MedPAC June 2024 Payment Report:

Recommendations Q&A

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In June of this year, the Medicare Payment Advisory Commission (MedPAC) issued the MedPAC June 2024 Medicare Payment Report with their concerns and recommendations. Six chapters were discussed in this MedPAC report:

- Clinician payments and participation in alternative payment models (A-APMs)
- Provider networks and Prior Authorization in Medicare Advantage (MA)
- Medicare Encounter Data Pitfalls
- Paying for software technologies in Medicare
- Medicare payment rates for select conditions
- Medicare's Acute Hospital Care at Home Program

Clinician Payments and Participation in A-APMs

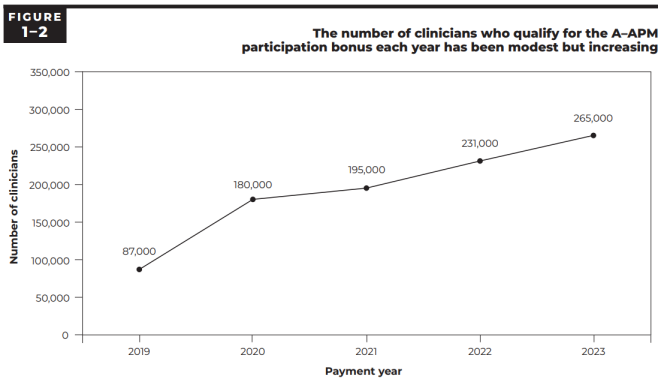
Every year, the commission reviews fee-for-service payments (FFS) for adequacy and recommends updates. Although the commission has found that the spending per Medicare beneficiary has consistently increased, there are concerns with payment rates in the future. Physician Fee Schedule (PFS) reimbursement rates will be flat in 2025 and slightly increase in 2026. Advanced Alternative Payment Model (A-APM) clinicians will receive an increase of 0.75% and all others will receive an increase of 0.25%. "Meanwhile, clinicians' input costs, as measured by the Medicare Economic Index (MEI), are expected to increase by an average of 2.3 percent per year from 2025 through 2033—exceeding the growth in PFS payment rates by more than has been the case over the past two decades." To combat the future financial pressures, the commission has proposed two options:

- Update the practice expense portion of the physician fee schedule by hospital market basket.
- Adjust the total fee schedule payment rates by the Medicare Economic Index (MEI) -1%

The commission also has concerns over future participation in A-APMs. A-APMs are advanced alternative payment models. Clinicians are rewarded for providing high-quality and efficient cost of care. The program is scheduled to end participation bonuses in 2026 and transition to the Merit-Based Incentive Payment system (MIPS). Currently, the highest A-APM incentive payment is 5% and the highest MIPS payment sits at 2.34%.

Q: What are the concerns for the adequacy of the future clinician payments? What is the impact to A-APM participation?

A: Without increases to future clinician payments, there will be an induced incentive for physicians to see less Medicare beneficiaries or potentially exit Medicare entirely. Due to lower incentive bonuses, A-APMs participation is expected to decrease drastically. The commission recommends temporarily extending the A-APM incentive bonus and repealing the MIPS program. The chart below shows the trend of A-APM participation. As of 2023, 265,000 physicians qualify for an A-APM bonus. A reduction in A-APM participation would lead to deteriorating quality and a potential increase in cost of care.



Provider Networks and Prior Authorization in MA

Provider networks and prior authorization have historically played a significant role in Medicare Advantage. "The Commission has long held that MA presents opportunities to achieve higher-quality care at lower cost. Using provider networks and utilization management tools such as prior authorization, MA plans can shape the services and providers that enrollees can access." Provider networks are used to ensure that Medicare patients have adequate access for their health needs and can also flag poorly performing physicians. Prior authorization has been a useful tool for utilization and cost management to prevent unnecessary services. Although these have been useful tools, there are still concerns over how these are operated and implemented.

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Q: What are the issues concerning Provider Networks and Prior Authorization?

A: CMS conducts reviews of network adequacy requirements. For plans and providers to properly meet these requirements, plan provider directories must be consistently monitored in order to maintain accuracy. This results in an administrative burden. Therefore, it is recommended that CMS establish a nationwide provider directory to reduce the administrative difficulties and logistical challenges that plans face. Prior authorization can cause delays in care for patients that have specific health needs. A review of prior authorizations was completed and found that 95 percent of prior authorization reviews resulted in positive determinations. "Although only a small share of prior authorization requests have been denied, Office of Inspector General (OIG) audits suggest that many denied requests should have been approved." The concerns over prior authorization are an area that the commission recommends continued review and analysis.

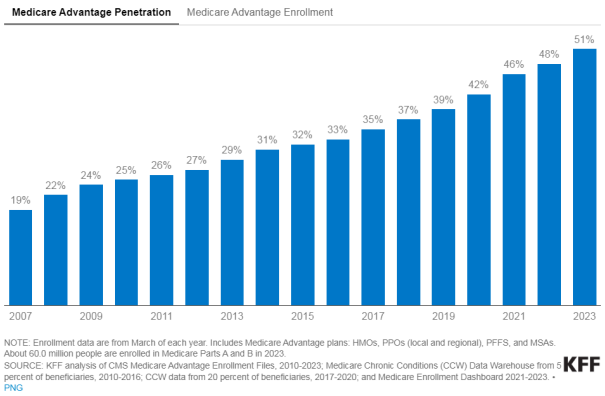
MA Encounter Data Pitfalls

The commission has found the MA encounter data is not always complete. There are many times that the data does not include all services rendered for an MA participant. The flaws in the data can have significant impacts on MA payment policy and new policies that could be implemented. In 2019, the commission recommended three changes which would provide a solution to the flawed system we have today:

- Implement benchmarks for the completeness and accuracy.
- Analyze MA plans' submitted data and provide feedback to organizations.
- Withhold plan payments that would be refunded to MA organizations that meet the required completeness and accuracy requirements.

Lack of reliable encounter data can lead to improper MA plan payments, which in turn would impact the benefit offering MA patients can receive. Given that MA now enrolls half of all Medicare beneficiaries, it is imperative that MA encounter data is improved. The commission strongly recommends implementing their recommendations from 2019. The following table shows the increase in MA beneficiaries from 2007 to 2023.

Figure 1
Total Medicare Advantage Enrollment, 2007-2023



NOTE: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023. • PNG

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Q: How would the Commission's encounter data recommendation address the flaws of MA encounter data?

A: The use of accuracy and completeness benchmarks will encourage MAOs to include all relative encounter data. Withholding plan payments, will give an incentive to comply with the encounter data guidelines as it will have an impact on their financial position. These plan payments have significant impact on MAO's benefit offerings each year and are a necessity in remaining competitive in the MA marketplace. Additionally, encounter data feedback will give MAOs insight into areas for improvement.

Paying for Software Technologies in Medicare

The vast changes and improvements in technology have increased the importance of technology in healthcare. "A key issue facing the FFS Medicare program is how medical software that is generally separate from the medical device should be paid for." Many FFS Medicare fee schedules pay for each service rendered. This can lead to excessive costs for the newer technologies. The commission has historically supported bundling payments for care involving medical software. This gives physicians flexibility to use their preferred technology in the most cost-effective way. This also can lead to physicians pushing for a reduction in costs for these newer technologies. Due to the emerging technological landscape, the commission will continue to review and discuss potential changes to payments for innovative technologies.

Medicare Payment Rates for Select Conditions

Since 2009, MedPAC has recommended the reduction of FFS payments to Inpatient Rehabilitation Facilities (IRFs) for patients with certain conditions. Historical analysis shows that payments to IRFs are high compared to the actual cost of care. This has led to Medicare margins exceeding 10 percent for the last two decades. In 2018, the OIG conducted a study that revealed the high profitability may incentivize IRFs to unnecessarily admit

patients with certain conditions. IRFs have a 60 percent compliance threshold, meaning that 60% percent of admits must meet 1 of 13 specific conditions. This means that the other 40% are not required to meet certain conditions and could potentially be treated elsewhere, such as a skilled nursing facility (SNF). If patients that did not need to be treated at an IRF could be identified, lawmakers could implement a payment structure that would significantly reduce the payments made to IRFs. CMS and the OIG conducted a review of medical records for patients that did not meet 1 of the 13 specific conditions and found that a significant number of patients admitted to IRFs did not meet the medical necessity to be admitted. Therefore, MedPAC continues to recommend the reduction of FFS payments to IRFs. The commission will continue to reevaluate their stance in December 2024 when they review the adequacy of IRF payments for fiscal year 2026.

Q: What would be the impact of FFS reductions to IRFs?

A: A reduction in FFS payments to IRFs could cause improper admissions to decrease. Patients that are not suited for an IRF could be admitted to a SNF. Data finds that Medicare payments to SNFs were roughly 40 percent lower than payments to IRFs for patients that did not meet the IRF criteria described above. The table below shows the cost difference for certain conditions.

TABLE 5-5 **Medicare payments for SNF cases were about 40 percent lower than payments to IRFs for cases not contributing to the compliance threshold, FY 2021**

Condition category	Median payment		Percent difference
	IRF	SNF	
All cases not contributing to the compliance threshold	$20,880	$12,650	39%
Debility	21,060	12,690	40
Other orthopedic conditions	20,830	13,870	33
Cardiac disorders	20,100	11,430	43
Other neurologic conditions	21,490	14,570	32
Replacement of lower extremity joint	18,420	10,190	45
Other disabling impairment	21,830	11,590	47
COPD	21,130	13,110	38
Other	22,660	12,900	43

Note: SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), FY (fiscal year), COPD (chronic obstructive pulmonary disease). "All cases not contributing to the compliance threshold" includes only cases with clinical conditions that do not contribute to meeting CMS's 60 percent rule for IRFs. Comparable SNF cases were identified by applying the same criteria used for IRF cases to SNF cases. The study population is defined in Table 5-1 (p. 181). The payments were not risk adjusted. IRF payments include wage index, rural, teaching, outlier, and low-income subsidy adjustments. IRF and SNF payments are rounded to the nearest $10. Payments to IRFs and SNFs cover most ancillary services but do not include payments made to physicians under the physician fee schedule. Percentage differences were calculated using unrounded values. Conditions are classified by impairment group categories (IGCs). Cases mapped to IGCs with fewer than 1,000 IRF cases or SNF cases that were not assigned to an IGC were classified as "other."

Source: Analysis of fiscal year 2021 Medicare FFS claims conducted by Acumen LLC for MedPAC.

Medicare's Acute Hospital Care at Home Program

The Coronavirus pandemic led CMS to initiate Medicare's Acute Hospital Care at Home Program (AHCAH). AHCAH is a concept where hospitals provide acute care at home rather than in a hospital setting. Advocates of this program believe that hospital care at home can give a patient appropriate care while also reducing the cost of care. However, studies find that this may not necessarily be true. "Hospitals active in AHCAH in 2022 tended to have higher all-payer patient volume, higher occupancy, and nonprofit ownership status, and they tended to be located in urban areas." Further, the commission found through interviews with hospitals that participate in AHCAH, patients tend to receive fewer services and resources compared to a traditional inpatient stay. The AHCAH program is still in its infancy and the view that improved quality and decreased cost of care has not been fully determined. If the program were to continue, CMS is encouraged to monitor the quality and cost of care.