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MedPAC Holds March 2025 Meeting

On March 6 and 7, the Medicare Payment Advisory Commission (MedPAC) held a virtual public meeting, which included the following sessions:

- Reforming Physician Fee Schedule Updates and Improving the Accuracy of Relative Payment Rates,
- Reducing Beneficiary Cost-Sharing for Outpatient Services at Critical Access Hospitals,
- Background: Medicare Insurance Agents,
- Preliminary Work on Medigap,
- Examining Home Health Care Use among Medicare Advantage Enrollees, and
- Institutional Special Needs Plans.

The full agenda and presentations for the sessions are available here.

MEDPAC DISCUSSES REFORMING PHYSICIAN FEE SCHEDULE UPDATES AND IMPROVING THE ACCURACY OF RELATIVE PAYMENT RATES

In this session, MedPAC staff discussed ways to reform future physician fee schedule (PFS) updates and improve the accuracy of relative payment rates. The PFS covers approximately 9,000 clinician services, including both discrete procedures and bundled care. Payment rates are determined using Relative Value Units (RVUs), which factor in clinician effort (work RVUs), practice expenses (PE RVUs), and malpractice costs.

First, MedPAC staff provided background on PFS updates. Since 2015, scheduled annual updates to the physician fee schedule have been modest (at or below 0.5 percent), though have been supplemented with one-off adjustments since 2021 (between 2.5 percent and 4.18 percent). Despite these supplements, there is a growing gap between the Medicare Economic Index (MEI - a measure of medical practice cost inflation) growth and fee schedule updates. Historically, MEI growth exceeded PFS updates by just over 1 percentage point per year. However, since 2020, this gap has widened, with projections from 2025 to 2034 anticipating even larger discrepancies. If left unaddressed, MedPAC staff highlighted this could negatively impact Medicare beneficiaries' access to care. Additionally, scheduled differential updates for Alternative Advanced Payment Model (A-APM) participants currently create weak incentives for A-APM participation. However, if no additional changes are made, A-APM participants

would receive over 10 percent higher payment for services than other clinicians in the 2040s.

To address these concerns, MedPAC staff proposed to replace the dual-update system with a single update tied to MEI growth. This approach aims to ensure sustainable increases to accurately reflect the cost of services and provide access to care, while avoiding financial strain on beneficiaries and taxpayers.

Next, MedPAC staff shared their concerns about the accuracy of relevant payment rates. Without an accurate RVU fee schedule, provider incentives are distorted, which has impacts across the healthcare system, including the availability of care and potential provider consolidation decisions. MedPAC staff highlighted concerns about the data used to determine the RVU fee schedule, and how these calculations do not take into consideration the ownership status of physician practices. The RVU fee schedule also uses a formula to set rates that consider the relative share of different types of costs (work RVU, PE RVU, and malpractice insurance) as well as the location of service. MedPAC's research found that these cost shares are outdated (as they currently use MEI based on data from 2006), and do not accurately account for indirect practice expenses in certain places of service. With hospitals currently receiving payments for both indirect and direct practice expenses, a policy change that reduces indirect expenses could save billions while increasing incentives for independent practice. Additionally, MedPAC staff identified the need to improve the relative accuracy of global surgical codes, which currently overestimate the number of postoperative visits a performing clinician typically performs.

In response to this research, MedPAC staff proposed to improve the accuracy of payment rates for clinician services through updating cost data regularly, and ensuring the payment rate methodology appropriately reflects the settings where clinicians practice.

Feedback from commissioners considering both these recommendations was wide ranging. First, commissioners highlighted concerns about appointment wait times for beneficiaries, with some arguing that the comparison to private insurance is subjective. Commissioners then highlighted discrepancies in establishing a minimum update floor for MEI-based increases, suggesting a 0.05 percent floor. Other issues included the latency in updates, omission of global surgical codes, and site neutrality concerns. Commissioners also debated volatility in MEI adjustments, the sustainability of A-APM participation incentives, and behavioral impact of these proposed changes. Further discussion centered around market volatility, the American Medical Association's control over CPT codes, and the balance between volume and intensity of physician services. Some suggested implementing ceilings and floors for service durations. Finally, concerns were raised about how much facility-based adjustments should be

made when procedures are performed in hospital settings, emphasizing the need for a predictable and transparent update process.

Commissioners did not hold a vote on these recommendations during this meeting, but plan to do so in the coming months.

MEDPAC DISCUSSES REDUCING BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES AT CRITICAL ACCESS HOSPITALS

During this session, MedPAC staff reviewed a draft recommendation to modify outpatient cost-sharing policies for Critical Access Hospitals (CAHs). Currently, Medicare beneficiaries receiving outpatient services at CAHs pay 20 percent of the hospital's charges, which can be significantly higher than actual costs due to markups. For example, a beneficiary at a high-markup CAH could pay nearly 80 percent of the total payment in coinsurance, while at a lower-markup facility, this share might be closer to 33 percent. This contrasts with outpatient prospective payment system (OPPS) hospitals, where coinsurance is based on 20 percent of the Medicare payment rate. MedPAC's proposed recommendation would set CAH outpatient coinsurance at 20 percent of the Medicare payment amount and introduce a cap equal to the inpatient deductible to protect beneficiaries from excessive out-of-pocket costs.

Commissioners broadly supported the recommendation, with many emphasizing the need for fairness in cost-sharing across different care settings. Several commissioners noted that under the current system, two CAHs with identical costs could impose vastly different coinsurance amounts due to markup disparities. Others expressed concern that high cost-sharing could deter beneficiaries from seeking care at CAHs, undermining access to rural healthcare. Commissioners also discussed the impact on Medigap premiums, state Medicaid programs, and employer coverage; with some staff suggesting that lower cost-sharing could lead to premium reductions over time. There was also discussion regarding whether the policy change would significantly affect CAH revenues, but staff analysis on this subject pointed to a minimal financial impact, as increased Medicare payments would help offset the reduction in beneficiary cost-sharing.

The commissioners reached a consensus that this policy change would improve equity without materially harming CAHs. The Chair summarized the discussion by underscoring the importance of aligning CAH coinsurance with other Medicare outpatient policies while protecting rural beneficiaries from excessive costs. The Commission voted unanimously in favor of the recommendation.

MEDPAC DISCUSSES THE ROLE OF MEDICARE INSURANCE AGENTS IN BENEFICIARY PLAN SELECTION

In this session, MedPAC examined the role of insurance agents in Medicare enrollment and the financial incentives that shape their interactions with beneficiaries. Agents and brokers are the most commonly cited resources for beneficiaries selecting Medicare Advantage (MA), Medigap, or stand-alone Part D plans. However, concerns have emerged regarding agent compensation, potential conflicts of interest, and agent transparency on beneficiary plan selection.

In this presentation, MedPAC staff highlighted the federal and state requirements agents must meet, including licensing, annual testing, and adherence to marketing regulations. However, agents can represent a variety of insurance companies, and they are not obligated to present all plan choices to beneficiaries. This lack of transparency may result in beneficiaries not being fully informed of all available options. Additionally, agent compensation structures, which often favor higher-premium plans and MA enrollments over Medigap and standalone Part D plans, raise concerns about whether financial incentives for agents influence beneficiary decision-making.

Commissioners expressed concerns about the lack of comprehensive data on agent activity and its impact on beneficiary choices. Some noted that beneficiaries often do not realize they are working with an agent, mistakenly believing that the information they receive comes directly from Medicare. Others questioned whether SHIP (State Health Insurance Assistance Programs), an unbiased source of Medicare guidance, is sufficiently funded and equipped to address this beneficiary need.

Several commissioners suggested exploring policy options such as greater disclosure requirements for agents, expanded public counseling programs, or even fully shifting the role of plan selection assistance from private agents to government employees. Others cautioned against overly paternalistic approaches, arguing that Medicare beneficiaries, like other consumers, should be trusted to navigate their options while acknowledging the need for more accessible and accurate information.

The Commission agreed that further research and data collection are necessary, including interviews with SHIP counselors, tracking regulatory changes in agent compensation, and gathering additional beneficiary perspectives.

MEDPAC PRESENTS PRELIMINARY ANALYSIS ON MEDIGAP

To begin this session, MedPAC staff provided an overview of the Medigap program, including information on plan types, enrollment, premiums, and minimum loss ratios. Beneficiaries on fee-for-service (FFS) Medicare have the option to add supplemental private Medigap coverage to help cover out of pocket costs, and can select coverage from 10 standardized plans offered by various carriers. Though Medigap enrollment varies substantially by state, it has modestly increased nationwide between 2017 and 2021, with approximately 45 percent of FFS Medicare beneficiaries electing for

Medigap coverage in 2021. Medigap regulation also varies by state. Though federal regulations set Medigap standards and beneficiary protections, individual states have wide-ranging discretion regarding enrollment and premium policies. These include flexibilities regarding changing Medigap plans following the initial open enrollment period when a beneficiary turns 65, and whether premiums can be based on individual policyholder factors (e.g. age, tobacco use status, and sex). One Federal protection is the minimum loss ratio, where the share of enrollee premiums spent on medical claims versus nonclaims expenses must remain at or above 75 percent for group policies, and 65 percent for individual policies. However, the nationwide average minimum loss ratio for Medigap plans in 2023 was 83.6 percent for group policies and 84.7 percent for individual policies, and has steadily increased over the last decade.

In discussion, some commissioners questioned the disparity in Medigap enrollment between under-65 and over-65 Medicare beneficiaries. Another commissioner responded by explaining that many states do not require insurers to offer Medigap to under-65 beneficiaries, and that when these plans are available to them, they are often prohibitively expensive. Several commissioners also made specific requests for future Medigap analysis. One commissioner was interested in further research on Medigap price variation and its effect on enrollment, while another was curious about the frequency beneficiaries switch plans, sustainability of the program at large, and coverage for supplemental benefits such as dental and hearing. In response to a question concerning the use of ratings agencies in selecting a Medigap plan, MedPAC staff said they are in the process of determining whether they have sufficient data to conduct the analysis. Commissioners also highlighted the presence of outlier states with low enrollment and requested further analysis to assess potential causes.

Overall, commissioners in this session focused mainly on understanding the nuances and the present state of Medigap, as well as identifying future areas of research. In his concluding remarks, Chair Chernew stated that people do not respond predictably to benefit design, and noted that Medigap price variation indicates complex consumer choice dynamics.

MEDPAC EXAMINES HOME HEALTH CARE USE AMONG MEDICARE ADVANTAGE ENROLLEES

In this session, the Commission examined trends and use of home health care in Medicare Advantage (MA) enrollees. The presentation combined multiple data sources to provide a more complete picture of utilization patterns. The Commission discussed these findings as part of ongoing preliminary research that will contribute to their June 2025 report to Congress.

Commissioners looked to understand the use of post-acute care in MA; particularly, home health care, which is the most used post-acute service among Fee-for-Service

(FFS) beneficiaries. Home health care provides skilled treatment in beneficiaries' homes and can be utilized following an acute inpatient hospitalization, a stay in a skilled nursing facility (SNF), or without any prior institutional care. In October 2024, MedPAC assessed the completeness of MA home health data using 2021 data and presented initial unadjusted estimates comparing home health care use among MA to FFS enrollees.

To gain a more comprehensive understanding, MedPAC combined encounter data with Outcome and Assessment Information Set (OASIS) records. 87 percent of MA enrollees had both types of records, while 7 percent had only home health encounter data and 6 percent had only OASIS data. This incomplete reporting suggests that studies relying solely on OASIS data may underestimate home health care use for MA enrollees. In contrast, the match rate for FFS beneficiaries were 98 percent, suggesting a more clearer reporting pattern. By merging the data, MedPAC expanded on previous work—incorporating beneficiary, plan, and provider characteristics. They estimated differences in home health care use between MA and FFS beneficiaries, analyzed overall use rates and the number of visits per beneficiary. Informal interviews with home health agencies (HHAs) were held and provided further insights. MedPAC's analysis focused on counties with more complete MA home health care data from 2021.

Use of home health care among MA enrollees in 2021 was higher for those who were older, had low incomes, or had a hospital stay. Unadjusted data showed that 8.5 percent of MA enrollees used home health care. The likelihood of use was notably higher for individuals with these characteristics, as well as those with a history of acute care hospitalizations (ACH). On average, MA enrollees who used home health care had 18.2 visits per user, with more visits observed among those with specific characteristics above.

MedPAC staff found the type of MA plan influenced home health care use. PPO plans were associated with more visits per beneficiary compared to HMO plans. In contrast, provider-sponsored plans (who are affiliated with hospitals or health systems) were linked to fewer home health visits.

Home health care cost sharing (deductibles or copays) were also associated with reduced use of services. Beneficiaries who have cost sharing were 6.7 percent less likely to use home health care (8.0 percent vs. 8.6 percent). Additionally, those with cost sharing averaged 17.9 visits per user, compared to 18.4 for those without—a 3.0 percent difference. This reduced utilization could be due to the lower reimbursement rates for MA plans, which may discourage home health agencies from providing care to MA beneficiaries.

In 2021, home health care use varied between MA and FFS beneficiaries, especially based on hospital stays. Overall, 8.4 percent of MA enrollees used home health care, compared to 8.5 percent of FFS beneficiaries. However, for those with a hospital stay, 42.0 percent of MA enrollees used home health care, slightly higher than the 39.6 percent for FFS enrollees. Despite this, MA users had fewer visits—18.7 visits per user on average, compared to 20.7 for FFS. This difference persisted even after accounting for hospital stays, with MA enrollees having 1.8 fewer visits on average.

The Commission followed this analysis by highlighting some potential limitations of the study. There is a trade-off between representativeness and data completeness when focusing on counties with higher data match rates, limiting generalizability. To add, MA enrollees could receive in-home care through supplemental benefits not captured under the Medicare home health benefit, potentially underestimating true utilization rates. The study could not also determine the appropriate level of home health care use for individual beneficiaries.

The Commission went on to provide feedback and questions in their discussions. For Round 1, they raised several points regarding the analysis of home health care use. Commissioners inquired about the availability of more recent data than just 2021. They emphasized the need to better understand the appropriateness of home health use, including the conditions that it used for, and whether services outside of the Medicare home health benefit (self-paid care) are being considered. The group also requested more information on cost data, particularly comparing rural and urban home health facilities, and the addition of outcomes data. They asked for clarification on the connection between provider-sponsored plans, HMOs, and lower home health care use, while acknowledging the challenges of operating environments in MA plans. There was also interest in exploring the impact of prior authorization requirements and whether approval or denial data for home health is adequately captured. Lastly, the Commissioners noted that since the differences in home health use across plans are small, more clarity and neutral language are needed while moving forward presenting.

In Round 2, the Commissioners highlighted the importance of studying post-acute care as it plays a key role in alternative and managed care settings, with potential to be more efficient. They noted that previous studies have consistently found lower home health care utilization in MA compared to FFS, but with no significant differences in outcomes. Given the presence of prior authorization and cost sharing in MA, they expected utilization to be lower, though acknowledged that the current analysis suggests largely similar rates between MA and FFS. The Commissioners emphasized the importance of data completeness, particularly the need to use encounter data to fully capture MA home health use. They called for a better distinction between community-initiated and post-acute home health services, as these serve different populations. Looking forward, they recommended breaking down home health data by

types of care and examining the impact of cost sharing, risk adjustment, and health outcomes, such as readmissions or hospitalizations. They stressed the need for more detailed data and segmentation in future work to better understand the dynamics of home health care utilization.

MEDPAC DISCUSSES INSTITUTIONAL SPECIAL NEEDS PLANS (I-SNPS)

In this session, MedPAC examined the role of Institutional Special Needs Plans (I-SNPs), which serve Medicare beneficiaries residing in nursing homes. The presentation focused on I-SNPs current market presence, enrollment trends, financial incentives, and integration with nursing home care. Staff highlighted that I-SNPs remain a small but growing segment of Medicare Advantage (MA), with their expansion largely driven by provider-sponsored plans. The discussion also addressed challenges in I-SNP enrollment, including concerns about financial risk for nursing homes, reluctance to shift from fee-for-service (FFS) revenue, and barriers to broader adoption.

Staff analysis indicated that I-SNPs are designed to align financial incentives by managing care for long-term nursing home residents, aiming to reduce avoidable hospitalizations and improve care coordination. However, integration remains low, in part because many nursing homes are hesitant to assume financial risk or lack the scale to justify participation. Nursing homes currently rely on the FFS model and have concerns about assuming responsibility for care costs, especially hospitalizations. Smaller facilities can lack the resources to handle potential losses, making the shift to value-based payment models (like I-SNPs) challenging. Interviewees noted that while the COVID-19 pandemic temporarily slowed I-SNP growth, more providers are expected to enter the market. Additionally, the discussion raised concerns about whether I-SNPs disproportionately focus on nursing homes with well-developed I-SNP infrastructure, potentially overstating their impact on a broader scale.

Commissioners explored several key issues related to I-SNPs. Some were interested in how I-SNP enrollees compare to beneficiaries in other Medicare plans, particularly regarding diagnoses and transitions out of I-SNPs. Others raised concerns about potential coercion, given that institutionalized beneficiaries may have limited capacity to make informed coverage decisions. The role of nurse practitioners (NPs) in I-SNPs was also discussed, with commissioners acknowledging that regular NP visits could be a major advantage but questioning how these practitioners are integrated when they are not employed by the nursing home.

Some commissioners suggested further investigation into differences between I-SNPs and Dual Eligible Special Needs Plans (D-SNPs), particularly in terms of care outcomes and beneficiary experiences. They also discussed transferability between I-SNPs and D-SNPs, examining whether and how beneficiaries move between the two plans and the implications for care continuity. Others questioned the extent to which D-SNPs

successfully delay or prevent long-term nursing home stays. Several commissioners emphasized that nursing homes have historically lacked strong incentives to manage care effectively, often defaulting to hospital transfers rather than providing in-house treatment. They expressed interest in policies that could make I-SNPs more attractive to nursing homes, particularly smaller facilities that struggle with enrollment. Finally, the discussion turned to the potential for spillover effects, such as whether the presence of an I-SNP in a facility improves care quality for all residents, including those not enrolled in the plan.

Looking ahead, commissioners agreed that additional analysis is needed on I-SNPs' impact, particularly regarding cost, quality, and beneficiary experience. Some suggested integrating insights from consumer advocacy groups and exploring financial incentives to encourage broader participation among nursing homes. The Chair concluded the session by noting that work on this topic will continue, with an emphasis on how I-SNPs, D-SNPs, and PACE programs interact to create a more comprehensive long-term care strategy for Medicare beneficiaries.

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This Applied Policy® Summary was prepared by Hugh O'Connor with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact him at hoconnor@appliedpolicy.com or at 202-558-5272.