

Bolstering Chronic Care through Physician Payment:
Current Challenges and Policy Options in Medicare Part B

Senate Committee on Finance

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Introduction

Ensuring access to high-quality health care for the 67 million Americans¹ currently enrolled in Medicare, along with the program's future beneficiaries, remains a longstanding priority for the Senate Finance Committee (hereinafter referred to as the "Committee"). This Congress, the Committee has worked to advance a range of consensus-driven policy solutions to address challenges facing Medicare and its enrollees, from persistent gaps in behavioral health care² to misaligned incentives driving up prescription drug costs.³

As the Committee continues to build on this bipartisan work and tackle additional urgent issues confronting seniors and working families, the prevalence of chronic diseases, from cancer and COPD to heart disease and diabetes, warrants serious attention. Patients living with these conditions bear substantial care burdens and outsized out-of-pocket costs. In 1965, Medicare was designed to meet the acute-care needs of older and disabled Americans. Even with important changes added by Congress, Medicare benefits and payment systems, unfortunately, sometimes still fall short of meeting the chronic care needs of beneficiaries today.

On April 11, 2024, the Committee held a hearing entitled "Bolstering Chronic Care through Medicare Physician Payment," which underscored the importance of high-quality and accessible clinician care in improving health outcomes, including for patients with chronic diseases.⁴ The hearing also, however, served to highlight pervasive challenges within Medicare's Physician Fee Schedule (PFS) and Medicare fee-for-service (FFS), particularly in the midst of widespread provider burnout, heightened practice and input costs, increased administrative burden, an aging population,⁵ and volatility in year-to-year adjustments in Medicare payments.

This white paper describes key issues related to Medicare Part B payment that may jeopardize a clinicians' ability to own and operate a health care practice and meet patient needs. The paper also explores potential policy solutions. Issues and concepts unrelated to the Medicare PFS and outpatient chronic illness care fall outside the scope of this document, which will focus primarily on clinician payment policy (including policies related to primary care), alternative payment models, and telehealth.

The policy concepts referenced or discussed in this white paper reflect preliminary areas of interest, rather than formalized proposals, and the Committee will continue to conduct outreach to stakeholders and experts to inform our legislative process. The Committee also will continue to engage with members of the Committee on these issues and process, which will ideally culminate in bipartisan legislation.

Part I: Background on the Medicare Physician Fee Schedule

Overview of the PFS

Medicare Part B pays for clinician care under the PFS,⁶ which provides payment to physicians and other health professionals for more than 8,000 medical items and services furnished in physician offices, hospitals, ambulatory surgical centers (ASCs), and a range of other health care settings.

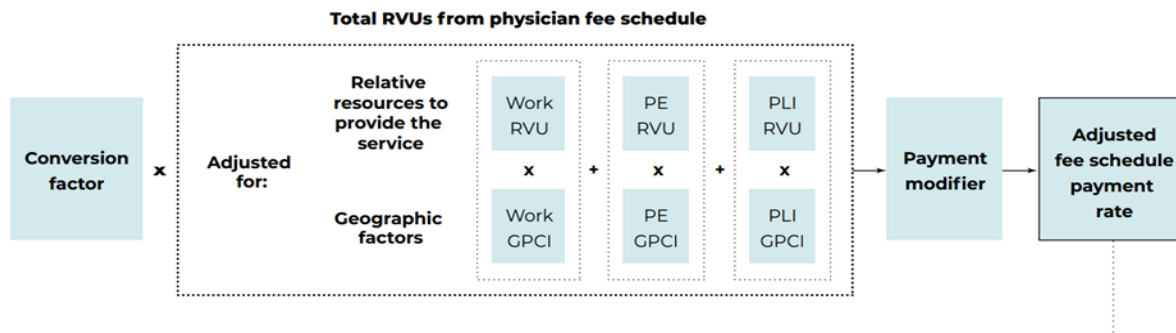
In 2022, Medicare spending for care furnished under the PFS (inclusive of beneficiary cost sharing) totaled \$91.7 billion, accounting for slightly below 17 percent of all Medicare FFS spending.⁷ Excluding beneficiary cost sharing, Medicare PFS expenditures for 2022 amounted to \$73.4 billion.⁸ The Congressional Budget Office (CBO) projects that annual federal spending under the PFS will increase to \$86 billion (or 17 percent) by 2033, whereas annual expenditures for hospital outpatient services will more than double over the same period.⁹ CBO estimates that annual hospital outpatient spending under Part B will outpace and exceed yearly PFS expenditures beginning in 2026.¹⁰ Notably, while the PFS spending accounts for less than 20 percent of Medicare FFS spending, physicians direct the majority of health spending for beneficiaries (analysts frequently cite 80 percent as a reasonable estimate) across all care settings and Medicare services.¹¹ Incentives within Medicare payment policy can influence clinician decision-making and thus impact a much broader scope of care delivery and outlays.

A number of trends and factors account for PFS spending shifts, including statutory limitations on PFS spending growth, health care provider consolidation, and enrollment growth in Medicare Advantage (MA), which now covers more than half of all eligible Medicare beneficiaries. That said, even though Medicare FFS now accounts for less than 50 percent of total program enrollment and spending, PFS payment policies and methodologies remain the basis for payment negotiation across various payers and markets, and Medicare FFS spending continues to influence MA benchmarks.

In 2022, nearly 1.3 million clinicians billed Medicare under the PFS.¹² From 2017 to 2022, the number of clinicians furnishing services under the fee schedule grew by an average rate of roughly 2.4 percent per year, keeping pace with overall Medicare Part B enrollment (inclusive of MA plan enrollees). Over that same period, the annual number of clinician encounters per FFS beneficiary rose from 21.5 to 22.3, although the mix of encounters shifted, with beneficiaries seeing advanced practice registered nurses (APRNs) and physician assistants (PAs), along with other non-physician practitioners (NPPs), more often, even as the number of primary and specialty care physician encounters per FFS beneficiary declined.

PFS Rate-Setting Methodology Overview

Under current law, the PFS reimburses for a unit of service by way of a combination of relative value units (RVUs), weighted to reflect the cost/resource inputs required to deliver said service, along with geographic adjustments, all multiplied by a conversion factor (CF). These units of service can describe unique procedures, such as a therapeutic injection, or can encompass “global” bundles of services to account for both a procedure and corresponding pre- and post-operative interactions.



Source: “MedPAC Payment Basics, Physician and Other Health Professional Payment System,” MedPAC¹³

Relative Value Units (RVUs)

Relative value units, or RVUs, serve as the basis for determining payment rates for services billed under the PFS. Established and updated with significant input from the AMA/Specialty Society Relative Value Scale Update Committee (RUC), RVUs aim to provide national uniform measures of the relative resources clinicians require to perform a given service, as subdivided into three different categories: work, practice expense, and malpractice insurance.¹⁴

1. **Work RVUs (wRVUs)** reflect the physician time and intensity necessitated to deliver a service;
2. **Practice Expense RVUs (PE RVUs)** account for both direct and indirect physician practice expenses, such as the costs associated with the requisite supplies, equipment, and personnel needed to furnish a service; and
3. **Malpractice RVUs (MP RVUs)** encompass the costs associated with purchasing professional liability insurance.

As the Centers for Medicare & Medicaid Services (CMS) explained in the calendar year (CY) 2024 PFS final rule, “[T]he RVUs used in developing rates should reflect the same weights in each component as the cost share weights in the Medicare Economic Index (MEI),”¹⁵ which “measures the change in clinician input prices” over time.”¹⁶ In terms of relative weights, “the total RVUs on the PFS are proportioned to approximately 51 percent work RVUs, 45 percent PE RVUs, and 4 percent MP RVUs.”¹⁷ PFS payment determination relies on summing the relevant RVUs (geographically adjusted) and multiplying the total by the relevant CF for the year.

For purposes of determining the resource inputs specific to RVUs, CMS relies on a range of data sources and surveys. With respect to the inputs for PE RVUs, for instance, the agency phased in an update to the equipment and supply components of direct PE resource estimates from CY 2019 through CY 2022. Beginning in CY 2022, CMS initiated a four-year phase-in of a clinical labor pricing update, based on more recent data from the Bureau of Labor Statistics.

Under current law, CMS applies budget-neutrality adjustments if changes in RVUs (or in components of an RVU) would otherwise lead to an increase in total annual spending under the PFS above \$20 million per year. As a result, RVU updates inherently trigger upward payment adjustments for certain specialties and downward payment adjustments for others. In the CY

2022 PFS final rule, CMS acknowledged that “specialties with a substantially lower or higher than average share of direct costs attributable to labor would experience significant declines or increases, respectively,” under the clinical labor pricing update that began with CY 2022.¹⁸

Geographic Practice Cost Index (GPCI)

As detailed by the Government Accountability Office (GAO) in a February 2022 report, “CMS separately adjusts each of the three RVUs to account for variations in physicians’ costs of providing care in different geographic areas.”¹⁹ The agency relies on geographic practice cost indices (GPCIs) to make these adjustments across 112 distinct physician payment localities, subject to a statutory floor for the work GPCI, which Congress has extended numerous times, most recently under section 303 of Division G, Title I, Subtitle C of the Consolidated Appropriations Act, 2024 (CAA 24),²⁰ which provided for an extension through the end of CY 2024.

Conversion Factor (CF)

As noted above, payment under the PFS also relies on a statutorily-derived CF, a dollar amount used as the multiplier to calculate Medicare payment amounts for physician services in any given calendar year. Prior to the enactment of CAA 24, the CF would have declined from its CY 2023 level (\$33.89), due largely to the declining statutory CF increases codified under the Consolidated Appropriations Act, 2023 and the framework established in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The CAA 24, however, enacted a larger 2.93-percent CF payment bump for the remainder of CY 2024, resulting in a \$33.29 CF through the end of 2024.²¹

Under current law, beginning in 2026, the CF for physicians who participate in advanced alternative payment models (A-APMs) will increase 0.75 percent per year, with a compounding effect over time, while the CF for other physicians not affiliated with A-APMs will increase by a lower 0.25 percent each year. The MedPAC chart below shows changes in physician payment from 2021 through 2026. The table predates the passage of CAA 24 (and therefore reflects the lower 1.25 percent CF increase for 2024, not the higher 2.93 increase subsequently codified for most of the year). The temporary payment increases enacted by Congress in recent years constitute “one-time” CF boosts and thus lack any compounding effects.

	2021	2022	2023	2024	2025	2026 and later
A-APM clinicians						
Update	0%	0%	0%	0%	0%	0.75%
A-APM bonus (one time)	5%	5%	5%	5%	3.5%	N/A
Other clinicians						
Update	0%	0%	0%	0%	0%	0.25%
MIPS adjustments (one time)*	(-7% to +1.8%)	(-9% to +1.9%)	(-9% to +2.3%)	(-9% to +9%)	(-9% to +9%)	(-9% to +9%)
All clinicians						
Payment increase (one time)	3.75%	3.0%	2.5%	1.25%	N/A	N/A
Sequestration (one time)	0%	0% (3 months), -1% (3 months), -2% (6 months)	-2%	-2%	-2%	-2%

Note: “One time” adjustments apply in a given year only and are not included in subsequent years’ payment rates. A-APM bonuses and MIPS adjustments are based on clinicians’ A-APM participation and quality measure performance from two years prior. The annual change to the conversion factor (a fixed dollar amount) for Medicare’s physician fee schedule is based on (1) the updates specified in law (e.g., 0 percent plus a one-time increase of 1.25 percent in 2024); (2) expiration of one-time increases (e.g., the one-time increase of 2.5 percent in 2023); (3) CMS’s budget-neutrality adjustment (e.g., -2.2 percent in 2024), which ensures that changes to the relative values of particular billing codes in the fee schedule do not change total physician fee schedule spending by more than \$20 million (not shown); and (4) the -2 percent sequester (which applies for one year at a time and is not built into subsequent years’ payment rates). *Includes \$500 million of additional MIPS adjustments per year for “exceptional” performance through 2024. The maximum positive MIPS adjustments shown for 2021–2023 are the highest adjustments actually made in those years, while the maximum adjustments for 2024 and onward are theoretical maximums specified in law. In 2024, the maximum MIPS adjustment is up to +9% plus \$500 million for exceptional performance (not shown).

Source: MedPAC Report to Congress (March 2024)

Overview of MACRA

Congress undertook years of bipartisan and bicameral efforts²² to move away from the sustainable growth rate (SGR) formula and associated ad-hoc doc fixes in favor of more streamlined payment policies, culminating in the enactment of the MACRA of April 16, 2015.²³ MACRA repealed the SGR formula and codified major reforms to PFS payment provisions. At the time of enactment, CBO projected that MACRA would increase the federal deficit, on net, by \$141 billion over the ten-year budget window, but that the law’s costs would fall slightly below an alternative approach that simply froze PFS rates over the same period.²⁴ Nearly 10 years after MACRA’s enactment, the Committee recognizes challenges within the framework related to CF statutory updates, incentives to transition to value-based care, quality measurement, and administrative burden.

Notably, the law introduced a significant new program, the Quality Payment Program (QPP), to help shift clinicians away from volume-based payments and toward value-based care. The QPP consolidated previous quality and cost-containment initiatives into two primary pathways for clinicians: the Merit-based Incentive Payment System (MIPS) and A-APMs. As summarized by CMS, the QPP aims “to reward high-value, high-quality Medicare clinicians with payment increases – while at the same time reducing payments to those clinicians who [a]ren’t meeting performance standards.”²⁵ While the QPP offers two broad tracks for clinician participation,

some providers remain ineligible for either pathway due to low Medicare beneficiary patient volume.



Source: CMS

According to MedPAC, in 2023:

- Roughly 227,000 clinicians, accounting for around 17 percent of participating providers, received an A-APM Incentive Payment (based on meeting participation thresholds during performance year 2021);
- Roughly 600,000 clinicians received an upward MIPS payment adjustment, for either positive or exceptional performance, of up to 2.34 percent;
 - An additional 74,000 clinicians received neutral (zero) MIPS payment adjustments, having met (but not exceeded) the relevant performance threshold, and 23,000 clinicians received downward MIPS payment adjustments of up to nine percent; and
- More than 460,000 clinicians were ineligible for A-APM Incentive Payment and MIPS payment adjustment, largely due to insufficient Medicare patient volume.²⁶

Alternative Payment Models (APMs)

Prior to MACRA's enactment, CMS had begun developing and launching a number of different alternative payment models (APMs), designed to improve health care outcomes and generate programmatic savings by instituting value-based payment mechanisms overlaying, or in place of, traditional FFS reimbursement. Through accountable care organizations (ACOs),²⁷ for instance, Medicare identified avenues to incentivize groups of providers, including clinicians, to engage in more coordinated beneficiary care and to avoid unnecessary services and other sources of error, principally under the Medicare Shared Savings Program (MSSP).²⁸

Traditionally, providers participating in ACOs under Medicare have continued to receive standard FFS payments, but with the potential to share (with the Medicare program) in savings produced relative to certain benchmarks over a given period. Some ACO-focused APMs also introduce potential downside risk for overspending, generally in exchange for a higher ceiling for possible upside in the event that savings accrue.

APMs in Medicare have taken various forms, including Accountable Care (reliant largely on ACOs), disease-specific, episode-based, and primary-care-focused models, among others. Some such models leverage bundled or capitated payments, either layered onto standard FFS rates or paid as an alternative.²⁹ Under the QPP, some APMs qualify as A-APMs, whereas others continue to require clinician participants to engage in MIPS.

Advanced Alternative Payment Models (A-APMs)

In order to qualify as an A-APM for QPP purposes, a model must generally require participants to bear significant downside risk, as well as to utilize certified electronic health record (EHR) technology and to receive payment based on quality measures.³⁰ Clinicians who meet a statutory threshold with respect to either the percentage of Medicare beneficiaries seen or the percentage of Medicare Part B payments received through an A-APM may meet QP standards for a given performance year.³¹ QP status exempts clinicians from MIPS reporting requirements, in addition to providing access to A-APM-related financial incentives.

While clinicians who meet a lower statutory threshold with respect to A-APM participation may qualify as Partial QPs, resulting in an optional MIPS exemption,¹ Partial QPs do not receive A-APM Incentive Payments.

A-APM Incentive Payments

Clinicians who qualify as QPs during a given performance year receive, to the extent available under statute, a lump-sum A-APM Incentive Payment two years later (the payment year), calculated as a percentage of Medicare payments from the year prior. Under MACRA, as enacted, A-APM Incentive Payments would have expired after payment year 2024 (based on performance year 2022).

Congress has intervened twice, however, to enact one-year A-APM Incentive extensions. For each of payment years 2019 through 2024, these payments amounted to five-percent, but for payment year 2025, the rate will fall to 3.5 percent, and for payment year 2026, QPs will earn 1.88-percent bonuses. Also beginning in payment year 2026, QPs will receive a higher statutory CF update of 0.75 percent per year, as opposed to 0.25 percent for other clinicians.

MIPS Payment Adjustments

Clinicians remaining in Medicare FFS and not participating in an A-APM must, unless otherwise exempt, participate in MIPS.² MACRA requires these clinicians to report clinical quality measures, health IT usage, and quality improvement activities to CMS, which combines this information with cost data to assign each provider a MIPS score.³² Based on this score, clinicians

¹ Because Partial QP status confers no A-APM-related financial incentives, a clinician who qualifies as a Partial QP may opt, voluntarily, to participate in MIPS in order to earn a potential MIPS payment adjustment.

² CMS estimates that about 42 percent of clinicians in 2023 are subject to MIPS (affecting their payment adjustments in 2025). Clinicians are exempt from MIPS if they are newly enrolled in the Medicare program, serve only a low volume of Medicare beneficiaries, have a sufficiently high share of patients or payments in an A-APM, or meet another exclusion criterion. (MedPAC)

can receive a payment increase or decrease of up to 9 percent, applied to payments two years after the performance year in question.³³

Because of the MIPS program's budget-neutrality requirements, funds available for rewarding performance bonuses cannot exceed penalties imposed on clinicians with poor performance. In 2021, 86 percent of clinicians scored high enough for a positive adjustment, while 11 percent received no adjustment, and 3 percent received negative adjustments.³⁴ Given this imbalance, the maximum positive adjustment that physicians could receive amounted to just 2.34 percent.³⁵

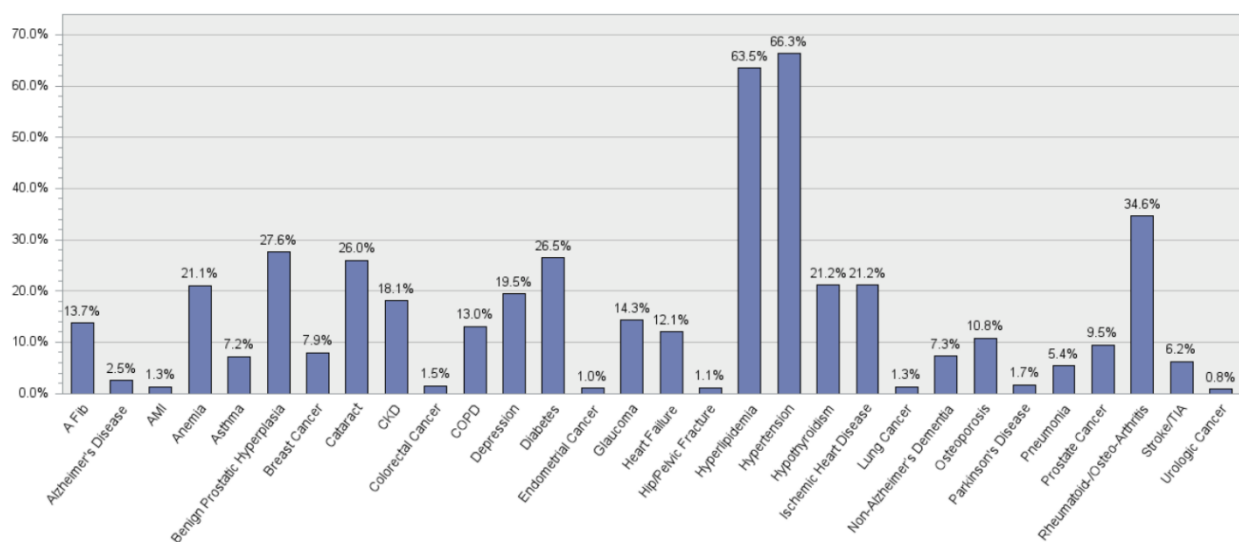
Beginning in 2026, MIPS participants will qualify for annual 0.25-percent statutory CF updates under the PFS.

Part II: Chronic Disease and Medicare FFS

During the Committee's recent hearing on chronic disease and clinician payment, Members heard witness testimony cautioning that chronic diseases, "may be the single most important challenge affecting Medicare beneficiaries, and thus the Medicare program."³⁶ In the CY 2024 PFS rule,³⁷ CMS defined chronic conditions as those expected to last at least 12 months and that place an individual at increased risk of death, acute exacerbation or decompensation, or functional decline. Estimates of the prevalence and cost of chronic conditions for beneficiaries and the Medicare program vary, but experts broadly concur that these diseases account for a disproportionate share of service utilization and spending, particularly for seniors. According to a 2022 *JAMA Internal Medicine* study, 66 percent of adults aged 65 or older have received diagnoses for at least two common chronic conditions, and 16 percent have six or more chronic disease diagnoses.³⁸ An April 2022 report from the National Council on Aging (NCOA) projected that roughly 94.9 percent of individuals aged 60 or older live with at least one chronic disease.³⁹

Relative to other populations, older adults, including those enrolled in Medicare, face a higher risk of living with or developing virtually any major chronic condition, as well as experiencing more serious complications associated with said conditions. A broad range of chronic diseases, from hypertension and diabetes to arthritis and various cancers, affect sizable shares of Medicare beneficiaries.⁴⁰

30 CCW Chronic Conditions Period Prevalence, 2021



Source: CMS, Chronic Condition Warehouse

Medicare covers a broad array of services and procedures related to chronic disease prevention, mitigation, and treatment, ranging from screening tests for certain cancers and chronic care management (CCM) services to therapeutic interventions and surgical procedures. Data from the Medicare Chronic Condition Warehouse (CCW) highlight the fact that while utilization of services by beneficiaries with chronic conditions spans all parts of the Medicare program and varies significantly from one condition to the next, Part B comprises a large and growing share of claims and expenditures for chronic care services.⁴¹

As outlined in testimony to the Committee, more than one third of Medicare beneficiaries received care from five or more physicians in 2019. Testimony also conveyed that to “effectively coordinate care for a single medical condition, it can require upwards of 50 interactions in a three-month period (through various modes of communication) between patient, primary care physician, and other physicians.”⁴²

Given the diverse care settings and clinicians managing the needs of beneficiaries with chronic conditions, coordination and communication across different sites and practitioners can prove particularly pivotal in the chronic disease context. To that end, a 2023 systematic review of recent research identified a “significant association between fragmented care and adverse outcomes of chronic illnesses,” noting that “[i]ndividuals with chronic illnesses experience high rates of care fragmentation because they often require lifelong continuous care.”⁴³

Cost of Chronic Diseases

The Centers for Disease Control and Prevention (CDC) estimates that spending on individuals with chronic diseases, along with mental health conditions, accounts for roughly 90 percent of all health care expenditures in the U.S.⁴⁴ According to analysis from the RAND Corporation, average annual Medicare spending for an enrollee with one or two chronic conditions amounts to more than double the annual expenditures for a beneficiary with no such diagnoses, and program spending for an enrollee with five or more chronic diseases totals nearly nine times the average

expenditures for a beneficiary with no diagnosed chronic conditions.⁴⁵ Medicare beneficiaries living with multiple chronic conditions also incur substantially higher out-of-pocket costs, on average.

According to CMS, one in seven beneficiaries (15%) have six or more chronic conditions, accounting for \$92 billion in emergency visits, hospitalizations, and post-acute care. The overall annual cost of care for beneficiaries with six or more chronic conditions amounts to more than \$150 billion dollars of Medicare spend.⁴⁶

Part III: Actions Taken to Improve Care of Chronic Diseases under Medicare

In recent years, both Congress and CMS have taken a number of steps intended to enhance care coordination for Medicare beneficiaries with chronic diseases.

The CHRONIC Care Act

In 2018, Congress passed the CHRONIC Care Act as part of the Bipartisan Budget Act of 2018. This bill aimed to improve care provided to Medicare and dually-eligible beneficiaries with chronic conditions, such as diabetes, kidney disease and heart conditions. The CHRONIC Care Act expanded access to telehealth services, including for dialysis patients; allowed Medicare Advantage (MA) plans to expand supplemental benefits for beneficiaries with chronic diseases, beginning in 2020; and established a program enabling certain ACOs to use their own funds to help reduce out-of-pocket costs for patients seeking certain primary care services needed to manage their chronic conditions.⁴⁷

As part of the CHRONIC Care Act, beginning in 2020, MA plans could offer non-health benefits with a reasonable expectation of improving or maintaining the health or function of chronically ill enrollees. According to GAO, in 2022, about one-fifth of MA plans offered at least one of the newer chronic care supplemental benefits, the most common being food and produce.⁴⁸ Although MA plans are required to submit detailed, service-level utilization data to CMS, this data is limited, due in part to the fact that some of the newer services provided as supplemental benefits are not associated with existing Medicare billing codes (i.e., HCPCS codes).

In February 2024, CMS announced the creation of default billing codes and instructions for MA plans on how to submit data for cases in which diagnosis, procedure, or revenue codes do not currently exist. While the CHRONIC Care Act allows MA plans to cover certain non-medical, health related services (such as transportation to medical appointments, meals, and minor home modifications to prevent falls), Medicare FFS generally does not cover these types of services.

Regulatory Actions related to Chronic Disease Management

CMS has finalized several PFS policy changes aimed at increasing the level and scope of Medicare payment for certain services intended to support the clinical management of chronic disease, focused largely on primary care. Previous PFS final rules have included, among other provisions with chronic care applications, the following:

- **Updates to the codes used to bill for physician office visits** in order to encompass variable levels of complexity, medical decision-making, and duration, resulting in increased payments for these services;
- **Addition of new billing codes focused on care management services, such as accounting for non-face-to-face components of services, with applicability to chronic disease management**, including codes for chronic care management (CCM), transitional care management (TCM), principal care management (PCM), complex care management (Complex CCM), prolonged E/M-related services (code 99417), remote physiologic monitoring (RPM), and remote therapeutic monitoring (RTM);
- **Addition of new billing codes related to care navigation, social determinants of health, and community health integration;** and
- **Establishment, beginning this year, of add-on code (G2211),** to pay for increased complexity of services furnished as part of longitudinal care.

CMS Innovation Center (CMMI)

CMMI has expanded its portfolio to address the needs of beneficiaries with chronic disease, primarily through testing models that focus on primary care. The Comprehensive Primary Care Plus (CPC+) model, for instance, tested a national multi-payer primary care medical home model that included per-beneficiary, per-month “Comprehensive Primary Care Payments” in Medicare FFS.⁴⁹ In the independent evaluation of this model, CPC+ practices saw reductions in emergency department (ED) visits, acute hospitalizations, and acute hospitalization expenditures, as well as improvement in some quality-of-care measures, although overall savings to Medicare were offset by increases in expenditures on other services.⁵⁰ Notably, independent practices and those participating in MSSP tended to have more favorable results.

To that end, in March 2024 CMS announced the ACO Primary Care Flex (PC Flex) Model to test a one-time, prospective primary care payment, along with per-member, per-month payments, under the MSSP.⁵¹ This model aims to shift primary care away from per-visit volume and towards a more predictable investment in primary care. According to CMS, the model is based on a recommendation made by the National Academies of Sciences, Engineering and Medicine (NASEM) in a report titled “Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care,” which recommends that Medicare payments flow to primary care through ACOs to better support team-based care and provider infrastructure.⁵²

In addition to the above, CMMI has tested various other models aimed at increasing access to primary care services, improving outcomes, and lowering health care costs for beneficiaries. The Committee continues to explore these models and evaluations to inform its work on physician payment and chronic care.

Part IV: Policy Challenges and Potential Reforms

Congress has intervened multiple times to enact broad changes to the PFS framework, as well as to advance numerous smaller “doc fixes” for short-term adjustments. Even so, challenges remain in Medicare’s current approach to physician payment, threatening the ability of physicians to sustain their practices and exacerbating the growing trends of consolidation and workforce

shortages. The Committee hopes to address these challenges to ensure that Medicare Part B reimbursement structures keep pace with the cost of providing care, in addition to attracting a viable workforce to care for beneficiaries. This section explores opportunities to modernize Medicare FFS and physician payment to better align incentives, reduce fragmentation, and improve access to comprehensive care while allowing physicians to remain independent.

Conversion Factor Fluctuations and Constraints

In contrast with other Medicare payment systems, the PFS CF includes no inflation-related annual adjustments. As summarized by a range of clinician organizations in a letter last year, “As one of the few Medicare providers without a payment update tied to inflation, physicians have watched inflation-adjusted payments decline 26 percent from 2001 to 2023.”⁵³ At the same time, per-beneficiary spending has grown “substantially faster” than MEI or PFS updates, indicating that when accounting for increased volume and intensity of services, overall physician compensation has exceeded inflation.⁵⁴

The 2023 Medicare Trustees Report raised the current CF update schedule and methodology under the PFS as a source of “challenges for the Medicare program,” explaining:

*“Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large.”*⁵⁵

The 2024 Trustees Report and companion memorandum struck a similar tone, postulating that “access to Medicare-participating physicians will become a significant issue in the long term” and projecting that the relative gap between commercial rates and Medicare payments will continue to widen in the decades ahead, imperiling seniors’ access to clinical services.⁵⁶

To that end, for instance, a 2023 Avalere analysis found that from 2014 to 2023, due largely to a stagnant CF update schedule and downward budget neutrality adjustments, the PFS payment rate for chemotherapy administration declined from roughly \$133 in 2014 to \$132 in 2023, and the standard PFS fee for non-chemotherapy IV infusion fell from \$69 to \$65 over the same period.⁵⁷

Due to regulatory changes, the CF can experience dramatic adjustments from year to year,⁵⁸ even in the absence of statutory modifications, making long-term planning and predictability challenging, in addition to exacerbating financial volatility. A wide range of state medical associations and national clinician organizations have raised concerns around these “relatively large and abrupt changes in conversion factor calculations” and have called for the establishment of statutory limits on year-over-year CF adjustments in order to “provide greater stability for the Medicare physician payment system.”⁵⁹

Some stakeholders and experts suggest that Congress adopt an adjustment schedule for PFS payments that accounts for shifts in cost inputs over time. In its March 2024 report to Congress, MedPAC analysis concluded that “[i]n 2022 and 2023, most clinician payment adequacy

indicators remained positive or improved,” also noting that in the Commission’s 2023 annual survey and several recent national surveys, “beneficiaries reported access to clinician services...that was comparable with, or better than, that of privately insured people.”

However, MedPAC estimated that clinicians’ input costs have grown faster than the historical trend and, at its April meeting, conveyed “concerns about future access to care,” particularly given that “a larger gap between [Medicare Economic Index (MEI)] growth and updates could negatively affect beneficiary access in the future.”⁶⁰ The Commission’s March report recommended a CF update for CY 2025 equal to “50 percent of the projected increase in the MEI[, the Medicare Economic Index],” codified as “a permanent update that would be built into subsequent years’ payment.”⁶¹

MedPAC has also called for PFS add-on payments for services furnished to beneficiaries with lower incomes, particularly in light of reimbursement dynamics related to treating individuals dually enrolled in Medicare and Medicaid.

Adjustments along these lines would have direct fiscal implications for Medicare and beneficiary cost sharing,⁶² although outlay effects remain uncertain at this point, particularly since annual MEI growth accelerated from one to two percent, prior to the pandemic, to 4.6 percent in 2022, before beginning to decline again, with a projected plateau in future years of roughly 2.5 percent, if not slightly lower.⁶³

Numerous clinician organizations have recommended that Congress go further than MedPAC has advised and adopt a 100-percent MEI update, which would result in significantly higher outlay growth. Those in favor of this approach have contended that the MEI, like the market-basket and inflation-based adjustments incorporated into other payment systems, has included a productivity adjustment since its inception, mitigating the risk of explosive cost hikes.⁶⁴ Others, however, have cautioned against the risk of unsustainable spending growth, particularly as Part B continues to account for a rising share of Medicare FFS spending, in addition to exerting direct upward pressure on MA benchmarks.

Addressing Payment Update Adequacy and Sustainability

The Committee shares stakeholders’ and experts’ concerns around the sustainability of owning and operating a physician practice, particularly as acquisitions by hospitals and corporations have increased significantly in recent years. Projected Medicare enrollment growth heightens these concerns, given the need for widespread clinician care access. The Committee is interested in examining the role of the current-law CF update schedule, particularly over the longer term, to enable physicians to maintain independent practice and ensure that Medicare FFS can remain viable. The Committee is also interested in exploring policy options that would update the CF in a more predictable manner and by an amount that better accounts for shifts in input costs and other relevant economic dynamics.

CMS has described the MEI as “the best measure available of the relative weights of the three components in payments under the PFS—work, practice expense (PE), and malpractice (MP).”⁶⁵ The data that currently serves as the basis for the MEI in the context of PFS rate-setting

originates from an AMA-led Physician Practice Information Survey (PPIS) that relied on 2006 cost information,⁶⁶ although medical and clinician organizations have enlisted Mathematica to conduct an updated PPIS, with the RUC forecasting last year, “Data would be shared with CMS in early 2025 for the 2026 Medicare Physician Payment Schedule rulemaking process.”⁶⁷ Referencing this ongoing survey, public comments, and significant payment shifts, CMS has postponed incorporation of MEI rebasing and revisions, based on an alternative methodology and different data sources, through its CY 2023 and 2024 PFS final rules.⁶⁸ With these considerations in mind, MEI-based cost weights for future years remain subject to substantial uncertainty, with significant implications for the RVUs that form one of the key elements of PFS payments.

Additionally, the current-law adjustments to the CF do not reflect practice cost inflation. The Committee will explore how to provide greater predictability in the CF statutory update schedule while also maintaining responsible stewardship over the Medicare program and taxpayer dollars.

Questions under Consideration

1. As an alternative to the current-law updates, how should the CF be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?
2. Current law updates reflect a differential between A-APMs and non-participants. How, if at all, should a new CF framework reflect participation in A-APMs as an incentive for participation?
3. What targeted policies should Congress consider pursuing to offset the costs associated with an alternative CF framework?

Budget Neutrality Adjustments to the Conversion Factor

CF changes often stem from budget-neutrality adjustments required by statute. The table below from CMS’s CY 2024 PFS Final Rule presents an illustrative example, whereby a number of new and existing policy changes finalized under the regulation resulted in a downward adjustment of 2.20 percent to the CF for CY 2024. According to the agency, “Approximately 90 percent of the budget neutrality adjustment is attributable to the E/M visit inherent complexity add-on code, with all other proposed valuation changes making up the other 10 percent.”⁶⁹

TABLE 116: Calculation of the CY 2024 PFS Conversion Factor

CY 2023 Conversion Factor		33.8872
Conversion Factor without the CAA, 2023 (2.5 Percent Increase for CY 2023)		33.0607
CY 2024 RVU Budget Neutrality Adjustment	-2.20 percent (0.9780)	
CY 2024 1.25 Percent Increase Provided by the CAA, 2023	1.25 percent (1.0125)	
CY 2024 Conversion Factor		32.7375

The PFS statute requires CMS to make budget neutrality adjustments for policy updates that the agency’s actuaries project will result in outlay changes exceeding a statutory threshold of \$20 million in a calendar year. Congress has never increased this threshold, which receives no automatic updates under current law. A cross-cutting coalition of clinician organizations has advocated for a higher threshold, coupled with automatic adjustments over time based on changes in the MEI, in order to “allow for greater flexibility in determining pricing and policy changes for services without triggering across-the-board cuts.”⁷⁰

Stakeholders and experts have also raised concerns over the role of utilization assumptions in driving disproportionate adjustments. With respect to the 2013 introduction of Transitional Care Management (TCM) codes, for instance, CMS reduced PFS payments for the year by more than \$700 million based on an overestimate of TCM service utilization, with the agency projecting roughly 5.6 million TCM claims when actual claim volume fell below 300,000 for the first year and had not reached one million annual claims even three years after implementation.⁷¹ A similar overestimate occurred with the addition of CCM codes, where CMS instituted budget-neutrality adjustments based on assumed utilization in the first year of 4.7 million claims, when actual claim volume totaled less than one million.⁷²

That said, without budget-neutrality requirements, policy changes within the PFS could result in increased spending. In effect, budget neutrality precludes potential cost overruns by way of expansions in the number, scope, and associated fees for procedures and services under the PFS. At the same time, as a result of this structure, policy changes that drive higher reimbursement for certain services trigger across-the-board payment reductions for all clinicians, including those who derive no gains from the updates driving said adjustments.

Addressing Concerns regarding Budget Neutrality in the PFS

The Committee is interested in exploring structural refinements to statutory PFS budget-neutrality requirements that would provide greater flexibility in determining pricing adjustments for services while maintaining financial responsibility and integrity.

Questions under Consideration

1. What policies, if any, would help to address inaccurate utilization assumptions that trigger budget-neutrality adjustments, or else to account for said assumptions in subsequent rate-setting processes?
2. Should the Committee consider additional parameters to align the statute's budget-neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?

Incentivizing Participation in Alternative Payment Models

As discussed, current law includes a differential CF update for participants in A-APMs beginning in 2026, the final payment year for the A-APM incentive bonus.

To date, the largest MIPS bonus has amounted to 2.34 percent, making participation in A-APMs more financially attractive to providers. However, stakeholders and experts have expressed concerns that this dynamic will begin to shift as the A-APM incentive bonus ends. For example, it is not until 2035 that the differential CF update for A-APMs will be five percent higher, on a compounded basis, than for non-participating clinicians. At the same time, the compounding differential also risks yielding its own set of policy challenges. In 2045, for instance, under current law, the CF differential will exceed 10 percent for A-APM-participating providers.

The Committee is interested in exploring ways to improve and sustain meaningful incentives for A-APM participation, particularly if Congress pursues CF reforms that diminish or eliminate the current-law differential conversion factor updates for A-APM and non-A-APM participants. Ideally, policies to extend or expand financial incentives to participate in A-APMs should account for lessons learned from successful models and programs, as well as for providers with lower A-APM uptake, and such potential incentives must reckon with budgetary conditions and realities.

Recent CBO analysis shows that ACOs led by independent physician groups, ACOs with a larger proportion of primary care providers, and ACOs whose initial baseline spending was higher than the regional average have been associated with greater savings.⁷³ Several other studies have also found that physician-led ACOs result in greater savings, likely because physician groups have robust incentives to avoid more expensive, hospital-based care and to redirect care patients to lower-cost settings.^{74,75,76,77} A-APM participation incentives should increase and support independent physician participation in ACO models, including with respect to smaller, rural practices.

The Committee is also interested in examining incentive payment reforms that would mitigate potentially misaligned linkages between bonus amounts and total PFS revenue, given that A-APMs operate most effectively when pursuing greater value for patients, rather than higher volume. Without substantive structural enhancements along these lines, incentive bonuses could risk increasing health care provider consolidation and crowding out independent, physician-owned groups. Similarly, like other provider payment incentives furnished within Medicare FFS with no corresponding MA requirement or directive in the past, A-APM participation bonuses may prove more targeted and less costly if excluded from MA benchmark calculations, ensuring Medicare program integrity. The Committee also has an interest, more broadly, in better aligning any future bonus payments with providers within an A-APM who contribute to beneficiary attribution.

Moreover, with respect to A-APM options, under MACRA, Congress codified the Physician-Focused Payment Model Technical Advisory Committee (PTAC),⁷⁸ designed in an effort to advance a range of A-APMs tailored to achieve broad participation among clinicians from all specialties and subspecialties. In practice, despite dozens of proposals recommended by PTAC after submission and consideration, none have seen implementation due to not meeting required criteria, although CMS has acknowledged concepts and ideas included in certain proposals.⁷⁹ As a result, many clinicians convey they see a lack of clinically relevant A-APM options within Medicare's value-based care initiatives.

One analysis, to that end, noted that certain program policies, particularly with respect to ACOs, have inadvertently "discouraged partnership with certain types of providers with higher-revenue volume, such as hospitals and specialists," resulting in a distortive dynamic under which "some ACOs have opted to drop hospitals or specialists from their participation lists" based on factors largely unrelated to care quality.⁸⁰

In light of these challenges, a growing body of research has sought to design and identify potential models oriented toward patient-focused, longitudinal care, with an emphasis on promoting team-based coordination among primary and specialty care clinicians treating beneficiaries with chronic diseases. In a December 2023 *Health Affairs* piece, Duke Margolis Center researchers argued for the "adoption of payment reforms to support primary and specialty care coordination in the longitudinal management of serious chronic conditions," including through more diverse payment models, better-tailored quality measures, and "alternatives to fee-for-service payments, such as per-member-per-month payments and subcapitated contracts for select in-network specialty-care partners."⁸¹ Other experts have cited "financial opacity" as a barrier to broadening APM participation by some specialties, calling for "appropriate data and analytic tools to manage actuarial risk" as one potential solution.⁸²

Questions for Consideration

1. In considering a new design for future A-APM bonus payments, are there existing demonstrations that structure A-APM incentive payments to reward providers that attribute beneficiaries to the A-APM?
2. What methodology should form the basis for incentive bonuses, if not total PFS revenue for all providers participating within an A-APM? What bonus structure best encourages new providers participating in A-APMs?
3. Should the bonus continue to require participation thresholds, or modify or eliminate thresholds to allow for greater participation? How?
4. Are there other A-APM programmatic designs that would make participation more attractive for providers?
5. How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options? How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?
6. What programmatic flexibilities, with respect to A-APMs or smaller models or pilots, would help to ensure a broader and more diverse array of options for clinicians?
7. Are there other A-APM programmatic designs that would make A-APMs more attractive to beneficiaries to increase attribution and thus support A-APMs?

Rethinking MIPS

The Committee has heard repeatedly of the immense administrative burden placed upon providers subjected to MIPS reporting requirements. Regarding primary care physicians, the MIPS program may not accurately capture the quality of care provided: a 2022 JAMA study of 80,246 primary care physicians found that MIPS scores were inconsistently related to performance on process and outcome measures, and that physicians caring for medically complex patients were more likely to receive low MIPS scores even when delivering relatively high-quality care. This study concluded that the MIPS program may be “ineffective at measuring quality improvement among physicians.”⁸³

A range of specialty clinicians have also taken issue with the limited scope of quality measures considered under MIPS. In April, CMS acknowledged these limitations in the context of APMs, launching a new Quality Pathway slated to prioritize patient outcomes and experience, although it remains unclear whether this initiative will have implications for MIPS.⁸⁴

Reducing Physician Reporting Burden Related to MIPS

Numerous experts and stakeholders, including witnesses testifying before the Senate Finance Committee and Energy and Commerce Committee, have recommended eliminating the MIPS

program. Given the lack of improvement in patient outcomes and quality of care, the Finance Committee is considering repealing or scaling back the MIPS program to relieve physicians' administrative burden and alleviate churn from A-APMs back to MIPS.

Questions for Consideration

1. What other policies, if any, would appropriately encourage improvement in quality of care delivered by clinicians under FFS Medicare?
2. Are there existing practice improvement activities or incentives, such as data registry participation, that should continue as a means of promoting individual clinician quality of care?

Improving Primary Care and Chronic Care

A number of experts and stakeholders have asserted that addressing the chronic care needs of patients necessitates improved payment policies for primary care.⁸⁵ While previous administrative efforts in FFS to bolster primary care have focused on the addition or restructuring of billing codes, primary care clinicians have noted that new codes produce additional administrative burden, along with uncertainty and ambiguity. Oversight initiatives have underlined the challenges associated with leveraging added codes as a means of strengthening support for primary care, particularly given the non-face-to-face nature of some of the services involved.⁸⁶

Uptake of the CCM code, for instance, has fallen well below prior projections. While early analysis by Mathematica showed that those who participated in the service had reduced emergency room and inpatient hospital visits, in addition to lower total health spending (saving Medicare about \$888 per patient per year),⁸⁷ more recent analysis indicates that only around four percent of eligible beneficiaries in Medicare FFS had enrolled in the program.⁸⁸ A Kaiser Family Foundation Health News analysis of federal data shows around 12,000 physicians billed for CCM in Medicare in 2021, and roughly 4,500 physicians received at least \$100,000 each in CCM pay that same year.⁸⁹

Ultimately, despite the potentially high value of these low-cost services, their associated quantification and billing requirements can prove burdensome, particularly for independent primary care practices. While A-APMs theoretically have the capacity to address care fragmentation, as well as to relieve administrative burden for primary care clinicians, and some success stories suggest high-performing participants and models can achieve these goals, numerous clinicians operating outside of ACOs or other A-APMs could benefit from reporting requirement relief, increased investment, and a more linear pathway to value-based care.

Supporting Chronic Care in the Primary Care Setting

In order to reduce administrative burden, appropriately compensate primary care, and create a viable pathway for independent primary care physicians to an APM, the Committee is exploring a hybrid payment model in FFS that would allow for a per-beneficiary, per-month (PBPM) payment, provided in advance to the clinician. The Committee is also interested in pursuing reforms to A-APMs, which have the built-in administrative infrastructure to alleviate some of the burden associated with additional primary care codes, such as through targeted, reduced cost-sharing to improve care coordination and decrease patient financial burden.

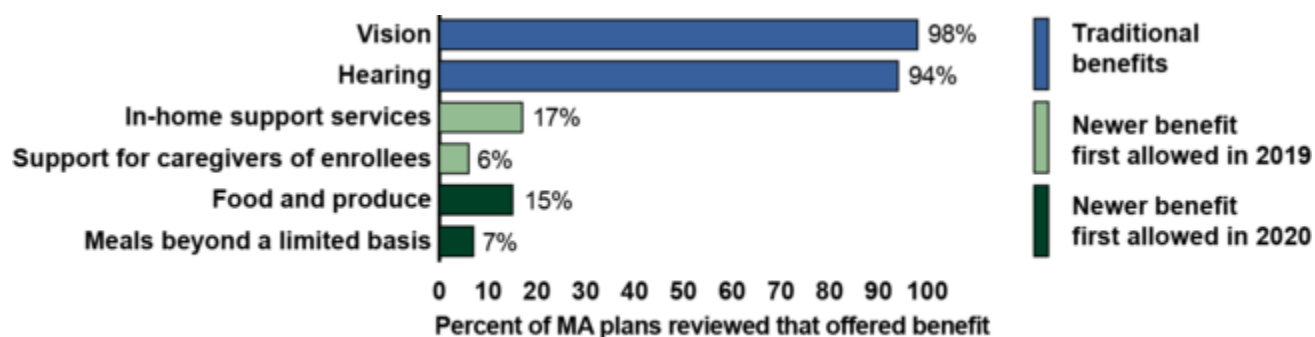
Questions for Consideration

1. In a hybrid PBPM payment model under FFS, which services should be paid through FFS versus the PBPM? Are there services beyond primary care that would benefit from this type of payment model as well?
2. Should a hybrid model design include a hybrid-specific risk adjuster for primary care?
3. How can such a policy account for quality?
4. Are there benefit design flexibilities that would ease financial burden for ACO-attributed beneficiaries who require chronic care management?
5. If Congress were to pursue such a hybrid model design, should policymakers also differentiate the CF, budget-neutrality adjustments, and other mechanisms to promote team-based care and appropriately account for distinctions in payment models across specialties and subspecialties?
6. If so, how should Congress structure such differentiation?

Supporting Chronic Care Benefits in FFS

The CHRONIC Care Act established supplemental benefits for MA plans that would reasonably improve or maintain the health or function of enrollees with chronic illness. According to GAO, in 2022 about one-fifth of plans reviewed offered at least one chronic care benefit, the most common being in-home support services and food and produce.⁹⁰

Most Common Supplemental Benefits, by Type, Offered by Medicare Advantage (MA) Plans Reviewed, 2022



Source: GAO review of Centers for Medicare & Medicaid Services data. | GAO-23-105527

Other examples of benefits for the chronically ill include medically-tailored meals, transportation for non-medical needs such as a grocery store, and minor structural home modifications to prevent falls. Given the prevalence of chronically ill beneficiaries in both MA and Medicare FFS, the Committee is interested in exploring which benefits would be the most meaningful in addressing health outcomes for beneficiaries in Medicare FFS.

Questions for Consideration

1. Which services provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill?
2. What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?

Additional Considerations: Ensuring Accuracy of Values within the PFS

Since the implementation of the PFS, Congress has intervened multiple times to address the program's broader programmatic design (i.e. MVPS, SGR, and MACRA) as well as various annual "doc fixes" to provide near-term relief for negative PFS adjustments. However, regardless of the PFS framework and cost-containment strategies, analysis shows that the volume and intensity of services delivered by clinicians have continued to increase in Medicare FFS.

The Committee maintains a longstanding interest in ensuring and upholding the accuracy and integrity of the PFS, including with respect to its underlying inputs. Per statute, the PFS requires a range of processes regarding the PFS and its components, including potentially misvalued codes, which CMS routinely reviews and revalues. That said, studies and analyses continue to point to the need for ongoing rigor with respect to these processes and policies,^{91,92} especially as the data underlying a number of determinations and rates becomes increasingly outdated or opaque.

Ensuring the Integrity of the PFS

The Committee is interested in exploring recommendations from experts and stakeholders regarding the program integrity and accuracy of all of the inputs to the PFS, including RVUs.

Questions for Consideration

1. What structural improvements, if any, would help to bolster program integrity, reliability, and accuracy in CMS’s RVU and rate-setting processes?
2. For more than 25 years, a Refinement Panel provided a relative value appeals process for CMS’s annual PFS processes. Should the agency consider reinstating such a panel, and if so, what modifications, if any, would help to ensure independence, objectivity, and rigor?
3. What third-party entities could produce the most credible and reliable analysis of CMS’s RVU determination and rate-setting processes, and what key areas should such analysis examine?

Ensuring Beneficiaries’ Continued Access to Telehealth

Prior to the COVID-19 public health emergency (PHE), Medicare FFS provided coverage for services furnished via telehealth under only restrictive conditions and circumstances,⁹³ with limited exceptions, impeding access for the vast majority of beneficiaries. As summarized by MedPAC:

“Before the PHE, Medicare coverage of telehealth services was limited by statute under the PFS. Medicare covered a limited set of telehealth services, modalities, and providers, and only in rural locations (with certain exceptions). For most telehealth services, Medicare required the patient to be located at an “originating site”—specified types of health care providers—in a rural area and required the clinician to be located at a “distant site” without any geographic limitations. During the PHE, Medicare coverage of telehealth was expanded to include additional allowable telehealth services and providers, and originating site and geographic restrictions were lifted.”⁹⁴

Congress had codified certain targeted measures, such as for telehealth stroke care, under the CHRONIC Care Act,⁹⁵ but the telehealth flexibilities and waivers issued beginning in 2020 relied largely on temporary legislative and administrative policies and authorities, which Congress has generally extended through subsequent provisions. Most recently, section 4113 of the CAA 2023⁹⁶ enacted extensions, through December 31, 2024, of the following key flexibilities, among others:⁹⁷

- Eliminating geographic restrictions on a beneficiary’s location when receiving care via telehealth;

- Enabling beneficiaries to receive clinically appropriate telehealth services in the home, including for certain non-behavioral health services;
- Permitting the use of audio-only modalities for certain telehealth services;
- Allowing Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to serve as distant site providers, and allowing certain non-physician, non-practitioner providers, such as occupational therapists and physical therapists, to furnish telehealth services; and
- Waiving statutory and regulatory “in-person” requirements that would otherwise force beneficiaries to have an in-person visit with a behavioral health provider at least once every six months³ in order to ensure coverage for telehealth visits with said provider between these in-person appointments.

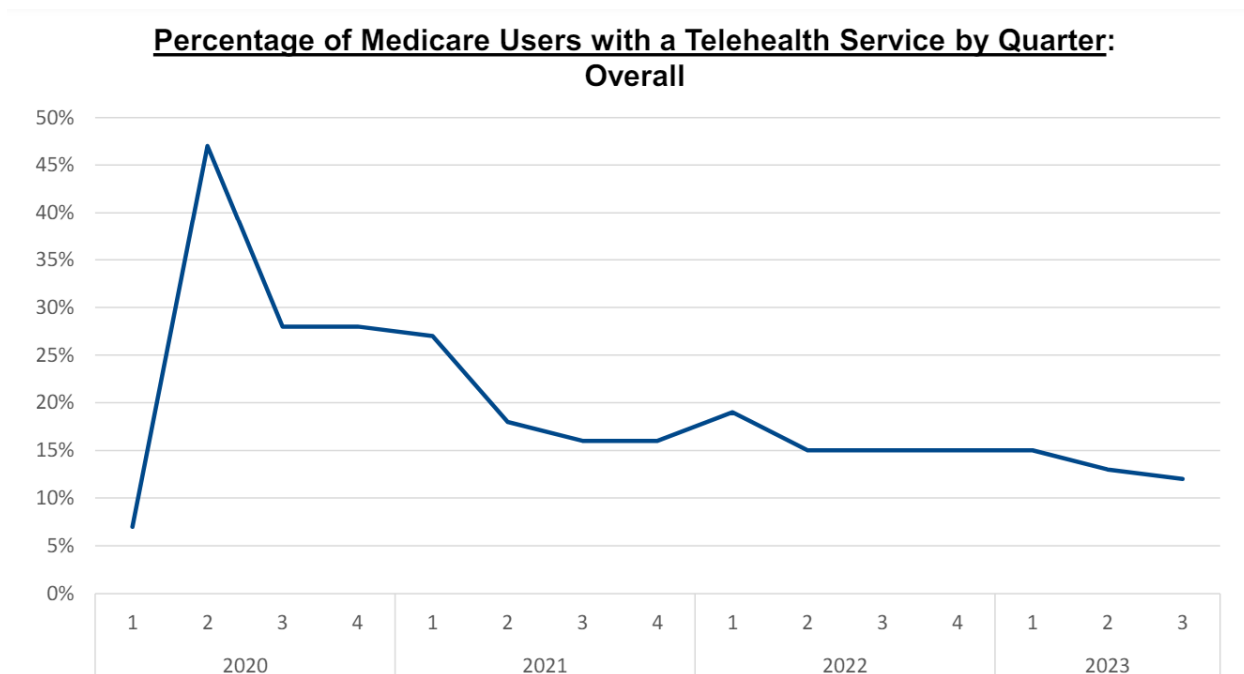
In the absence of legislative action, these flexibilities will expire at the end of the year, severely curtailing access to telehealth services for seniors and Americans with disabilities who receive coverage under Medicare FFS.⁹⁸ While Congress codified permanent flexibilities for certain behavioral health and substance use disorder-related telehealth services under the Consolidated Appropriations Act, 2021,⁹⁹ the in-person visit mandate included in those provisions would retain hurdles to meaningful access to care, if permitted to go into effect beginning next year.

The Committee has long advocated for bipartisan measures to bolster patients’ access to clinically appropriate telehealth services under Medicare FFS. To that end, in May 2022, the Chairman and Ranking Member joined Senators Cardin and Thune in releasing a discussion draft entitled the Telemental Health Access to Care Act,¹⁰⁰ which would rescind the burdensome in-person requirements for behavioral health and substance use disorder services, in addition to codifying beneficiary access to audio-only telehealth for these services.

The Committee has also worked on a bipartisan, bicameral basis to codify crucial oversight measures to ensure clinically appropriate provision and utilization of telehealth services. These policies have helped to provide agencies with the tools needed¹⁰¹ to uphold program integrity and combat waste, fraud, and abuse, in alignment with their oversight work related to non-telehealth services.

CMS has also released regular updates on utilization trends, which will aid policymakers in understanding the budgetary implications of telehealth policy extensions, as well as of any permanent flexibility provisions.¹⁰² According to the most recent data available, an estimated 12 percent of Medicare FFS beneficiaries used at least one telehealth service in the third quarter of 2023, comparable to the 13 percent utilization rate from the quarter before. These trends indicate a steep decline from the fourth quarter of 2020, which saw 28 percent of beneficiaries use a telehealth service, undercutting notions of pervasive and persistent over-utilization.¹⁰³

³ Under the Consolidated Appropriations Act, 2021, Congress established a statutory once-per-12-months in-person requirement, but CMS subsequently instituted a more stringent once-per-six-months requirement via regulation.



For beneficiaries who have come to rely on telehealth as a lifeline for access to critical services, the risk of a coverage cliff at the close of 2024 could pose dire consequences. The Committee shares concerns voiced by patients, frontline clinicians, and countless others that inaction by Congress on extending Medicare telehealth flexibilities would likely result in diminished health care outcomes for scores of seniors. With those considerations in mind, the Committee plans to engage in a bipartisan, bicameral basis to chart a responsible path forward that preserves access to crucial telehealth services under Medicare FFS.

Conclusion

The Finance Committee has undertaken a range of bipartisan initiatives thus far this Congress, advancing meaningful proposals and solutions to strengthen behavioral health care, reduce prescription drug costs, and prevent and mitigate drug shortages, among other vital goals. This white paper will serve as the foundation for another impactful legislative effort, focused on bolstering clinician care, particularly for Medicare beneficiaries with chronic diseases. The Committee looks forward to continued engagement with experts, stakeholders, and members of the Committee on policy concepts and options.

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