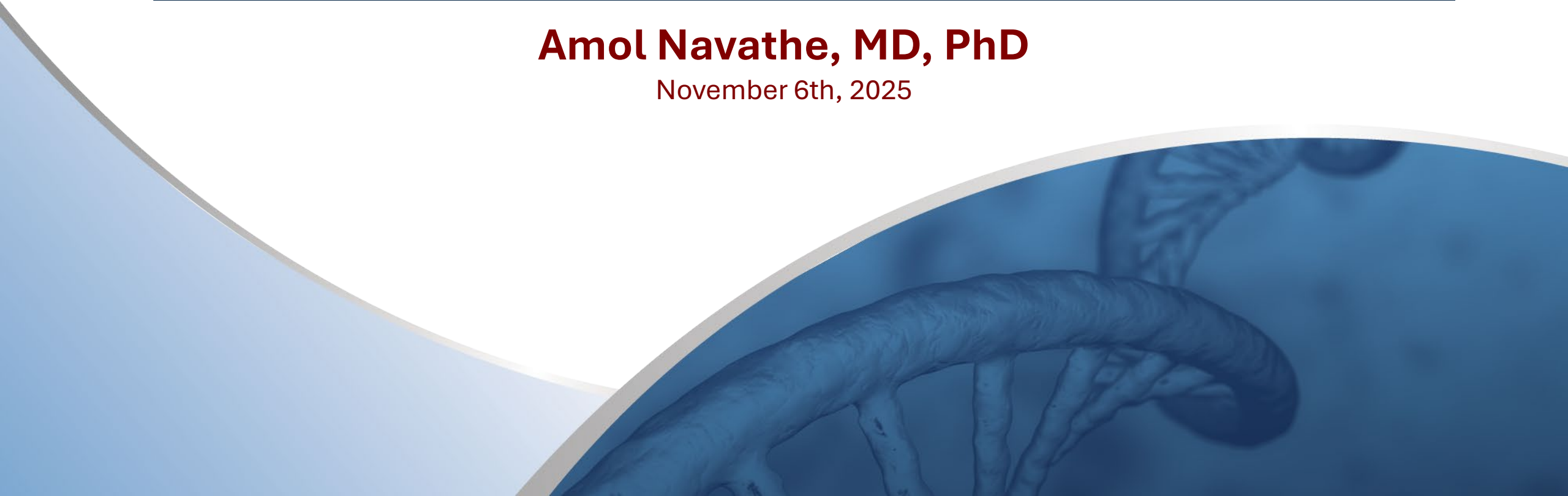


Physician Payment Issues: Opportunities for Reform

Amol Navathe, MD, PhD

November 6th, 2025



Disclosures

- ▶ Commissioner (2019-2025) and Vice Chair (2022-2025) of MedPAC
- ▶ Dr. Navathe reports grants from Hawaii Medical Service Association, grants from Commonwealth Fund, grants from Robert Wood Johnson Foundation, grants from Donaghue Foundation, grants from the Veterans Affairs Administration*, grants from Arnold Ventures, grants from Humana, personal fees from Navvis Healthcare, personal fees from Elsevier Press, personal fees from Medicare Payment Advisory Commission, personal fees from Analysis Group, personal fees from Catholic Health Services Long Island, and equity from Clarify Health and Otter Health, personal fees and board membership for The Scan Group and Hawaii Medical Service Association, outside the submitted work in the past 3 years.

The Key Issues in Physician Payment (i.e., what Jay said)



The system pays for inputs, rather than output (but maybe this is not necessarily a bad thing) → RVU does not equal the health gained from a service



There are mis-valued codes / many RVUs do not reflect the inputs accurately



The heavy weight on inputs like time, skill, complexity + the process of determining RVUs + new tech/procedures and budget neutrality → leads to undervaluing/underinvestment in primary care

MedPAC Recommendations on Fee Schedule Reforms

- ▶ Update PFS payment rates by a measure of inflation below full Medicare Economic Index¹
 - MEI minus 1 percentage point
- ▶ Improve accuracy of relative valuations (RVUs) by collecting timely data that reflect current costs of care¹
 - Accurately size indirect practice expenses
 - Update 2006 cost share data currently used to calculate aggregate allocation of RVUs
 - Revalue post-operative global surgical codes
- ▶ Establish add-on payments for services delivered to low-income Medicare beneficiaries²
 - Establish safety-net add-on payments under PFS for services delivered to low-income Medicare beneficiaries³
 - Enact non-budget neutral add-on payments: 15% for PCP and 5% for non-PCP⁴

1. Medicare Payment Advisory Commission. "Chapter 1: Reforming physician fee schedule updates and improving the accuracy of relative payment rates." In *June 2025 Report to the Congress: Medicare and the Health Care Delivery System* June 12, 2025. MedPAC.

2. Medicare Payment Advisory Commission. "Chapter 4: Physician and other health professional services." In *March 2025 Report to the Congress: Medicare Payment Policy*, March 13, 2025. MedPAC.

MedPAC Comments Propose Changes to CMS Proposal

CMS Proposed Physician Fee Service Payment⁵

- Impose two conversion factors for qualifying vs. non-qualifying alternative payment model participants
- Calculate efficiency adjustment to re-evaluate payment rates
- Update practice expense (PE) methodology to recognize technical service costs

Former MedPAC Leaders Commented With The Following to CMS⁶



MedPAC-aligned shift: CMS now acknowledges survey bias/low response rates; prioritizes objective empirical data for valuation going forward

Mis-valuation touches >9,000 PFS codes, motivating application of efficiency adjustment



Coding modernization: CMS is urged to explore bundled payments for primary care, leverage CMMI demonstrations to channel improvements in payment and coding

5. Centers for Medicare & Medicaid Services, 2025, [Calendar Year \(CY\) 2026 Medicare Physician Fee Schedule \(PFS\) Proposed Rule \(CMS-1832-P\)](#) | CMS.

6. Letter to Dr. Mehmet Oz from former Medicare Payment Advisory Commission, September 8, 2025.

Former MedPAC Leader Comment Letter to CMS

All of us are former Chairs or Vice Chairs of the Medicare Payment Advisory Commission (MedPAC), who served during the 2006-2025 period, when MedPAC, in many of its reports to Congress, discussed shortcomings in the process used to refine and update the Medicare physician fee schedule. Former MedPAC leaders rarely, if ever, have come together to submit a common comment letter on a proposed Medicare rule. However, we consider the “efficiency adjustment” approach CMS adopted in the proposed Physician Fee Schedule rule to be of sufficient importance that we do so now to provide support.

Robert A. Berenson, M.D.
Vice Chair, 2011-2012

Francis J. Crosson, M.D.
Chair, 2016-2020

Jon Christianson, Ph.D.
Vice Chair 2014-2019

Paul B. Ginsburg, Ph.D.
Vice Chair, 2019-2022

Glenn Hackbarth, J.D., MPP
Chair, 2001-2015

Amol S. Navathe, M.D., Ph.D.
Vice Chair, 2022-2025

Robert D. Reischauer, Ph.D.
Vice Chair, 2002-2008

Given these flaws in prior estimates of work that have been applied to over 9,000 fee schedule codes, CMS proposes adopting an “efficiency adjustment” to apply to non-time-based codes to begin the process of reevaluating the work relying much more on empirical data. We endorse CMS’s view that applying the efficiency adjustment to non-time-based services broadly, rather than targeted only to demonstrably overvalued work estimates, “may help to improve the overall accuracy of our valuation of these services under the PFS.”

Even more important, the Fact Sheet from CMS goes on to state, “We are also proposing that, going forward, CMS may give preference to empiric studies of time to incorporate into service valuation, compared to low-response rate survey data, and solicit comment on the types of empiric data that CMS should consider. CMS expects that moving away from survey data would lead to more accurate valuation of services over time and help address some of the distortions

Congressional Committee Proposals



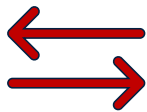
Pay for PCPs Act of 2024⁷

Establishes new technical advisory committee (TAC) to modernize RVU determinations

- Composed of 13 members with experience in primary care or family medicine
- Duties include design new valuation methods, advise on RVU-centric research, identify opportunities for coding changes, and assess vulnerabilities in the new approach

Establishes hybrid primary care payments within the PFS comprised of

- Per-member-per-month payments
- Fee-for-service payments
- Cuts beneficiary cost-sharing by 50%



Shifts valuation toward empirical data via RUC-independent input (but does not eliminate RUC's role)

118TH CONGRESS
2D SESSION

S. 4338

To provide for the establishment of hybrid primary care payments under the Medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 15, 2024

Mr. WHITEHOUSE (for himself and Mr. CASSIDY) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide for the establishment of hybrid primary care payments under the Medicare program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE.

4 This Act may be cited as the “Pay PCPs Act of
5 2024”.

U.S. Congress. Senate. *Pay PCPs Act of 2024*. S. 4338,
Introduced May 15, 2024. [Congress.gov](https://www.congress.gov).



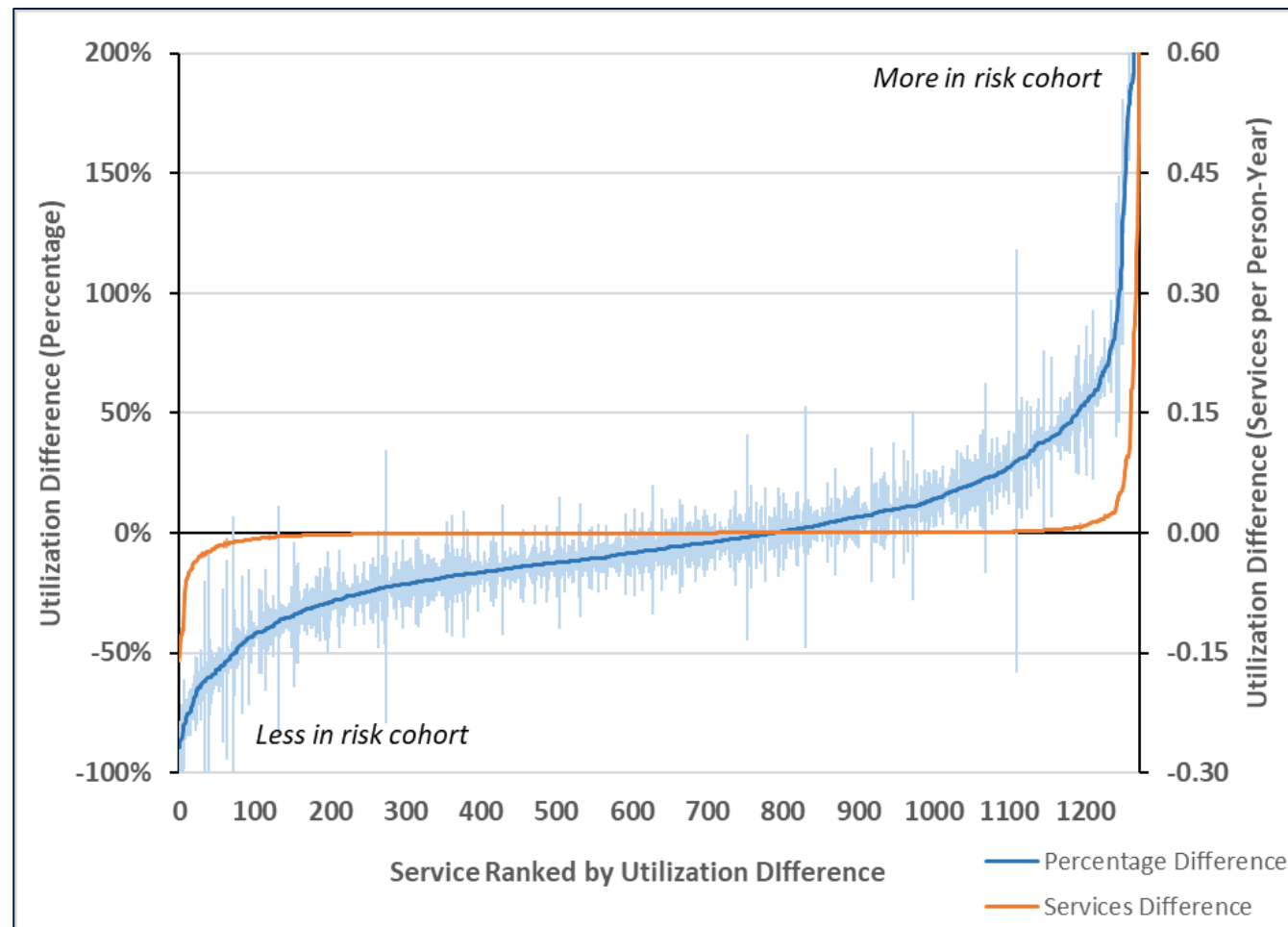
Our Current Work On The Value-Based Fee Schedule Examines Differences in Care Practice Patterns

- ▶ **Question:** How do physician groups that fully internalize the cost of care practice differently than FFS?
- ▶ **Data:** National MA plan (2015-2019), 6.8M member-years within risk and FFS (2.8M two-sided risk)
- ▶ **Methods:** 100% claims/encounters billing data, IPW to balance risk and FFS populations, Bayesian shrinkage for low-frequency services
- ▶ **Application:** Simulated modifications to MPFS to show directional fee-schedule changes that would incentivize value-based use
 - Adjusted payment rate based on risk and FFS use difference
 - Made budget-neutral adjustment

Comparing Service Utilization Between Risk-based And Non-risk Cohorts

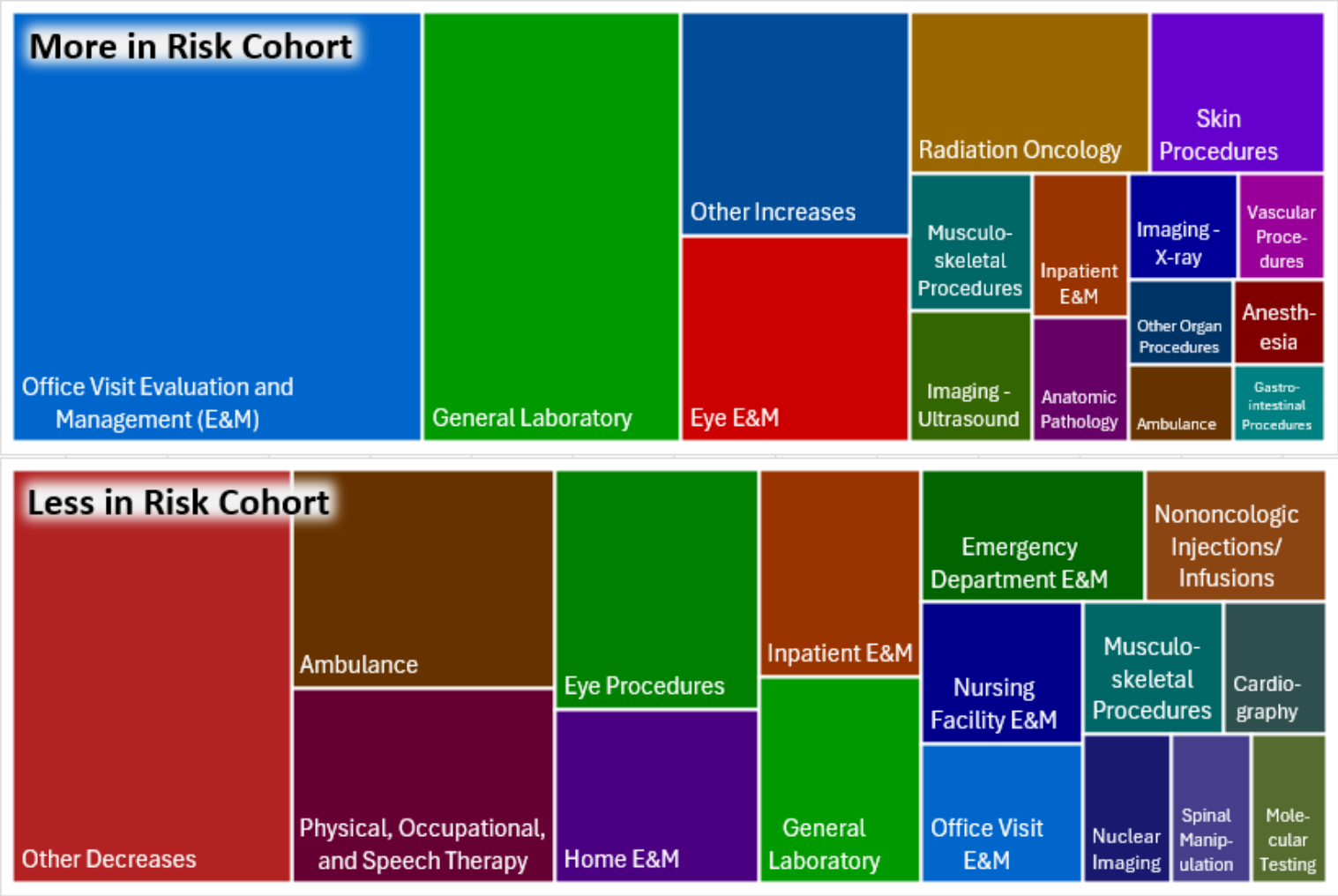
- Among the 1,273 services we analyzed, **62%** of services had *lower* utilization in risk contracts and **38%** had *higher* utilization.
- Differences were meaningful, with **51% of services** (N = 649) with *at least 10% lower* utilization in risk contracts and **31% of services** (N = 389) with *at least 10% higher* utilization.

Notes: The **light blue** and **orange** bars reflect 95% confidence intervals after Bayesian shrinkage. Seven outlier services with utilization differences > 200% are Winsorized at 200%.

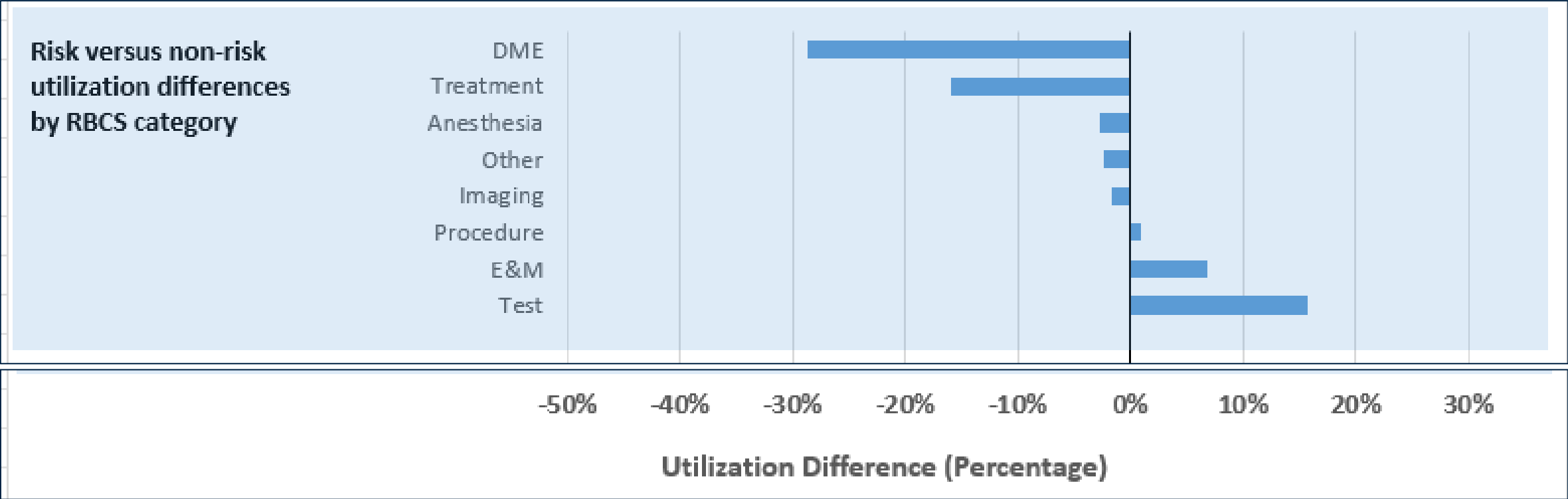


Clinical Categories Accounting for Service Differences Between the Risk and Non-Risk

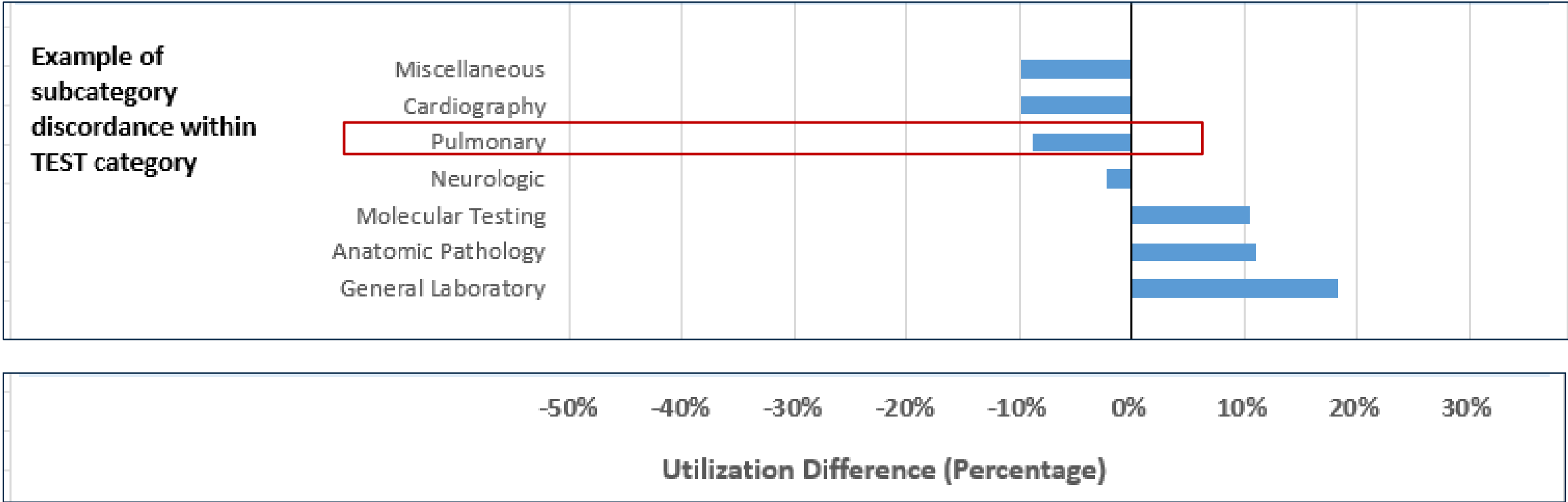
Cohorts (weighted by service price)



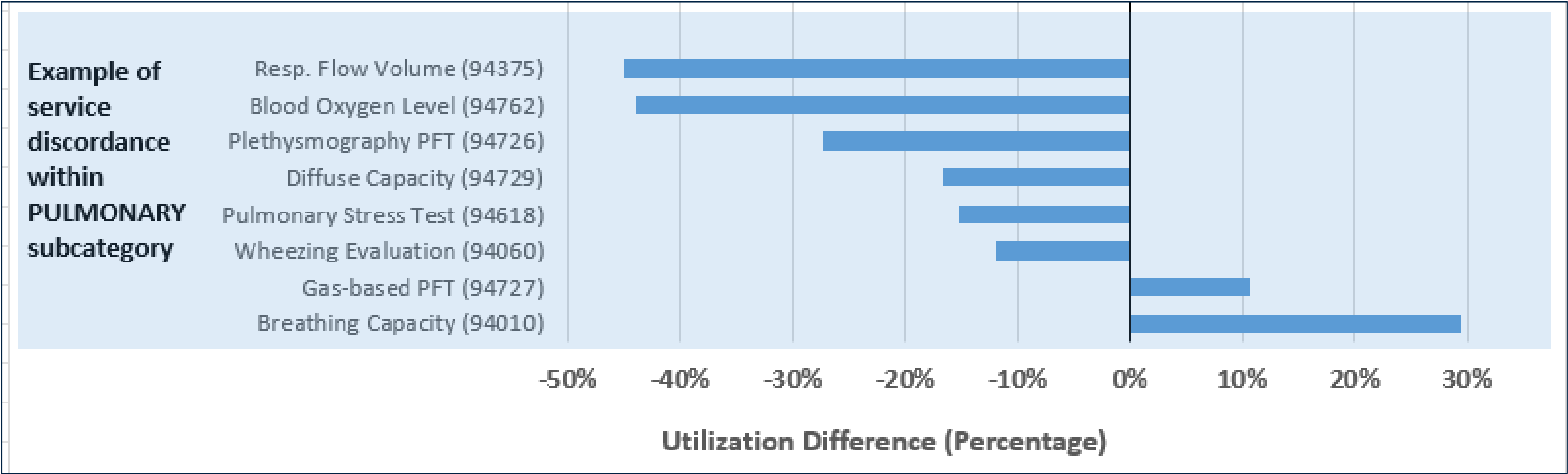
Relative Utilization Levels Between Risk and Non-Risk Cohorts



Relative Utilization Levels Between Risk and Non-Risk Cohorts by Testing Services



Relative Utilization Levels Between Risk And Non-risk Cohorts By Testing Services



Key Takeaways

↕ MPFS links costs to inputs, which are **hard to measure** and **neither reflect health outcomes nor value**.

🏠 MPFS requires **foundational structural reforms**.

↔ Empirical evidence and experience suggest **input costs often diverge from value**.

🏗️ Build a mechanism to incorporate value alongside inputs.

- TAC guidance should shape a new value-informed rate-setting approach
- Differentiate APM vs. non-APM payment levels

Thank you!

Simulated Estimates for Alternative Medicare Fee Schedule and Effects on Reimbursement Across Different Clinical Specialties

