability and predictability, which is crucial for maintaining access to care for Medicare patients.

Direct MedPAC to Upgrade Its Annual Report on Physician Payment Adequacy. During this transition time, Congress should also direct MedPAC to upgrade its annual report on payment adequacy, focusing on gathering better data to accurately assess the value of Part B physician services.[83] MedPAC and Congress should focus on reducing the CMS's sole dependence on RUC data and obtain more objective cost data through other means.[84] These could range from exploring alternative data sources and methodologies to more accurately calculating work and practice expense RVUs to a full-scale reconsideration of the relevance of the RBRVS itself.

In the long term, if Congress moves the entire Medicare program to a defined contribution system, with health plan payments based on a rational system of market-based competitive bidding, there will be no need for an external metric to administratively set prices because service prices would be set by private contracts in a competitive market.

2. Measures to Enhance Integration with Medicare Advantage. Although implementing short-term solutions can stabilize the current payment system, gradually phasing out the traditional, well-entrenched administrative pricing and transitioning toward a more competitive, market-based methodology is an important bridge to more comprehensive reforms.

MA's popularity and enrollment has steadily increased with over half of Medicare beneficiaries choosing from competing, private MA plans. Its growth has been accompanied by strong performance on quality metrics, as well.[85] With a greater proportion of patients and physicians participating in these arrangements, Congress should focus on better integration of physicians with MA plans.

Congress should:

Facilitate Participation in APMs by Clarifying Certain MA Plans as a Qualified APM Option for Physicians to Receive Bonuses. Policymakers should focus on fully realizing an original goal of MACRA by better facilitating medical professionals' participation in MA and advanced APMs.[86]

The CMS should make it clear that MA functions as an APM and should be designated as such. Conceptually, MA is essentially an ideal APM platform because it is a population-based payment model where the government provides a fixed rate to private plans, which are then responsible for providing comprehensive care for beneficiaries. Furthermore, unlike traditional Medicare, MA can experiment with different payment models without additional risk to the taxpayer, and they have already done that with advanced APMs.[87]

To facilitate greater participation, Congress should authorize the CMS to adjust the payment and patient thresholds to make it easier for clinicians to qualify for bonuses and financial incentives.

Currently, as established under MACRA, to receive advanced APM bonuses as a qualifying participant, physicians need to meet CMS payment and patient thresholds through participation in an advanced APM entity. Qualifying participants are exempt from MIPS reporting and payment adjustments and receive increases in fee schedule updates that are higher compared to non-participants.[88] However, not all physicians meet these thresholds—another reason for the lack of participation in advanced APMs in the past. Those who do not meet the requirements to become a qualifying participant are ineligible for the advanced APM bonuses.

Congress should also consider streamlining the guidelines for qualification of these advanced APM bonuses. For example, through the existing "All-Payer and Other Payer Option," participation in MA can also qualify clinicians for the advanced APM bonuses.[89] Right now, however, that option is not as clear as it should be for doctors. Congress should therefore authorize the CMS to make it abundantly clear that participation in certain MA plans can meet the threshold for physicians to participate in these advanced APM bonuses.

Clarifying the guidelines and facilitating greater participation in these advanced APM bonuses would shift the current system further away from the administrative burden of MIPS, the influence of outdated Medicare FFS methodology, and the rigid administrative payment and price control system that determines doctors' fees in traditional Medicare.[90]

Authorize the CMS to Adopt Competitive Pricing for Certain Services and Promote Broader Episode-Based Bundled Payments. Payment for durable

medical equipment (DME) is, under current law, based on competitive bidding, a process where private vendors bid for Medicare business by offering the best price for the medical equipment. The forecast for competitive bidding, particularly in DME pricing, appears promising, with the CMS anticipating total savings of $42 billion over the next decade, including $17 billion in out-of-pocket expenses for beneficiaries.[91] Given this potential, the CMS should take a rules-based approach to employing this process for medical services under Part B, if only on a limited basis. If successful, Congress could enact legislation to enable the CMS to implement competitive bidding for these services, thereby achieving further savings.

Episode-based bundled payment models provide a single, pre-determined reimbursement to health care providers for all services related to a specific condition or procedure over a defined period, such as a knee replacement surgery and 90 days of recovery. These models are designed to incentivize care coordination, efficiency, and quality, while reducing unnecessary services, transferring financial risk from taxpayers to insurers, and increasing cost transparency and predictability.[92] While not perfect, these models have the potential to generate greater savings if redesigned properly. A redesigned approach should establish standardized bundles for several high-volume interventions and then solicit bids in each market. Winning bids would have to be below the pricing of the current administered pricing models or clearly demonstrate superior outcomes for a higher price. Further, to incentivize beneficiaries to migrate to lower-priced options in many cases, beneficiaries should share in the savings. The bidders would be assessed on the prices they would charge and relevant indicators of their services' quality.[93]

Bundled payments are most effective when designed around a condition rather than a procedure, as this approach encourages providers to consider alternative treatment options beyond costly surgical interventions. Additionally, as part of its regular oversight responsibilities, Congress should closely monitor the implementation of these payment changes to mitigate potential unintended consequences, such as overuse of financially attractive bundles, underuse of appropriate care services, and exclusion of high-risk patients. For these payment models to succeed, accurate risk adjustment is essential, and it will ensure that providers are compensated based on the health status of their patients. By reimbursing providers at higher rates for treating patients with more conditions and risks, risk adjustment encourages providers to treat a diverse patient population rather than preferentially choosing healthier, less costly patients. Without this in place, providers may be incentivized to focus solely on treating patients who are less expensive and have fewer health issues.[94]

Level the Playing Field Between Independent Physicians and Hospital Systems by Enacting Site Neutrality in Medicare Payments. The principle is simple: Medicare should pay the same rate for a medical service or procedure whether it is delivered in a hospital setting, a clinic, or in a physician's office. In short, the payment would be site neutral. Aligning physician and hospital rates could achieve significant savings and blunt impending physician pay cuts without worsening the financial condition of the Medicare hospital insurance (HI) trust fund. The Trump Administration's Office of Management and Budget analysts projected that implementing site neutrality could lead to significant savings between 2021 and 2030. They estimated that paying hospital-owned physician offices located off-campus at the same rate as independent physician offices would save $47.2 billion over this period. Additionally, they calculated that paying on-campus hospital outpatient departments at the physician office rate for certain services would result in even greater savings of $117.2 billion from 2021 to 2030.[95]

More recently, analysts with the Blue Cross Blue Shield Association have estimated that a full Medicare site-neutral payment reform would save an estimated $471 billion for both patients and taxpayers over the period 2024 to 2033.[96] Further, Medicare beneficiaries would have a greater selection of providers from which to choose. As former Health and Human Services Secretaries Alex Azar, serving in a Republican Administration, and Kathleen Sebelius, serving in a Democratic Administration, have recently argued, "Site-neutral payments represent a commonsense policy that will reduce costs for patients and taxpayers. It will diminish perverse incentives for consolidation and incentivize care delivery in the right place for the right price. It's a no brainer that we believe could reduce costs for patients and payers."[97]

3. Restoring the Doctor–Patient Relationship. Central to reforming the Medicare physician payment system is to move away from decades of failed administrative pricing and toward a more stable competitive payment model. To further this objective, Congress should take certain actions to facilitate greater patient engagement and the restoration of the traditional doctor-patient relationship.

Congress should:

Build on Legislative Initiatives to Require Price Transparency for All Clinicians' Medical Procedures and Treatments and Revisit Current Statutory Restrictions on Balance Billing. Requiring physicians to report prices *in advance* will empower patients to make informed, cost-conscious health care decisions.

Balanced billing in Medicare was permitted before the enactment of OBRA. Circumstances and public sentiments have changed significantly since 1989, when the current Medicare physician payment system was created. Price transparency, for example, has achieved broad bipartisan support. Thus, it is not surprising that the House of Representatives has already passed on a bipartisan basis, a comprehensive price transparency bill, H.R. 5378, that would improve the functioning of private hospital and insurance markets. Its purpose is to provide patients with clear, easily accessible, consumer-friendly information on health care prices in those markets. There should be no "surprise billing" under any circumstances, and that principle should apply with equal force to billing from medical practices.

Balance billing occurs when a health care provider bills a patient for the difference between the total cost of services and the amount that the patient's insurance covers. This practice enables providers to charge fees that exceed the Medicare price caps or pre-negotiated rates set by insurance companies.

Perhaps with the foresight that government payment would lag behind commercial prices, between 1966 and 1989, physicians were legally allowed to balance bill Medicare patients for the difference between the Medicare reimbursement rate and the physician's full charge. At the same time, however, there was also no federal consumer protection against surprise billing, which could leave Medicare patients vulnerable during this period. Times have changed, and there is a broad political consensus that patients should be protected against surprise billing.

In pursuing long-term reforms, Congress may wish to reconsider the 1990s restrictions on balance billing and authorize a demonstration project to assess the impact of lifting them on patient access, cost, and provider competition. But if Congress does so, it should impose certain iron-clad consumer protections. The CMS should provide patients with information on which doctors accept Medicare payment in full and which do not. Moreover, to protect patients from unexpected costs, physicians should only be permitted to balance bill under Medicare if they provide up-front disclosure of their service prices.

Repeal Restrictions on the Traditional Rights of Doctors and Patients to Contract Privately for Personalized Medical Services. Current law imposes restrictions and regulatory burdens on doctors and patients who wish to enter into private agreements in the provision of medical services. Patients, for reasons that seem good to them, may wish to refrain from billing Medicare for legal medical services and maintain privacy in their encounters with doctors of their choice. While the 1997 statutory restriction on Medicare

private contracting was unprecedented, it provided the fig leaf of an exemption. If a doctor engages in a private agreement with one patient, the law requires that the physician opt out of treating all other Medicare patients, thus foregoing all Medicare reimbursement for a period of two full years.[98] Obviously, for most physicians, this is a financially impossible option, given the sheer size of the Medicare market. Practically, it confines the advantages of private medical contracting (including "concierge" medicine) to upper-income patient populations who can and do go outside the Medicare program for more personalized care.

The provision operationally is a direct restriction on patient choice. As noted, perhaps for reasons of confidentiality or a perceived higher quality of medical care, patients may want to engage the services of a physician privately, but current law obviously makes this virtually impossible.[99] Remarkably, American senior citizens have less personal freedom to engage with their doctors privately than any of the citizens of the United Kingdom, who have the freedom to opt out of the British National Health Service, a system of government-run national health insurance, and engage the services of a British physician privately without any similar regulatory hindrance. Medicare's restriction on the ability of Americans to pay out of pocket for a legal medical service they want or need from a doctor of their personal choice is an anomaly in a country that values the primacy of personal freedom.

Provide Direct Primary Care (DPC) Options in Medicare. DPC is a health care model where patients pay their physician or practice a flat monthly or annual fee, under contract, for a defined set of primary care services. This model allows physicians to practice as they see fit and enables patients to switch providers without involving the Medicare bureaucracy or insurance companies. DPC programs have been shown to generate more savings and address many challenges facing our primary care system.[100]

Congress could permit MA plans to create special accounts for DPC. Congress could also designate DPC arrangements and services as an APM option while permitting patients to use tax-free health-savings-account funds for direct primary care arrangements if they wish to do so.[101] Medicare FFS should also be able to create special accounts for patients who wish to take advantage of a DPC option.

Conclusion

Today's problems with Medicare physician payment are rooted in OBRA. Subsequently, the congressional record on Medicare physician payment,

spanning more than three decades, is not a stellar example of federal health policymaking. The repeated changes to payment policies have proven ineffective in resolving persistent issues, such as instability and unpredictability of physician payment. Those unresolved issues pose challenges for patients' future access to care. Meanwhile, medical professionals must bear costly administrative burdens and face complexities in navigating reimbursement processes in which the basic RBRVS formula is flawed, and the data and the accuracy of pricing are questionable.

In the short term, Congress can make genuine improvements in Medicare physician payment by updating physician payment based on the C-CPI rather than continual cuts based on the CMS payment formula, annually reviewing and adjusting payments to ensure more accurate pricing, revisiting the outdated statutory restrictions on balance billing, eliminating the restrictions on private medical contracting, taking advantage of MA's best payment practices, fostering real competition between big hospital systems and independent private practices through site-neutral payments, and, thus, allowing patients and taxpayers alike to secure serious savings by fostering choice among price-transparent medical professionals and institutions.

For the long term, market-based reforms of Medicare physician payment can help to transition the entire program into a comprehensive defined contribution ("premium support") system driven by consumer choice and market competition. Low-income beneficiaries would receive additional financial assistance, of course, as they do today. As previously noted, such a transitional change would secure major program savings for beneficiaries and taxpayers and help to ensure Medicare's long-term solvency.

The basic FFS methodology for compensating physicians enacted more than three decades ago is incompatible with the creation of such a modern, flexible, and competitive Medicare program. Meanwhile, Congress can take steps to deliver better value for health care dollars, resulting in improved care and better medical outcomes and reduced bureaucracy. Market-based physician payment reforms can ignite competition and innovation in care delivery, improve quality and replace the incentives of the outdated FFS system—a hideously complex system of administrative pricing and price controls that has fostered an increase in volume over value in the delivery of medical services. Congress must reform the Medicare physician payment system. Merely avoiding annual cuts or tweaking administrative pricing is insufficient. Physician payment reform should also be a bridge to the future, a down payment on a more comprehensive set of policy changes that restructure Medicare, where broad consumer choice among health plans, including traditional Medicare, drive intense competition among plans and

providers, control costs, and improve the quality of care delivered based on quality metrics that are not bureaucratically determined. In the end, these reforms would enhance patient engagement, help to restore the traditional doctor–patient relationship and ensure that beneficiaries have access to high-quality care under Medicare well into the future.

Endnotes

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