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Health Care ADVISORY ▪

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Is Medicare Physician Fee Schedule Reform on the Horizon?

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On October 11, 2023, the House Republican Doctors Caucus released a discussion draft of legislation, the Provider Reimbursement Stability Act of 2023 (PRSA) that would enact significant changes to the Medicare Physician Fee Schedule (PFS). The PRSA was further discussed and debated in a House Energy and Commerce (E&C) Health Subcommittee hearing on October 19, 2023. Republicans and Democrats agreed that the PFS must be modified and explained that Medicare reimbursement for PFS-paid providers has decreased to an unsustainable level due to the budget neutrality requirement and the lack of an inflationary update. Some E&C Members noted that low Medicare reimbursement could lead to provider shortages within the Medicare system, leading to reduced access to care for many patients.

The PRSA would reform the PFS in four ways. *First*, the bill would raise the budget neutrality threshold from $20 million to $53 million in 2025 and increase the threshold every five years by the cumulative increase in the Medicare Economic Index starting in 2030. The budget neutrality threshold has not been updated since the implementation of the PFS in 1992, which according to Representative Michael Burgess, M.D. (R-TX) leads to unpredictability in PFS reimbursement. Increasing the threshold would be a welcomed reform to the PFS because it gives the Centers for Medicare & Medicaid Services (CMS) greater flexibility to implement new policies without triggering budget neutrality adjustments – a reduction – to the PFS conversion factor.

Second, the legislation would require CMS to analyze its utilization estimates compared to actual utilization by September 1 of a given year. If there is a difference between the estimate and the actual utilization, and that difference implicates budget neutrality, CMS will adjust payments made to providers to account for the actual utilization data. This lookback adjustment would begin in 2027 for payments made in 2025. Notably, the adjustment would not be taken into account when CMS establishes a budget neutrality adjustment for the impacted year. Should this provision be enacted, the resulting impact could be severe for certain services that had high (or low) estimated utilization rates that would have to be adjusted in the future.

Third, the bill would require CMS to update, at least every five years, the direct cost inputs for practice expense (PE) relative value units (RVU) of clinical staff wage rates, medical supplies, and equipment. For some services, regular PE input updates would be welcomed, especially since many of these inputs have gone several years without an update and because of the challenges with the existing process to obtain an update. However, this section will be

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incredibly difficult to implement as evidenced by CMS's previous attempts to update supply and equipment costs and the 15-year gap between the American Medical Association's prior and ongoing Physician Practice Information Survey. While CMS could rely on wage data from the Bureau of Labor Statistics (as it has recently) to make necessary PE wage updates, there appears to be limited available data sources for other PE components.

Fourth, the bill would limit the increases or decreases to the conversion factor to no more than 2.5% each year. This provision would provide greater PFS payment stability should there be budget neutrality adjustments that lead to significant decreases like what would have happened following a revaluation of evaluation and management services without congressional action in recent years. There is precedent for this type of policy, such as the phase-in of significant RVU reductions, which is a statutory requirement that the total RVUs for an existing service cannot decrease by an estimated amount of 20% or more in a year. Meanwhile, under the Medicare Inpatient Prospective Payment System, there is a 5% cap on any decrease to a hospital's wage index.

An important, yet omitted, piece of PFS reform is captured in H.R. 2474, the Strengthening Medicare for Patients and Providers Act. This bipartisan proposal by Representatives Raul Ruiz (D-CA), Larry Bucshon (R-IN), Ami Bera (D-CA), and Mariannette Miller-Meeks (R-IA) – all physicians – would modify the PFS to provide an annual update tied to inflation. Even though this bill was not officially noticed in the E&C legislative hearing, Members of Congress and some witnesses noted that the lack of an inflationary update to the PFS adds to the unsustainability of the PFS and expressed support for this change.

While there is growing congressional interest in reforming the PFS, it remains to be seen which of these proposals (if any) will be added to any must-pass end-of-the-year legislation. As the Senate begins to take steps to similarly address the PFS, it seems more likely that PFS reform would occur in 2024, impacting 2025 or 2026 PFS payments. Regardless of timing, it does appear that some manner of PFS reform is coming, and health care providers paid under the PFS should remain active as legislative proposals are considered – in terms of both the proposed reforms and the policies proposed to offset the billions of dollars needed to enact such reforms.

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