

Testimony of Matthew Fiedler, Ph.D.
Joseph A. Pechman Senior Fellow in Economic Studies
Brookings Schaeffer Initiative on Health Policy
The Brookings Institution

Before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

October 19, 2023

Chairman Guthrie, Ranking Member Eshoo, and members of the subcommittee, thank you for inviting me here today. My name is Matthew Fiedler, and I am a health economist and the Joseph A. Pechman Senior Fellow in Economic Studies at the Brookings Institution, where I am affiliated with the Schaeffer Initiative on Health Policy.¹ My research examines a range of topics in health care policy, including health care provider payment and health insurance regulation.

I am excited to be here today to discuss ways to improve Medicare’s physician payment system. My testimony begins by examining the tradeoffs that policymakers will face as they make decisions about the trajectory of Medicare’s physician payment rates. I make four points:

- Policy in this area must balance two important objectives: (1) ensuring Medicare beneficiaries can access high-quality physician care; and (2) limiting the costs that higher Medicare payment rates impose on taxpayers, beneficiaries, and even the privately insured.
- Data on Medicare beneficiaries’ ability to access physician care can guide policymakers as they balance these objectives. Most beneficiaries do not report major problems accessing physician care, and access to care among Medicare beneficiaries is currently comparable to—or even slightly better than—access to care among the privately insured.
- Strikingly, Medicare beneficiaries’ access to physician care has remained relatively stable over a two-decade period in which Medicare’s physician payment rates have grown more slowly than practices’ input costs. This could indicate that changes in Medicare payments currently have only modest effects on access or, alternatively, that other changes in the delivery system are offsetting the effects of lower input-cost-adjusted payment rates.
- Looking ahead, this experience suggests that there is some scope for Medicare’s payment rates to grow more slowly than input costs without eroding access. This conclusion is subject to some caveats, notably: during the next year or two, growth in input costs will likely exceed growth in payments by more than it did during a typical year in the past two decades; the delivery system could respond differently to the same payment change in the future relative to the past, especially if input costs outpace payment rates indefinitely; and outcomes other than access, like quality, might exhibit different trends.

¹ The views expressed in this testimony are my own and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

The second half of my testimony discusses potential improvements to the structure of Medicare’s physician payment system that are worth considering regardless of the level of payments:

- *Eliminate the Merit-Based Incentive Payment System (MIPS).* Evidence suggests that MIPS is doing little to improve patient care even as it imposes substantial compliance costs on physician practices. Eliminating these costs by eliminating MIPS would be a low-cost way of addressing concerns about the adequacy of Medicare’s physician payments.
- *Maintain bonuses for participation in advanced alternative payment models (APMs).* In contrast to MIPS, well-designed APMs do appear to improve the efficiency of patient care. The existing payment bonus for participation in “advanced” APMs encourages uptake of these models, while also giving the Centers for Medicare and Medicaid Services (CMS) greater flexibility to improve their design. However, under current law, this bonus will fall sharply starting in 2024 before gradually recovering in future years.
- *Insulate future physician payment rates from inflation shocks in a budget-neutral way.* Physician payment updates are currently fixed in law, so shocks to economy-wide inflation can cause inflation-adjusted payment rates to be higher or lower than expected. This could be avoided without a substantial scored cost by specifying that payment updates should equal the Medicare Economic Index minus an appropriate fixed percentage.
- *Adopt site-neutral payment for ambulatory services.* At present, Medicare often pays more for ambulatory services delivered in a hospital outpatient department rather than a physician office. A shift to site-neutral payment could reduce costs without threatening patients’ access to appropriate care. Importantly, the benefits of adopting site-neutral payment will likely grow over time if Medicare’s physician payment rates continue to grow slowly in the years to come, as is scheduled to occur under current law.

The remainder of my testimony will examine these points in greater detail.

Tradeoffs in Setting Medicare’s Physician Payment Rates

Policymakers face difficult tradeoffs when setting Medicare’s physician payment rates. Higher rates make treating Medicare patients more attractive and may thereby increase Medicare beneficiaries’ access to physician care. This is an important potential benefit since ensuring that beneficiaries have easy access to high-quality care is one of Medicare’s core goals.

But higher rates also come with costs, both obvious and not-so-obvious. Most directly, higher prices increase claims spending in traditional Medicare and, through various channels, payments to Medicare Advantage plans.² Three-quarters of the additional spending is borne by taxpayers,

² Medicare Advantage benchmarks are based on spending in traditional Medicare, so they rise mechanically when traditional Medicare spends more. Plan bids will likely rise as well, both because the prices that Medicare Advantage plans pay physicians closely track traditional Medicare’s and because bids tend to rise when benchmarks rise. For evidence on the latter two points, see, for example, Daria M. Pelech, “Prices for Physicians’ Services in Medicare Advantage and Commercial Plans,” *Medical Care Research and Review* 77, no. 3 (2020): 236–48, <https://doi.org/10.1177/1077558718780604>; Zirui Song, Mary Beth Landrum, and Michael E. Chernew, “Competitive Bidding in Medicare Advantage: Effect of Benchmark Changes on Plan Bids,” *Journal of Health Economics* 32, no. 6 (December 1, 2013): 1301–12, <https://doi.org/10.1016/j.jhealeco.2013.09.004>.

and the remaining 25% is borne by Medicare beneficiaries through higher Part B premiums. Higher rates also increase beneficiary cost-sharing, which, for these services, equals 20% of Medicare payment rate (after the Part B deductible is met). Beneficiaries without supplemental coverage bear this additional cost-sharing directly, while others bear it through higher Medigap premiums.

Raising payment rates in Medicare may also raise costs for people with private insurance. Research examining past changes in Medicare physician payment finds that when Medicare increases its physician payment rates, the prices that private insurers pay for physician services increase roughly proportionally.³ These higher prices translate into higher claims spending for private insurers, which enrollees ultimately bear in the form of higher premiums or higher cost-sharing.

Evidence on Medicare Beneficiaries' Access to Care

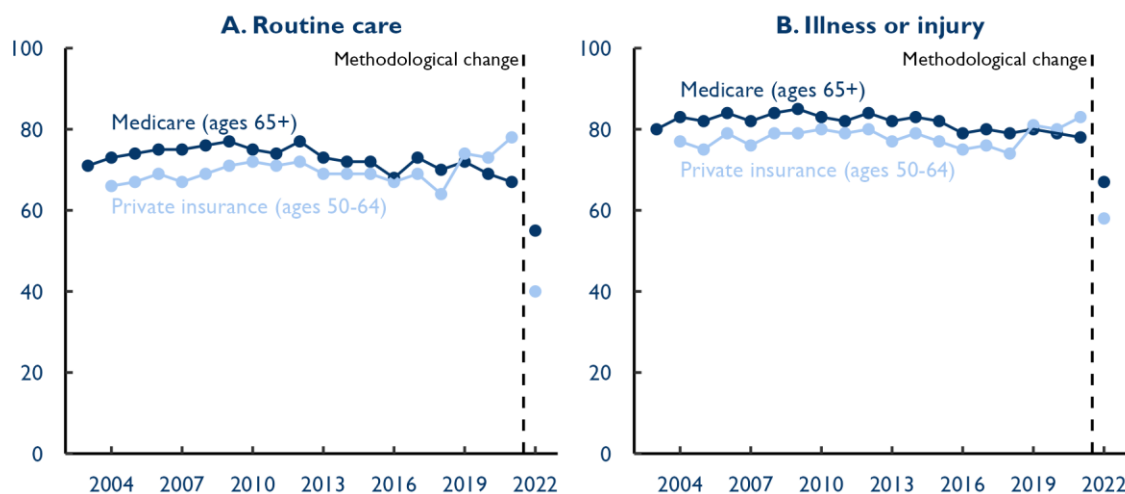
In light of the tradeoffs described above, it is useful to examine what level of access to physician services Medicare beneficiaries enjoy today and to ask how that level of access might evolve if physician payments remain on the trajectory envisioned under current law.

Current access to physician services in Medicare and private insurance

One measure of Medicare beneficiaries' access to care is whether they can obtain care in a timely fashion when they need it. Figure 1 presents estimates from an annual survey conducted by the Medicare Payment Advisory Commission (MedPAC) that asks Medicare beneficiaries and people with private insurance who have needed care over the past year whether they had to wait longer than they wanted to get an appointment. Panel A displays the share of respondents who sought routine care who "never" had to wait longer than they wanted to get an appointment, while Panel B displays the corresponding estimates for respondents seeking care for an illness or injury.

Figure 1. Wait to Get a Doctor's Appointment

Percent who "never" waited longer than wanted (among those seeking care in past year)



Source: MedPAC (various years)

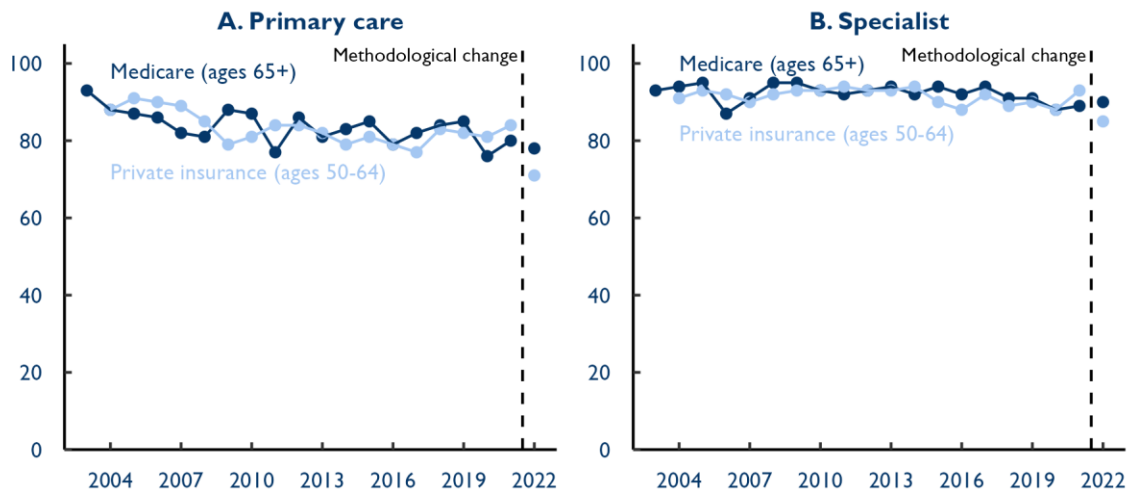
Note: Estimates for 2022 may not be comparable to estimates for prior years due to a change in survey methodology.

³ Jeffrey Clemens and Joshua D. Gottlieb, "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments," *Journal of Political Economy* 125, no. 1 (December 16, 2016): 1–39, <https://doi.org/10.1086/689772>.

Figure 2 reports estimates from questions in the same survey that ask people who searched for a new physician during the past year whether they had trouble finding one. Panel A displays the share of respondents who sought a new primary care physician who had “no problem” or a “small problem” doing so, while Panel B displays corresponding estimates for respondents seeking a new specialist. (In both figures, I show the estimate for 2022 separately because MedPAC changed its survey methodology in 2022, which likely makes this estimate incomparable to prior years.)

Figure 2. Ease of Finding a New Physician

Percent with "no" or "small" problem finding a new physician (among those looking in past year)



Source: MedPAC (various years)

Note: Estimates for 2022 may not be comparable to estimates for prior years due to a change in survey methodology.

A notable takeaway from both figures is that, at present, most Medicare beneficiaries do not report major problems in accessing physician care. Additionally, Medicare beneficiaries currently report similar—or even slightly better—access to physician care than people with private insurance.

Outlook for beneficiary access under current law

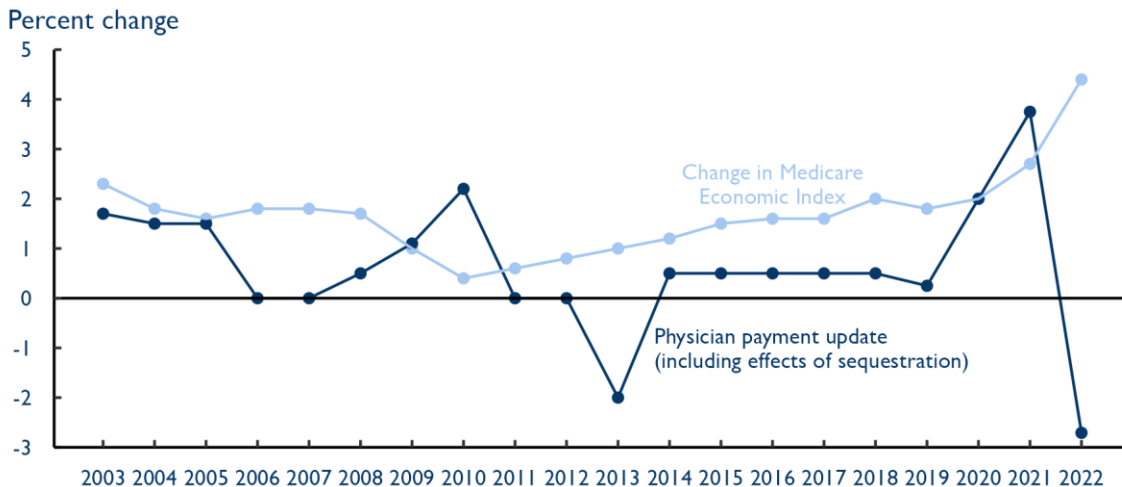
Under current law, Medicare’s physician payment rates are likely to grow more slowly than practices’ input costs. That seems virtually certain to have occurred in 2023; payment rates declined by about 0.5% as a temporary payment increase began to phase down, while growth in input costs has likely remained elevated alongside economywide inflation.

This qualitative pattern is likely to continue. Payment rates are scheduled to fall by about 1.25% in 2024 and then again in 2025 as the current temporary payment increase continues to phase down. Starting in 2026, rates will rise modestly each year, by 0.75% per year for physicians participating in certain alternative payment models and by 0.25% per year for other physicians. Input costs, on the other hand, seem likely to rise at a faster clip; a plausible (if uncertain) forecast is that growth in the Medicare Economic Index will ultimately return to something like the 2% per year pace observed before the pandemic as economywide inflation moderates.

A natural question is what these trends portend for beneficiary access. One source of insight on that question is experience over the last two decades, a period in which updates to Medicare

physician payment rates have consistently lagged growth in input costs, as shown in Figure 3. On average from 2002 through 2022, growth in Medicare’s physician payment rates was 1.1 percentage points per year lower than growth in the Medicare Economic Index. Nevertheless, access to care appears to have been relatively stable over this period, as shown in Figures 1 and 2.

Figure 3. Physician Payment Update vs. Change in Medicare Economic Index



Source: Centers for Medicare and Medicaid Services; author’s calculations
 Note: Payment updates reflect the change from December to December. Changes in the Medicare Economic Index reflect the actual change for the calendar year; for 2010 and later, estimates reflect the 2017-based index, while for earlier years, they reflect the 2006-based index.

Broadly, there are two possible explanations for the resilience of beneficiary access in the face of a persistent gap between growth in payment rates and input costs. One is that, over the range of payment rates observed over this period, changes in payment rates do not have much effect on physicians’ willingness to treat Medicare patients. The other is that some other ongoing change in the delivery system—for example, the rapid increase in the amount of care supplied by nurse practitioners and physician assistants—could have offset declines in access caused by declines in Medicare’s real (that is, input-cost-adjusted) payment rates.⁴ Either interpretation suggests that it may be possible for payment rates to grow more slowly than input costs to some degree and for some period without causing a decline in Medicare beneficiaries’ ability to access physician care.

There are important caveats to this conclusion. First, at least through 2025, the gap between growth in payment rates and growth in input costs will likely be larger than in typical years during the last two decades. Any ongoing delivery system changes that have been sufficient to offset the more gradual declines in real payment rates seen in the past might be too small to offset faster declines.

Second, while the decline in real physician payment rates have not translated into a decline in beneficiary access over the last two decades, the future could differ from the past, particularly if real payment rates continue to decline indefinitely. Notably, even if access has been relatively

⁴ Medicare Payment Advisory Commission (MedPAC), “Medicare and the Health Care Delivery System” (Medicare Payment Advisory Commission, June 2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf.

insensitive to payment rates in the past, that could change as payment rates reach lower levels. Indeed, experience from Medicaid illustrates that low enough payment rates can threaten access; physician payments in Medicaid are typically far lower than those in Medicare; in 2019, the prices Medicaid paid for a set of common physician services averaged just 72% of Medicare’s prices,⁵ and likely because of those low payment rates, physicians are far less likely to accept new Medicaid patients than patients with Medicare or private insurance.⁶ Similarly, even if ongoing trends in the delivery system have helped offset the effects of declines in real payment rates over the past two decades, there is no guarantee that those trends will continue forever.

Third, while I focus here on access, there are other outcomes that policymakers may care about, such as quality of care. Physician practices may sometimes adapt to lower payment rates in ways that preserve access but still have adverse effects on quality of care. For example, some practices might respond to lower payment rates by reducing their input costs (e.g., hiring less staff), which might (or might not) have implications for quality. Additionally, evidence suggests that a substantial part of reductions in Medicare’s physician payment rates is accommodated through reductions in physician earnings.⁷ Over the long run, that could change who chooses to enter the medical profession, which could have long-run consequences for quality of care.

A final note is that even if real payment rates do decline without eroding access, that does not necessarily mean that the path of payment rates was appropriate. If policymakers believe that Medicare beneficiaries currently have too little access to physician care, they should aim to improve access, which might entail raising real payment rates (either broadly or in specific cases).

Reforming the Structure of the Medicare Physician Payment System

The remainder of my testimony focuses on four changes to how Medicare pays for physician services that are worth considering regardless of the overall trajectory of payment rates.

Eliminate the Merit-Based Incentive Payment System⁸

The Merit-Based Incentive Payment System (MIPS) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); it adjusts most clinicians’ Medicare payments upward or downward based in their performance in several domains, including cost and quality.

⁵ Stephen Zuckerman, Laura Skopec, and Joshua Aarons, “Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019,” *Health Affairs* 40, no. 2 (February 2021): 343–48, <https://doi.org/10.1377/hlthaff.2020.00611>.

⁶ Medicaid and CHIP Payment and Access Commission (MACPAC), “Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey,” June 2021, <https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf>.

⁷ Joshua D Gottlieb et al., “Who Values Human Capitalists’ Human Capital? The Earnings and Labor Supply of U.S. Physicians,” July 2023, <https://www.gottlieb.ca/papers/DoctorsIncomePaper.pdf>.

⁸ This portion of my testimony has been adapted from testimony I delivered before the House Committee on Small Business, Subcommittee on Oversight, Investigations, and Regulations on July 19, 2023.

While clinicians who participate in certain alternative payment models are exempt from MIPS, only a minority of clinicians participate in those models, so most are subject to MIPS.⁹

Unfortunately, there is little reason to believe that MIPS is achieving its goal of improving the quality or efficiency of patient care.¹⁰ One fundamental problem is that MIPS allows clinicians to choose many of the measures that they are evaluated on. In practice, different clinicians choose different measures, and they likely do so at least in part based on which measures they expect to perform best on. This makes it impossible to use MIPS scores to meaningfully compare clinicians and, thus, doubtful that MIPS can motivate better outcomes.

Measuring cost and quality performance at the level of individual clinicians or practices, as MIPS aims to do, is also challenging. Patients' outcomes are shaped by the efforts of many different providers, which makes it difficult to determine who is responsible for what, plus it can be hard to construct statistically reliable performance estimates at the provider level. This is a recipe for weak, incoherent incentives, and it is likely why a plethora of programs that have adjusted providers' payment rates based on provider-level measures of cost and quality performance (including programs that avoid some of MIPS' distinctive shortcomings) have failed to improve care.¹¹

MIPS does, however, impose large compliance burdens on practices. Much of the information used to compute a practice's MIPS score—notably its performance on quality measures—is reported by the practice itself. Practices are also responsible for deciding *which* quality measures to report, as well as how they want to be scored in other MIPS domains. These activities are costly. A recent study that interviewed practices about their MIPS compliance costs estimated that

⁹ Centers for Medicare and Medicaid Services (CMS), “2020 Quality Payment Program Experience Report,” August 2022, <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2013/2020%20QPP%20Experience%20Report.pdf>.

¹⁰ For more discussion of these points, see Matthew Fiedler et al., “Congress Should Replace Medicare’s Merit-Based Incentive Payment System,” *Health Affairs Blog* (blog), February 26, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180222.35120/full/>; Matthew Fiedler, “Medicare Physician Payment Reform after Two Years: Examining MACRA Implementation and the Road Ahead,” § Committee on Finance (2019), <https://www.finance.senate.gov/imo/media/doc/08MAY2019FIEDLERSTMNT.pdf>; Medicare Payment Advisory Commission (MedPAC), “Medicare Payment Policy” (Medicare Payment Advisory Commission, March 2018), http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec_rev_0518.pdf?sfvrsn=0; Eric C. Schneider and Cornelia J. Hall, “Improve Quality, Control Spending, Maintain Access — Can the Merit-Based Incentive Payment System Deliver?,” *New England Journal of Medicine* 376, no. 8 (February 23, 2017): 708–10, <https://doi.org/10.1056/NEJMp1613876>; Vinay K. Rathi and J. Michael McWilliams, “First-Year Report Cards From the Merit-Based Incentive Payment System (MIPS): What Will Be Learned and What Next?,” *JAMA* 321, no. 12 (March 26, 2019): 1157–58, <https://doi.org/10.1001/jama.2019.1295>.

¹¹ See, for example, Eric T. Roberts, Alan M. Zaslavsky, and J. Michael McWilliams, “The Value-Based Payment Modifier: Program Outcomes and Implications for Disparities,” *Annals of Internal Medicine* 168, no. 4 (February 20, 2018): 255–65, <https://doi.org/10.7326/M17-1740>; Andrew M. Ryan et al., “Changes in Hospital Quality Associated with Hospital Value-Based Purchasing,” *New England Journal of Medicine* 376, no. 24 (June 15, 2017): 2358–66, <https://doi.org/10.1056/NEJMSa1613412>; Jose F. Figueroa et al., “Association between the Value-Based Purchasing Pay for Performance Program and Patient Mortality in US Hospitals: Observational Study,” *BMJ* 353 (May 9, 2016): i2214, <https://doi.org/10.1136/bmj.i2214>; Ashish K. Jha et al., “The Long-Term Effect of Premier Pay for Performance on Patient Outcomes,” *New England Journal of Medicine* 366, no. 17 (April 26, 2012): 1606–15, <https://doi.org/10.1056/NEJMSa112351>.

practices spent nearly \$13,000 per physician to comply with MIPS in 2019, on average.¹² If this estimate is representative of all MIPS participants, then total compliance costs in 2019 amounted to \$12 billion or 13% of total provider revenue under the physician fee schedule.¹³ Even if this estimate overstates compliance costs by an order of magnitude, they would still be sizeable.¹⁴

In sum, I see little reason to believe that MIPS generates benefits that justify its substantial costs. With colleagues, I have argued for repealing MIPS and replacing it with small, targeted incentives for practices to undertake specific high-value activities: (1) using a certified electronic health record, which can help advance broader federal efforts to ensure that clinical data can flow across providers when needed; and (2) reporting data to a clinical registry, which can help facilitate valuable clinical research.¹⁵ In parallel, policymakers should strengthen incentives to participate in advanced APMs, an idea I return to in the next section.

Before proceeding, I note that because eliminating MIPS would reduce practices' costs of serving Medicare beneficiaries, eliminating MIPS would, in effect, make Medicare's physician payments more generous.¹⁶ Thus, if policymakers are concerned that current-law payment rates are inadequate, eliminating MIPS could help address that concern at little cost.

Extend the bonus for participation in advanced alternative payment models

In addition to MIPS, MACRA created bonuses for physicians participating in certain "advanced" APMs, notably including accountable care organization (ACO) models. This bonus was initially 5% of a physician's payments but has fallen to 3.5% for 2023.¹⁷ Under current law, the bonus will disappear entirely for 2024. Advanced APM participants will benefit from higher base payment rates than other physicians based on participation during 2024, but this differential will start at just

¹² Dhruv Khullar et al., "Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-Based Incentive Payment System," *JAMA Health Forum* 2, no. 5 (May 14, 2021): e210527, <https://doi.org/10.1001/jamahealthforum.2021.0527>.

¹³ This estimate was obtained using CMS' estimate of the total number of MIPS-eligible clinicians in 2019 and the Medicare Trustees' estimate of total spending under the physician fee schedule in that year. See Centers for Medicare and Medicaid Services (CMS), "2019 Quality Payment Program Experience Report," October 2021, <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1653/2019%20QPP%20Experience%20Report.pdf>; Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2023 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," April 2023, <https://www.cms.gov/oact/tr/2023>.

¹⁴ There is some reason to suspect that this estimate overstates practices' actual costs. These estimated costs exceed the difference between the largest positive and largest negative MIPS payment adjustment applied for 2019. (See Centers for Medicare and Medicaid Services (CMS), "2019 Quality Payment Program Experience Report."). This implies that practices would have been better off simply ignoring their obligations under MIPS. Since few did, this suggests that the costs faced by typical practices may not have been quite this large. Additionally, costs may have declined since 2019 as practices have gained experience and as CMS has tried to simplify the program.

¹⁵ Fiedler et al., "Congress Should Replace Medicare's Merit-Based Incentive Payment System"; Fiedler, Medicare physician payment reform after two years: Examining MACRA implementation and the road ahead.

¹⁶ Abe Dunn et al., "A Denial a Day Keeps the Doctor Away," *The Quarterly Journal of Economics*, June 28, 2023, qjad035, <https://doi.org/10.1093/qje/qjad035>.

¹⁷ Payment of the bonus occurs with a lag, so the final year in which the bonus will be paid under current law is 2025. Similarly, the differential updates to underlying payment rates will first affect payments during 2026.

0.5% and then grow at 0.5 percentage points per year thereafter, so incentives for advanced APMs participation will take many years to return to their current level.

Evidence suggests that, unlike MIPS, many APMs—particularly ACO models—have been successful in improving the efficiency of patient care,¹⁸ and the advanced APM bonus encourages participation in these models. The bonus also gives CMS greater flexibility to improve the design of these models. Notably, many ACO models originally based the “benchmarks” used to assess each ACO’s spending performance on the ACO’s own historical spending.¹⁹ This approach had the virtue of ensuring that all ACOs had a realistic chance of reducing spending below its benchmark and thus helped elicit participation from a broad range of ACOs. But this approach also had a downside: if ACOs expect *future* benchmarks to be based on their own current spending, then that undermines ACOs’ incentives to reduce spending; under this regime, ACOs know that better performance today will be punished with a lower benchmark tomorrow.

CMS has been working to address this “ratchet effect” by partially decoupling benchmarks from ACOs’ own past performance. This approach strengthens ACOs’ incentives to reduce spending but can also result in benchmarks that do not accurately reflect the costs of serving the ACO’s population or that reflect a level of performance that the ACO is unlikely to be able to attain in the short run. This can cause ACOs with hard-to-attain benchmarks to stop participating while those with easy-to-attain benchmarks remain and collect shared savings payments that are out of proportion with how much they have actually reduced spending. Incentives for advanced APM participation attenuate this “selective participation” dynamic by encouraging ACOs with harder-to-attain benchmarks to continue participating, which can allow CMS to go further in decoupling benchmarks from past performance and thereby strengthening incentives to reduce spending.

Continuing the existing bonus would help preserve existing levels of advanced APM participation and CMS flexibility in model design, but there are also ways to build on the existing bonus. First, a larger bonus would encourage more APM participation and give CMS additional flexibility in model design.²⁰ To offer a large bonus while limiting the associated fiscal cost, policymakers could consider implementing a budget-neutral combination of additional bonuses for advanced APM participation and penalties for non-participation.²¹

¹⁸ For a recent review of evidence on this point, see J. Michael McWilliams, Alice Chen, and Michael E. Chernew, “From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-Based Payments” (Brookings Institution, October 13, 2021), <https://www.brookings.edu/research/from-vision-to-design-in-advancing-medicare-payment-reform-a-blueprint-for-population-based-payments/>.

¹⁹ For more discussion of the history of ACO benchmark setting and the effects of different regimes, see Matthew Fiedler, “Comments on the Medicare Shared Savings Program” (Brookings Institution, September 2022), <https://www.brookings.edu/articles/comments-on-the-medicare-shared-savings-program/>; McWilliams, Chen, and Chernew, “From Vision to Design in Advancing Medicare Payment Reform.”

²⁰ McWilliams, Chen, and Chernew, “From Vision to Design in Advancing Medicare Payment Reform.”

²¹ Fiedler et al., “Congress Should Replace Medicare’s Merit-Based Incentive Payment System”; Fiedler, Medicare physician payment reform after two years: Examining MACRA implementation and the road ahead.

Second, policymakers could change the bonus payment to be a flat amount per beneficiary associated with an APM rather than a percentage of the participating clinician's payments²² Relative to the current structure, this structure would remove an incentive to increase utilization.

Third, policymakers could consider making bonuses available in a wider array of circumstances. One objection to the current bonus structure is that there are few advanced APMs targeted at specialist physicians. One way to address this concern would be to make specialists eligible for a portion of the bonus available to full advanced APM participants if they enter into a collaboration agreement with a qualifying ACO.²³ This structure would give ACOs leverage to obtain better cooperation from specialists, while also giving specialists a path to obtaining bonus payments. This would likely be a better approach to engaging specialists in APMs than developing a plethora of specialty-specific models, which would add considerable administrative complexity for both providers and CMS; this approach would also allow specialists to seek out whichever model happened to offer them the best financial terms and thereby increase program costs.

Insulate future physician payment rates from inflation shocks in a budget-neutral way

At present, physician payment updates for all future years are currently fixed in law. Thus, if economywide inflation is higher than expected, inflation-adjusted payment rates will be lower than expected, while if inflation turns out to be lower than expected, then inflation-adjusted payment rates will be higher than currently expected. Whether policymakers believe that the current trajectory of payment rates is most likely too high or too low, it is likely undesirable for the path of inflation-adjusted payment rates to depend on random shocks to economywide inflation.²⁴

This outcome could be avoided by restoring some linkage between Medicare's physician payment rates and a measure of price growth. One approach to doing so would be to specify that the annual update as equaling growth in the Medicare Economic Index (MEI). But this approach would be likely to lead to much larger payment updates, on average, than would occur under current law and, as such, would likely have a large fiscal cost. Additionally, consistent with the discussion earlier in my testimony, if policymakers are aiming simply to maintain beneficiary access to care at something close to its current level, payment updates this large may not be necessary.

An alternative would be to specify updates equal to growth in MEI *minus some fixed percentage*. Under this approach, changes in economywide inflation would be reflected in the MEI and, thus, in Medicare's payment updates. But if the fixed percentage was large enough, then this approach would not be assigned a substantial cost under Congressional Budget Office (CBO) scoring. In particular, if the fixed percentage were set to equal the current CBO projection of growth in the MEI, less the payment update scheduled under current law, then this approach would be equally likely to raise or lower future physician payment rates and, thus, would have little scored cost.

²² McWilliams, Chen, and Chernew, "From Vision to Design in Advancing Medicare Payment Reform."

²³ Fiedler et al., "Congress Should Replace Medicare's Merit-Based Incentive Payment System"; Fiedler, Medicare physician payment reform after two years: Examining MACRA implementation and the road ahead.

²⁴ In particular, for this aspect of the status quo to be desirable, a given increase in payment rates would need to generate larger benefits when payment rates are high than when they are low, which is unlikely.

Adopt site-neutral payments for ambulatory services

Medicare pays for services delivered in hospital outpatient departments under the hospital outpatient prospective payment system (OPPS), while it pays for services delivered in physician offices under the physician fee schedule (PFS). In general, payment for a given service is higher under the OPPS than under the PFS.²⁵ Congress took action to curtail this differential in 2015 for new hospital outpatient departments off a hospital’s main campus, and the Trump administration extended this policy to certain services delivered in existing hospital outpatient departments. Recently, the Committee has discussed proposals to move further toward site-neutral payment for many ambulatory services, potentially including services delivered on a hospital’s main campus.²⁶

The arguments for site-neutral payment are likely familiar, so I will only review them quickly here.²⁷ In brief, the current system increases costs for the federal government and for beneficiaries, while also encouraging services to shift into the hospital outpatient setting even if that is not the most appropriate site of care. In many cases, health systems effectuate those shifts by acquiring existing physician practices,²⁸ which may increase prices in commercial insurance markets by increasing concentration in those markets. But there are likely few or no clinical benefits to delivering the types of services targeted by site-neutral payment proposals in hospital outpatient departments rather than physician offices since, by design, these proposals target services that are routinely delivered in the physician office setting. Nor is there evidence that patients typically treated in outpatient departments differ in ways that would justify much larger payments.²⁹

There is, however, one additional point that I do wish to highlight here. As noted earlier, payment rates under the PFS are scheduled to grow slowly or even decline (in nominal terms) in the coming years. By contrast, OPPS rates are likely to grow because they are updated annually to reflect changes in input costs. This means that the gap between OPPS and PFS rates are likely to grow over the coming years, causing the benefits of a shift to site-neutral payment to grow as well.

²⁵ Medicare Payment Advisory Commission (MedPAC), “Medicare and the Health Care Delivery System,” June 2023, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

²⁶ For more discussion, see Loren Adler, Matthew Fiedler, and Benedic Ippolito, “Assessing Recent Health Care Proposals from the House Committee on Energy and Commerce,” May 12, 2023, <https://www.brookings.edu/articles/assessing-recent-health-care-proposals-from-the-house-committee-on-energy-and-commerce/>; Benedic Ippolito, Matthew Fiedler, and Loren Adler, “Weighing Policy Options for Returning Savings from Site-Neutral Payment Reforms to Hospitals” (Brookings Institution, May 26, 2023), <https://www.brookings.edu/articles/weighing-policy-options-for-returning-savings-from-site-neutral-payment-reforms-to-hospitals/>.

²⁷ For additional discussion, see Adler, Fiedler, and Ippolito, “Assessing Recent Health Care Proposals from the House Committee on Energy and Commerce.”

²⁸ David Dranove and Christopher Ody, “Employed for Higher Pay? How Medicare Payment Rules Affect Hospital Employment of Physicians,” *American Economic Journal: Economic Policy* 11, no. 4 (November 2019): 249–71, <https://doi.org/10.1257/pol.20170020>; Brady Post et al., “Hospital-Physician Integration and Medicare’s Site-Based Outpatient Payments,” *Health Services Research* 56, no. 1 (2021): 7–15, <https://doi.org/10.1111/1475-6773.13613>.

²⁹ Medicare Payment Advisory Commission (MedPAC), “Medicare and the Health Care Delivery System,” June 2023.

Conclusion

Policymakers face consequential decisions about the path of Medicare's physician payments. In making those decisions, policymakers must balance two important objectives: (1) ensuring that Medicare beneficiaries can access high-quality physician care; and (2) limiting the costs that higher Medicare payment rates impose on taxpayers, beneficiaries, even the privately insured.

Data on Medicare beneficiaries' ability to access physician care can guide policymakers as they seek to balance these objectives. At present, most beneficiaries are not reporting major problems accessing care, and access to care among Medicare beneficiaries remains comparable to access to care among the privately insured. Strikingly, this remains the case even after two decades in which Medicare's payment updates have grown more slowly than practices' input costs. Subject to some caveats, this suggests that there may be some scope for Medicare's payment rates to grow more slowly than input costs in the years to come without triggering a decline in access.

Regardless of what policymakers decide about the overall trajectory of Medicare's physician payment rates, there are structural changes to the Medicare physician payment system worth considering. These include eliminating MIPS, maintaining (and potentially improving) bonuses for participation in advanced APMs, insulating payment rates from shocks to economywide inflation in a budget-neutral way, and adopting site-neutral payment for ambulatory care.