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MedPAC Holds November 2024 Meeting

On November 7 and 8, 2024, 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 payments,
- Considering the participation bonus for clinicians in advanced alternative payment models,
- Structural differences between the PDP and MA–PD markets,
- Workplan: Assessing Medicare Advantage provider networks, and
- Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities.

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

MEDPAC DISSCUSSES REFORMING PHYSICIAN FEE SCHEDULE UPDATES AND IMPROVING THE ACCURACY OF PAYMENTS

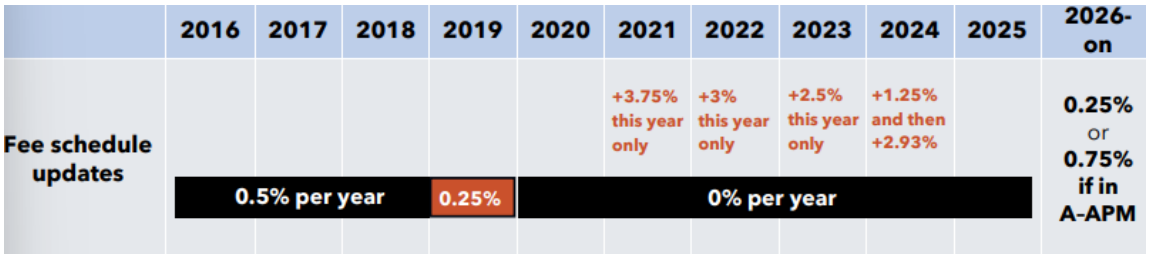
On November 7, 2024, MedPAC held a session on reforming Physician Fee Schedule (PFS) updates and improving the accuracy of payments. The Commission provided a background of the PFS, examined current concerns with its structure, adequacy and accuracy of payments, and discussed potential policy reforms. Key areas to improve were identified, focusing on aligning payment updates with service costs and addressing disparities within the payment structure.

Physician Fee Schedule and Payment Background

The PFS determines Medicare payments for around 9,000 clinician services across various settings from offices to hospitals. Payments are based on Relative Value Units (RVUs), which factor in 1) the clinician's work, 2) practice expenses (indirect and direct), and 3) malpractice insurance costs. RVUs are multiplied by a conversion factor to

determine final payment amounts. RVUs vary by service and may be adjusted based on service setting.

While the Medicare Access and CHIP Reauthorization Act (MACRA) mandates annual PFS updates, these adjustments are usually less than 1 percent and do not keep pace with economic changes such as inflation—which poses a significant challenge for many clinicians and practices. By 2026, PFS payments will differ based on clinician participation in Alternative Payment Models (APMs). See here below in a chart from MedPAC:



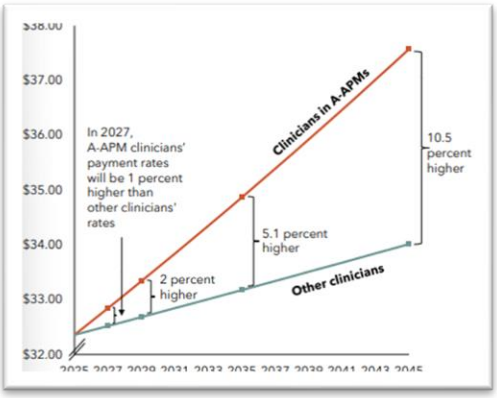
When considering PFS updates and payments, MedPAC looks to ensure three key principles: continued access to care, efficient care delivery, and high-quality care. All of these are key to MedPAC's recommendations below.

Current Concerns with PFS Updates

Concern #1: Growth of the Medicare Economic Index (MEI) vs. Fee Schedule Updates

One major concern is that MEI growth is projected to exceed fee schedule updates by a larger margin than in the past. MEI growth outpaced fee schedule updates by just over 1 percentage point annually for the two decades prior to the pandemic. However, from 2025 to 2034, the projected gap between MEI growth and PFS updates is expected to widen to 1.5 percent for clinicians in Advanced Alternative Payment Models (A-APMs) and 2.0 percent for those not in A-APMs. While Medicare beneficiaries currently have comparable access to care relative to privately insured individuals, this widening gap between MEI growth and PFS updates could negatively affect beneficiary access.

Concern #2: Incentive Structure for A-APM Participation



Another concern is the differential fee schedule updates for clinicians in A-APMs versus those who are not, which are currently set at 0.75 percent and 0.25 percent, respectively. While these differential updates aim to incentivize A-APM participation, the effect will vary with time. In the 2020s, the incentive to participate in A-APMs will be relatively small, but MedPAC asserts will become much more substantial by the 2040s, potentially creating uneven motivation to transition into A-APMs. See the graphic to the right from MedPAC:

Policy Option to Reform PFS Concerns

MedPAC has proposed a policy to update PFS rates annually based on a portion of Medicare Economic Index (MEI) growth, rather than separated, A-APM participation updates. Included in MedPAC's June 2024 report, policymakers could consider a range of options. One proposed example is adopting a formula like "MEI minus 1 percentage point" with a minimum update floor. Evidence suggests that a full MEI-based update is not required to maintain access to care.

This policy is designed to ensure beneficiary access while controlling Medicare spending. Basing updates on a portion of MEI growth offers several benefits, such as simplicity, inflation adjustments, predictability, and good value. If implemented, MedPAC would continue to monitor access to care and could recommend adjustments to the update rate if necessary.

Concerns with the Accuracy of PFS Payment Rates

MedPAC has raised concerns about the accuracy of the Relative Value Units (RVUs) used to set PFS payment rates, as these rates directly impact payment distribution, service incentives, and beneficiary cost-sharing. In previous years, MedPAC has provided various recommendations on how to improve RVUs and payment rates. Some recommendations include creating an expert panel to assist CMS in reviewing RVU recommendations from the RVS Update Committee (RUC), a regular review of existing RVUs that have experienced large changes in utilization (may indicate need for revaluation), reviewing codes where reductions in value are likely, and starting collection of data from cohort of efficient physician practices to inform valuation. RVUs are fundamental to Medicare's cost structure and have a significant impact on beneficiaries, who bear 20 percent of these costs. Addressing concerns with RVU accuracy is necessary.

Three key issues underline current payment concerns, highlighted below:

1. Lack of timely and accurate data to determine appropriate practice costs
2. Current RVUs may not accurately reflect current practice patterns
3. RVUs do not account for possible financial relationship between clinicians and facilities

To address these issues, MedPAC is considering three policies to improve payment rates: 1) Updating allocation of work, practice expense, and professional liability insurance RVUs, 2) Improving the accuracy of global surgical bundles, and 3) Improving the accuracy of payments for indirect practice expense.

Policy #1: Updating the Allocation of RVUs

To improve payment accuracy, MedPAC suggests updating the allocation of RVUs for work, practice expenses (PE), and professional liability insurance (PLI) to better reflect current practice costs. Currently, Medicare uses the MEI cost shares as the basis for RVU allocation and determination. However, CMS still relies on outdated MEI data from 2006 to determine RVUs, although newer data from 2017 is available and shows significant percentage shifts in practice costs since 2006. Current RVU allocations and calculations are not reflective of current practice. Regularly reallocating RVUs using up-to-date MEI data would improve RVU accuracy, minimize abrupt changes when MEI is updated, and better reflect actual practice expenses.

Policy #2: Improving Accuracy of Global Surgical Bundles

Roughly 4,000 billing codes represent 10- or 90-day global surgical bundles—about 10 percent of total PFS spending. These bundles are supposed to cover all care provided on the day of the procedure and any postoperative visits by the performing physician. However, the RVUs for these codes are based on the number of postoperative visits provided by the performing clinician, while visits by other clinicians are separate. It has been shown that performing clinicians typically provide fewer postoperative visits than assumed, often leading to overpayments and higher beneficiary cost-sharing.

One potential approach is to convert the 10- and 90-day global codes to 0-day codes which removes a portion of global RVUs assigned to postoperative visits. This would make procedure codes cover only the care on the day of the procedure, with separate payments for each postoperative visit. While this could reduce beneficiary liability for the procedure itself, it could also discourage postoperative care due to cost-sharing for each visit. If applied with budget neutrality, rates for other codes would increase.

Alternatively, global codes could be revalued based on more accurate, postoperative data. 10- and 90-day global codes would remain but reduce RVUs by an average of 28 percent, resulting in lower cost-sharing for beneficiaries and eliminating cost-sharing for postoperative visits. However, this option would require more time and data

collection. If applied with budget neutrality, rates for all other codes would increase by 2.6 percent.

Policy #3: Improving Accuracy of Payments for Indirect Practice Expenses

There are two sets of RVUs used for practice expenses: non-facility RVUs for services provided in office settings and facility RVUs for services provided in facility settings like hospitals or ambulatory surgical centers. Practice expenses are divided into two types: direct (supplies, equipment, clinical labor) and indirect (overhead expenses). Excluding indirect PE from facility RVUs may be appropriate when there is a direct financial relationship between clinicians and the facility, as the facility fee already covers these indirect expenses.

The allocation of indirect practice expenses (PE) directly impacts how RVUs are calculated for both facility and non-facility settings. When indirect PE is excluded from facility RVUs, the payments may not accurately reflect the true costs of services in facility settings, where clinicians do not bear the overhead costs directly. This misallocation can lead to inaccurate payments and distort financial incentives, potentially encouraging clinicians to favor certain settings over others. By adjusting how indirect PE is accounted for, this policy aims to improve the accuracy of RVU-based payments, ensuring fair compensation and promoting better setting choices.

Commission Discussion

The Commission discussion focused on whether the Commission supports a single conversion factor based on a portion of MEI growth and what additional steps are needed to improve the accuracy of payments.

In the first round of discussion, the size of the budget neutrality rule was debated and its impact on RVUs. The group also examined the relationship between access to care and payment, noting that while full MEI updates could increase spending, they may not necessarily improve access. Data revealed that commercial sector spending is 35-45 percent higher than Medicare, but it does not correlate with better access. This raises the question about the value of additional spending. The Commission also discussed alternative ways to define access, including looking at internal Medicare surveys, commercial/Medicare comparisons, and timeliness of care. Timeliness remains a concern, as Medicare patients often face delays in care compared to commercial patients. Additionally, there were concerns regarding global surgery bundles, especially regarding beneficiary awareness of what is covered. Clearer communication about bundled services is needed to ensure beneficiaries understand the full scope of their coverage.

In the second round, the Commission addressed the differences between A-APMs, acknowledging that while they could create challenges, they also provide incentives for

providers to engage in risk-based, value-oriented models. The discussion on global surgical bundles reinforced the need for revaluation to simplify and align them with current practices. The Commission emphasized that updates to the PFS must keep pace with inflation to ensure accurate payments. Mechanisms like the MEI and safety net indices were identified as critical tools to achieve this. The Commission also underscored the importance of proactively addressing access issues, as there are already signs from beneficiaries and providers of challenges related to Medicare reimbursement. Concerns were raised about the disincentive for practices to treat Medicare patients, especially if they are losing money on these cases, which could limit care options. Commissioners also noted the potential negative impact of hospital consolidation, as it could lead to a more restrictive delivery care model. Lastly, the Commission noted the upcoming qualitative beneficiary access survey, stressing that its findings should be considered in future policy discussions.

MedPAC Chair Dr. Michael Chernew may present draft recommendations for consideration in the spring.

MEDPAC CONSIDERS THE PARTICIPATION BONUS FOR CLINICANS IN ADVANCED ALTERNTATIVE PAYMENT MODELS

Advanced Alternative Payment Models (APMs) are one track of CMS's Quality Payment Program that provide physicians with incentives for meeting participation thresholds based on levels of payments or patients through A-APMs.[1] MedPAC asserts the Physician Fee Schedule incentivizes clinicians to increase volume, and APMs aim to counteract this by offering additional payments, such as shared savings if clinicians meet certain targets. The A-APM bonus for performance year 2025 is a 3.5 percent lump-sum bonus based on the prior year's Medicare Part B payments.[2] Clinicians participating in an APM may also incur a monetary loss if they perform poorly or make infrastructure investments but do not qualify for a performance bonus.

MedPAC analysis has found that APMs generate promising results, but not net savings. An increasing number of clinicians have qualified for the A-APM bonus over time, but for many, the participation bonus is worth a relatively small amount. However, the bonus is larger than estimated payments for most clinicians in the MSSP. Staff also examined an analysis on the effectiveness of A-APMs in improving care quality and achieving net savings. Staff further discussed the influence of new policies, such as CMS's episode-based payment model, on the A-AMP landscape. Overall, the

[1] https://qpp.cms.gov/apms/advanced-apms
[2] https://www.aafp.org/family-physician/practice-and-career/getting-paid/aapms.html

Commission noted that there is significant uncertainty regarding whether the participation bonus has influenced A-APM participation, and what programs and policies will exist in the late 2020s.

As the A-APM participation bonus is set to end, MedPAC staff considered the extension of this bonus to protect against A-AMP attrition, noting the goal of avoiding creating an incentive for clinicians to prefer the Merit-based Incentive Payment System (MIPS) over A-APMs. Staff also noted that there may be less of a need for the bonus if the number of clinicians in A-APMs continues to grow, even with the bonus size declining.

1. **Approach #1:** Under this approach, the bonus would be calculated as a share of clinician's A-APM payments and eliminate the requirement that a certain share of a clinician's payments or patients be attributed to them through A-APMs. This would decrease the bonus size but increase availability to all clinicians.
2. **Approach #2:** The bonus would be calculated as a flat, risk-adjusted payment for each beneficiary attributed to the clinician through an A-APM and eliminate the requirement that a certain share of a clinician's payments or patients be attributed to them through A-APMs. This would remove volume incentivization but limit specialist access.

Commissioners raised concerns over the effectiveness of A-APMs in reducing healthcare costs and improving care quality, with some suggesting a need to explore alternative models or strengthen mandatory requirements. Some noted that A-APMs might encourage consolidation without enhancing care, while others questioned the ethical implications surrounding autonomy through enrolling vulnerable Medicare beneficiaries in A-APMs. Commissioners also highlighted the limited influence of the participation bonus on larger organizations, which often have additional motivations to join A-APMs, while smaller organizations found the bonus more impactful. Commissioners discussed the limited appeal of A-APMs to specialists and the overall challenges in engaging a broader range of providers. Several commissioners expressed interest in examining how bonuses might better target specialist engagement and small practices to create a more inclusive A-APM environment.

Ultimately, the panel had divided opinions on extending the bonus, with some suggesting that bonuses serve as a bridge to value-based care, while others argued for a shift toward mandatory models to achieve more consistent outcomes. While no immediate recommendation was made, the Commission plans to further investigate

how A-APMs could be optimized for varied provider types and consider alternative incentives that might support long-term goals of quality improvement and cost savings.

COMMISSION REVIEWS STRUCTURAL DIFFERENCES IN PART D PLAN MARKETS AND IDENTIFIES AREAS FOR FUTURE WORK

Medicare Part D relies on competition amongst private plans. Plans vary by premium, cost, sharing, formulary, and pharmacy network. There are two distinct markets in Part D: standalone prescription drug plans (PDPs) for fee-for-service beneficiaries and combined medical and prescription drug coverage for Medicare Advantage (MA) beneficiaries, called MA-PD plans. MedPAC staff gave an overview of the Part D system and enrollment shifts, and then reviewed concerning trends in the prescription drug plan market, structural features of the MA program that may affect PDP and MA-PD offerings, and key changes in 2025.

The PDP market is important for Medicare beneficiaries because it allows beneficiaries in fee-for-service Medicare to receive Part D drug coverage, and also ensures that beneficiaries receiving the low-income subsidy (LIS) receive premium-free drug coverage. However, plan offerings and enrollment are moving away from PDPs and towards MA-PDs. Under the Part D benefit redesign, a component of the Inflation Reduction Act (IRA), plan sponsors will be responsible for a greater portion of costs above the deductible, beginning 2025. MedPAC staff assert that this redesign should improve plan incentives but may amplify the structural differences between the two markets. Chair Commissioner Dr. Michael Chernew noted that this shift in liability has left many wondering what the impact of this change will be. Recently, to address concerns about PDP stability, CMS announced the creation of the Part D Premium Stabilization Demonstration for PDPs that will begin in 2025, which includes features that are intended to promote stability for PDPs.

MedPAC has identified key trends that raise concerns about the stability of the PDP market:

- The average premium charged by PDPs exceeds premiums for MA-PDs. When comparing non-benchmark PDPs to convention MA-PDs, the difference in premiums ranged from $8 to $15 per month.
- Benchmark plans are PDPs with premiums at or below low-income subsidy (LIS) benchmarks. The number of benchmark plans has declined over the past decade. Fewer PDPs qualify as premium free to beneficiaries with the LIS.
- PDPs have higher average gross costs but lower risk scores than MA-PDs. Over the last decade, risk scores for PDPs have decreased, while they have increased for MA-PDs. Average gross costs have increased for both plans, with average

gross costs of $124 for PDPs and $122 for MA-PDs in 2023. The gap in the difference in average gross costs has decreased over time.

- PDPs are more likely to incur financial losses compared to MA-PDs.

There are structural features of the MA program that may impact PDP and MA-PD offerings:

- MA rebates are an additional source of funding available to MA-PDs that can be used to enhance Part D offerings or reduce premiums. PDPs do not have additional funding sources.
- To achieve their intended premiums, MA-PDs can adjust their premiums after CMS publishes national average bid and subsidy amounts. PDPs do not have this opportunity.
- MA-PDs can use market segmentation based on enrollees' LIS status through Dual-Eligible Special Needs Plans (SNPs), which is a plan type specific to MA only available to dually eligible beneficiaries. As all PDPs serve both LIS and non-LIS beneficiaries, they face greater challenges related to market segmentation.
- The ability of MA plans to document additional diagnosis codes may contribute to higher Part D risk scores. The average risk score for MA-PD enrollees has grown more quickly than for PDP enrollees since 2012.

Commission Discussion and Next Steps

Commissioners provided their feedback on the work and suggested additional areas for follow-up. Many commissioners noted that this is not an issue of only PDPs versus MA-PDs, but a broader issue concerning the differences between FFS and MA. Commissioners also noted that many of the same companies offer both PDPs and MA PDs, potentially raising cause for concern. Additionally, there was interest in further understanding the impact of the Part D Premium Stabilization Demo. Commissioners also noted the importance of access. Dr. Chernew closed the session by highlighting several subthemes of interest present in the discussion: market structure, including the numbers of plans, carriers, and who owns them, as well as changes occurring there; issues with benefit design and the impact on premiums with the changing benefit; issues impacting the LIS; and the impacts of coding.

As next steps, the Commission will conduct further analyses of Part D data focused on two main areas, and present findings in the spring: 1) how differential coding patterns may impact Part D risk scores, and 2) how different incentives and funding sources may impact the generosity of drug coverage and formulary design in both markets. As part

of the work on formulary design, the Commission is completing a formulary analysis and is currently selecting which categories of drugs to focus on. Biosimilars were suggested by one commissioner, and other commissioners have previously expressed interest in examining biosimilars.

MEDPAC DISCUSSES PROPOSED WORKPLAN FOR ASSESSING MEDICARE ADVANTAGE PROVIDER NETWORKS

Medicare Advantage (MA) plans use contracted networks of doctors, hospitals, and other providers to provide beneficiaries with access to services.[3] For these provider networks, CMS has established certain adequacy requirements for the 14 included facility types and the 29 specialty types, requiring networks to demonstrate and meet approved minimum number of providers, maximum travel time and distance to providers, and maximum wait times. MedPAC staff presented a proposed multi-step workplan for assessing Medicare Advantage (MA) provider networks through data collection and analysis. Before proposing the workplan for assessing MA provider networks, the MedPAC staff first presented key issues in MA provider network management:

- Current organizational systems for generating and maintaining MA directories of in-network providers are costly and inefficient, and often include inaccurate information.
- MA plans and providers can initiate or terminate contracts at any time, which can cause disruptions in care.
- Trade-offs in network breadth impact quality, cost, and access. Narrow networks may improve quality and/or reduce expenses but could hinder access. Broad networks may improve access, but enrollees may face lower-quality providers and reduce a plan's negotiation abilities.
- Limitations in network design may disproportionately affect beneficiaries with chronic illnesses.

To help address these issues, the Commission aims to better understand provider participation in MA networks, enrollee use of MA provider networks, and the impacts of MA network adequacy standards on access to care. Staff suggested a tool for analyzing MA provider networks: Ideon– a third-party data vendor that can be linked with CMS data on MA registries, enrollment, and encounter data to assess and verify plan types and provider details. Such data would be used in a proposed workplan to better understand:

[3] https://es.medicare.gov/publications/11941-understanding-your-medicare-advantage-plan.pdf

- Key information on provider enrollment in MA networks, including the breadth of provider participation in MA and fee-for-service (FFS) plans and key statistics on provider participation in plan networks, such as exit and joining rates that may help identify the drivers and impacts of contract changes.
- The use of in-network and out-of-network providers by MA enrollees in order to better grasp effective plan and provider characteristics and indicators of access and payment concerns.
- The association between network size and breadth and access-related indicators and quality standards in order to better evaluate MA network both subject and not subject to adequacy requirements.

Commissioners supported this work, noting its importance in improving care quality and MA network efficacy. Regarding their concerns, commissioners first discussed the need for clarification on MA provider network coverage, such as specifying which types of emergency and specialty care are included in various MA networks. Several commissioners noted that the current process has yielded significant beneficiary confusion on care pathways, plan delineations, and accurate provider networks, resulting in a disconnect between provision and access. In particular, they emphasized the need for clarification on the inclusion of specialty treatment and care, such as oncology and cardiology centers, in order to increase patient access and understanding.

The commissioners further discussed broad concerns regarding the MA network impact on beneficiaries, expressing concern about the ability of MA plans and providers to terminate contracts at any time within a contract year. Additionally, they highlighted the need to document and evaluate changes in MA network provider and beneficiary enrollment and use, in order to better understand participation incentives and disincentives. Similarly, the commissioners suggested including quality in network adequacy requirements, particularly for post-acute care, to help address major concerns on decreased quality due to narrow networks. Other key commissioner suggestions included the utilization of technology to help manage and improve MA network directory accuracy, clarifying the funding plan for Ideon data collection processes, and general improved education and information on MA network enrollment and coverage for beneficiaries.

MEDICARE SUPPORTS ELIMINATING THE 190-DAY LIMIT FOR IPF CARE

Medicare imposes a 190-day limit for coverage of care in Inpatient Psychiatric Facilities (IPFs). Congress originally implemented this limit when Medicare was created in 1965, at a time when state and local governments were the predominant providers of inpatient psychiatric care. At present, however, 84 percent of Medicare-covered IPF

days are in private psychiatric facilities. Medicaid and Medicare Advantage (MA) can in some cases provide some additional care past the 190-day limit, and there are hospital-based IPFs not subject to the limit. Nevertheless, those avenues to IPF care outside of Medicare coverage are limited. Medicare staff presented research demonstrating that, in practice, beneficiaries approaching the limit tend to receive less care, by an average of 2.2 days annually. Hospital-based IPF usage increases among these affected beneficiaries, so the 190-day limit may impose a burden on hospitals. If the limit were eliminated, Medicare staff estimated that Medicare fee-for-service spending would increase by approximately $40 million; although the total cost for Medicare would be higher because payments to MA plans would also increase.

The commissioners expressed unanimous support for eliminating the 190-day limit, primarily on the grounds that it is not appropriate for present-day care conditions. The vulnerable nature of patients receiving IPF care was a focal point of discussion. Commissioners also discussed the events which led to the deinstitutionalization of state-run psychiatric care facilities, such as poor quality of care. With that in mind, they counseled caution toward the prospect that, in eliminating the 190-day limit and increasing Medicare coverage of IPFs, history might repeat itself. Some commissioners discussed the unique challenges of dual-diagnosis patients with both substance abuse and mental disorders. Another commissioner suggested that reductions in hospital-based IPF usage in favor of non-hospital rehabilitative care would end up being cost-effective, due to the hospital setting being especially expensive. In closing remarks, Chair Michael Chernew reiterated the broad support for eliminating the 190-day limit and the need to care for the vulnerable population served by IPFs.

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