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MedPAC Holds September 2024 Meeting

On September 5, 2024, the Medicare Payment Advisory Commission (MedPAC) held a virtual public meeting, which included the following sessions:

- Context for Medicare payment policy;
- Cost sharing for outpatient services at critical access hospitals; and
- Medicare's measurement of rural provider quality.

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

TO BEGIN THE MEDPAC MEETING CYCLE, COMMISSION PROVIDES CONTEXT FOR MEDICARE PAYMENT POLICY

To provide a backdrop for commissioners' discussions and recommendations over the current MedPAC cycle, which began with this meeting, commission staff reviewed Medicare's overall financial situation and key issues impacting the program. This work will appear as the "Context" chapter in MedPAC's March 2025 Report to Congress, along with MedPAC's recommendations for 2026 payment updates. The draft chapter commissioners received will be updated in the winter after newer data is available, and commissioners will have an opportunity to review in January 2025. The draft chapter is not publicly available.

Spending Trends

In 2022, the US spent $4.5 trillion on healthcare, and $950 billion in Medicare spending. Looking ahead, CMS expects Medicare spending to grow by seven to eight percent every year over the next decade. The projected spending growth is driven by three factors: economy-wide price inflation, growth in the number of Medicare beneficiaries, and growth in the volume and intensity of services delivered per beneficiary. Medicare is paying for a more intense mix of services, in which providers are furnishing more expensive services instead of less expensive services.

For Part D, spending is expected to increase due to expanded coverage of GLP-1 drugs. Although law prohibits coverage of drugs for weight loss under Medicare Part D, expanded indications of these drugs are projected to increase spending. A GLP-1 was recently approved to reduce risk of death, heart attack, or stroke in patients with cardiovascular disease and obesity or overweight; the Congressional Budget Office (CBO) expects Medicare coverage of this indication to increase Part D spending by $36 billion over ten years.

Medicare has two trust funds: the Medicare Hospital Insurance (HI) Trust Fund that finances Part A services, and the Medicare Supplementary Medical Insurance (SMI) Trust Fund, which helps pay for Part B services and Part D drug coverage. The HI Trust Fund is expected to remain solvent until 2035 or 2036, which is an improvement to projections prior to the pandemic. However, the ratio of workers per beneficiary is declining, which creates a challenge for this fund. In contrast, the SMI Trust Fund automatically remains solvent because of taxes and other revenue sources but represents an increasing share of federal revenues.

Beneficiaries' Enrollment Options, Financial Obligations, and Care Disparities

Commission staff first highlighted facts about Medicare enrollment that are commonly misunderstood or unknown, including that enrollment is Medigap is typically a one-time decision and is not subsidized by the government, and that employers can subsidize retires Medigap, Part D, or Medicare Advantage (MA) plans.

There are racial and ethnic differences in the types of coverage beneficiaries enroll in. White beneficiaries are much more likely to have FFS and supplemental insurance, while Hispanic and Black beneficiaries are much more likely to enroll in an MA plan and to be dually enrolled in Medicaid or receive the Part D low-income subsidy. There are also disparities in health outcomes for beneficiaries of different races/ethnicities, with Black and Hispanic beneficiaries having worse health outcomes compared to White beneficiaries. Disparities are likely related to disparities in income and assets. However, there are few differences reported in experiences accessing care, according to beneficiary surveys.

For spending and costs, the median beneficiary has modest resources to draw on when paying for premiums and cost sharing, at $36,000 annual income and $104,000 in life savings. Seven percent of all Medicare beneficiaries report problems paying a medical bill. For specific coverage types, the percent of Medicare beneficiaries with problems paying a medical bill varies from 14 percent for beneficiaries with FFS and no supplemental coverage, to 23 percent for partial-benefit dual-eligible beneficiaries.

Healthcare Workforce

Noting that commissioners have expressed interest in addressing the healthcare workforce, MedPAC has added information on this topic to the Context chapter for this cycle. Assessing whether there are shortages of particular types of health care workers is complicated because there are overlapping responsibilities of some types of health care workers, and national counts of health care workers can hide shortages in certain geographic areas and medical specialties.

Medicare plays a role in the composition of the health care workforce. The U.S. does not produce enough medical school graduates to fill all of the post-medical training positions available nationally. Medicare helps subsidize residencies and fellowships but usually does not specify where or in which specialties physicians are trained. Payment rates also impact the health care workforce; advanced practice registered nurses and physician assistants are paid 85 percent or 100 percent of physicians' payment rates, but provider organizations pay them much less, incentivizing organizations to hire APRNs and PA. Medicare also has targeted policies intended to attract clinicians to rural/underserved areas.

Commission Discussion

Highlights from the discussion include:

- **Medigap:** Many commissioners were enthused that Medigap was highlighted in presentation and draft chapter, noting that high costs of Medigap policies are concerning and that affordability for patients is important. Commissioners were interested in more information on variations in pricing for Medigap policies and the timing and age of when beneficiaries enroll. Some commissioners also commented on the interaction between FFS Medicare and MA, and how in some cases, MA can be more affordable for beneficiaries, which may incentivize beneficiaries to choose MA over FFS and Medigap. Chair Chernew noted that there will be a separate set of work on Medigap on this cycle.
- **Consolidation:** Commissioners noted that they appreciated the discussion of consolidation in the draft chapter; however, no additional context was given during the public meeting.
- **Quality:** In discussions on quality, some commissioners noted that while quality might change where beneficiaries go to receive care, they are still more likely to go to the providers that are closest to home. Chair Chernew reminded commissioners that quality is included in each payment update chapter in the March 2025 report.
- **Health care workforce:** Commissioners were interested in the discussion on workforce and requested additional data on where shortages occur and for what specialties.

MEDPAC DISSCUSSES COST SHARING FOR OUTPATIENT SERVICES AT CRITICAL ACCESS HOSPITALS

MedPAC is taking initial steps to address cost-sharing in Critical Access Hospitals (CAHs), laying the groundwork for future policy considerations. This effort aims to gain a comprehensive understanding of the current landscape and gather insights on the direction stakeholders wish to take.

The Commission provided an overview of rural special payments, highlighting principles and current payment structures. MedPAC's Rural Payment Principles emphasize the importance of targeting payment adjusters to preserve access to care in rural areas, ensuring that the magnitude of these adjustments is empirically justified. The principles also stress the need to maintain incentives for cost control, with a particular focus on adjusting payments for low-volume, isolated providers to support their sustainability. MedPAC discusses three types of payment models that embody these principles for rural healthcare providers:

1. **Higher Prospective Payment Rates**: This model provides rural providers with higher predetermined rates for services to help cover the costs associated with delivering care in low-volume areas.
2. **Cost-Based Payments for CAHs (Critical Access Hospitals)**: Under this approach, CAHs are reimbursed based on the actual costs of providing care, ensuring they can sustain operations despite lower patient volumes.
3. **Fixed Monthly Payments and Prospective Rates for Services**: This model combines a fixed monthly payment with prospective rates for specific services, offering a predictable revenue stream while incentivizing efficient care delivery.

Many of these CAHs and smaller providers are rural-focused and outpatient heavy. Without supplemental payments beyond traditional fee-for-service (FFS) models, many CAHs and rural providers would face significant financial challenges, potentially jeopardizing their ability to continue providing essential care.

Although CAHs receive some financial support, current CAH payment structures increase cost-sharing liabilities for beneficiaries. Currently, CAH coinsurance is based on 20 percent of charges. These charges are list prices, often much higher than typical payments rates, and mark ups of these prices can vary hospital to hospital. There is no cap on coinsurance as there is in Prospective Payment System (PPS) hospitals. The Commission further highlights its concerns with CAH coinsurance:

1. **Marked-Up Charges Above Costs**: CAHs often markup charges significantly above the actual costs, leading to wide variation in coinsurance for identical

services. This practice can result in coinsurance amounts that do not adequately cover the costs of care.

2. **Lack of a Cap on Coinsurance**: Without a cap on coinsurance, the increasing performance of high-cost services under the Outpatient PPS (OPPS) shifts a greater financial burden onto patients. This disproportionately impacts rural beneficiaries, who may already face financial disadvantages.

These issues underscore the need for reforms in the CAH payment structure to protect rural beneficiaries from excessive financial burdens and ensure more equitable access to care. Addressing these challenges is crucial for maintaining the sustainability of rural healthcare.

The Commission proposed a potential alternative for discussion for CAH coinsurance. An alternative approach to CAH coinsurance involves shifting from the current model, where beneficiaries pay 20 percent of marked-up charges, to paying 20 percent of the OPPS rate. This change would significantly reduce the financial burden on beneficiaries, potentially lowering their costs by $2.1 billion, without altering the total payments to CAHs. This adjustment is particularly relevant because CAHs often function as critical community hospitals, making equitable cost-sharing essential.

The Commission then opened the material presented to a discussion. The Commission emphasized the persistent disparities in healthcare costs and the need to create greater value in the system. They stressed the importance of developing a clear pathway for reforms, including integrating CAHs into PPS Quality Programs and aligning their payments with PPS rates. The commissioners expressed concern over the financial burden placed on rural beneficiaries due to high charges at CAHs, urging immediate action to address this issue. They also highlighted the need to explore the implications for Medicare Advantage payments and beneficiaries, while remaining mindful of the administrative burden of implementing such changes. Understanding the pros and cons of each policy option was deemed crucial for informed decision-making.

MEDPAC DISSCUSSES THE MEASUREMENT OF RURAL PROVIDER QUALITY

MedPAC focused on how rural provider quality is measured, emphasizing its importance for informing beneficiaries, improving care quality, and ensuring the success of Medicare. Commissioners stressed that measuring rural care is crucial to maintaining equitable standards and quality care for beneficiaries.

Commission's Prior Work on Quality Measurement

MedPAC has outlined key principles for quality measurement (QM) to ensure consistent care across both urban and rural settings, particularly for non-emergency services. The Commission emphasizes that all providers, irrespective of their location, should be

assessed based on the services they deliver, and the outcomes of these evaluations should be made publicly accessible. This approach aims to maintain uniform quality standards and transparency in healthcare provision across different geographic areas.

Overview of Medicare's Current Quality Reporting Programs for Rural Providers

Medicare measures the care provided by rural healthcare providers through various Quality Payment Programs (QPPs), which incentivize quality through two primary models: pay for reporting data and pay for performance outcomes. MedPAC highlighted the following quality programs:

- **Hospital Quality Reporting Programs:** For both inpatient and outpatient settings, hospitals paid under the Prospective Payment System (PPS) are required to participate. Combined, hospitals measure their quality across 59 different quality measures based on both reporting and performance.
- **Post Acute Quality Reporting Programs:** Similarly, skilled nursing facilities (SNFs) and home health (HH) are required to participate if paid under the PPS. Together, they report and measure across 37 different measures such as mobility, readmission, and medication management.
- **Clinician Quality Reporting Program:** Through the Merit-based Incentive Payment System (MIPS), clinicians who have billed over the Part B threshold are eligible to participate. Clinicans alone report a variety of measures across quality, improvement activities, promoting interoperability, and cost. However, assessing the quality of clinician care in rural areas is particularly challenging. Medicare does not gather detailed clinical information or patient-reported outcomes from these providers. The reliance on MIPS for measuring quality has been criticized and MedPAC has recommended it be removed due to its limitations. The small number of cases handled by individual rural clinicians can result in unreliable and inequitable quality assessments, making it difficult to accurately evaluate care in these settings.
- **Accountable Care Organizations (ACO) Quality Reporting Programs:** For all ACO participants, ACO Realizing Equity, Access, and Community Health (REACH) program and the Medicare Shared Savings Program (MSSP) both focus on improving care quality through a range of quality measures. ACO REACH emphasizes equity and community health, while MSSP aims to enhance care coordination and patient outcomes, with both programs using comprehensive quality metrics to assess performance.
- **Medicare Advantage (MA) Quality Reporting Programs (QRPs):** MA QRPs involve CMS collecting data on a contract-wide basis across a diverse healthcare market with over 20,000 states, often proving challenging. The Commission

recommends shifting this collection to a local level rather than maintaining a national approach.

Despite many of these program successes, practical challenges have arisen, particularly for rural populations. Measuring rural care has proved difficult due to low population density, small patient volumes, and the heavier administrative burdens faced by rural providers with limited time, staff, and resources. Consequently, some rural providers do not participate in these quality reporting programs and/or lack eligibility.

Initiatives to Improve Measurement of Rural Care and Quality

To address these challenges, the Commission highlighted two key initiatives. First, they stressed the importance of identifying and developing metrics most relevant to rural providers, with input from an already established rural health advisory group. This group has identified quality measures tied to value, clinical outcomes, and patient experiences, though gaps remain in areas like telehealth and screenings. Second, they encouraged making technical assistance for quality measurement and improvement available to rural providers through quality improvement organizations.

Commission Discussion

Commission discussion emphasized the need for rural CAHs to participate in QRPs, despite current exemptions, as well as the difficulty rural clinicians face in meeting high thresholds for QRP eligibility. The commissioners expressed a desire for more information on the quality gaps and challenges between rural and urban healthcare, which will be addressed in MedPAC's 2025 report to Congress. They discussed the potential for lump-sum payments over rate updates to create a pathway for rural providers to enter quality reporting programs.

The Commission underscored the importance of moving small rural providers into quality programs to avoid harming beneficiaries, and stressed the need for patient experience measures in SNF and rural settings. They also discussed the balance between measuring all providers fairly and the tendency to tailor metrics toward certain populations, cautioning against discrimination while acknowledging the need for clarity. Finally, they highlighted the importance of being realistic about the administrative burdens placed on small practices, particularly in terms of time and staffing.

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This Applied Policy® Summary was prepared by Emma Hammer with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at ehammer@appliedpolicy.com or at 202-558-5272.