American College of Radiology™

MedPAC March 2024 Report to Congress Detailed Summary

The Medicare Payment Advisory Commission (MedPAC) released their March 2024 Report to Congress on March 15, 2024. The MedPAC is an independent congressional that advises the U.S. Congress on issues affecting the Medicare program. MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. The MedPAC points out that despite the official end of the COVID-19 public health emergency (PHE), Medicare beneficiaries, health care workers, and providers continue to experience lingering effects from COVID-19. The MedPAC recommended fee for service (FFS) payment updates above current law for acute care hospitals and physician and other health professional services.

Chapter 1: Context for Medicare payment policy

Each March, the MedPAC reports to the Congress on traditional Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. The first chapter highlights key trends in national health care spending and Medicare spending and reviews the factors that contribute to spending growth.

National health care spending has grown faster than GDP

In 2022, $4.5 trillion was spent on health care in the U.S. This accounted for 17.3 percent of the U.S.'s gross domestic product (GDP), up from 14.9 percent 20 years earlier. Medicare spending has also grown as a share of GDP over time, making up 3.7 percent of GDP in 2022. In 2020, national health care spending increased by 10.6 percent due to one-time spending by the federal government on PHE relief funds for health care providers, a relaxation of Medicaid's eligibility rules during the pandemic that allowed more people to be enrolled in that program, and an increase in spending on public health activities. This large increase occurred in a year when the country's GDP was shrinking, it resulted in a sharp increase in the share of the country's GDP devoted to national health care spending. National health care spending as a share of GDP is expected to have grown slightly to 17.6 percent of GDP. CMS expects familiar spending patterns to continue through 2031, with national health care spending growing faster than GDP in part because medical prices are projected to grow faster than economy-wide prices over this period.

Medicare spending is projected to double in the next 10 years

Medicare is the largest single purchaser of health care accounting for about a quarter of the nation's spending on personal health care. During the COVID-19 PHE, Medicare spending grew more slowly than had been expected. The most common types of care that Medicare beneficiaries reported skipping in the early months of the pandemic were dental care, regular check-ups, treatment for an ongoing condition, and diagnostic or medical screening tests.

Spending has recently grown particularly slowly for FFS Medicare for a few reasons highlighted in the report. One factor is the lower average morbidity among Medicare beneficiaries who survived the pandemic. Another factor is the shift of setting for joint replacement procedures from inpatient to (lower cost) outpatient facilities after these procedures were removed from Medicare's "inpatient only" list. In addition, beneficiaries dually enrolled in Medicare and Medicaid have

increasingly opted to enroll in MA plans rather than traditional FFS coverage. Between now and the early 2030s, CMS expects Medicare spending to grow at rates more consistent with historical norms, by 7 percent or 8 percent per year, on average. This will result in Medicare spending doubling over a 10-year period rising from over $900 billion in 2022 to $1.8 trillion in 2031.

Medicare faces a financing challenge
By 2029, the entire baby-boom generation will be Medicare eligible, and Medicare will be projected to have 75 million beneficiaries. At the same time, the ratio of workers financing Medicare through their taxes relative to the number of Medicare beneficiaries is expected to continue to decline. Medicare Part A is mainly financed through workers' Medicare payroll taxes, which are deposited into Medicare's Hospital Insurance Trust Fund. Without any intervention, the trust fund's balance will rise through 2024, then decline from 2025 on, and will fully deplete its balance by 2031. The Congressional Budget Office (CBO) also tracks the trust fund's financial status and projects that it will be depleted in 2035. There are several ways to extend the solvency of the HI Trust Fund. Two that are mentioned by the Trustees are to increase the Medicare payroll tax from its current rate of 2.9 percent to 3.6 percent or reduce Part A spending by 15.6 percent. A combination of more moderate spending reductions and tax increases is another option.

As Medicare spending increases, so too does beneficiary cost sharing
As Medicare spending grows, it affects beneficiaries' ability to afford health care by raising their premiums and cost sharing. Medicare beneficiaries typically do not pay premiums for Part A coverage, but the annual cost of Part B premiums was $1,979 in 2023. In 2023, the Medicare Trustees estimate that beneficiary spending on Medicare Part B and Part D premiums and cost-sharing consumed 28 percent of the average Social Security benefit. MedPAC stated restraining the annual growth in Medicare payment rates to providers and plans can help beneficiaries more easily afford their prescription drugs and health care since it translates to lower premiums and lower cost sharing for beneficiaries.

Chapter 2: Assessing payment adequacy and updating payments in fee-for-service

Note: This chapter provides a background assessment of payment adequacy to frame recommendations made in later chapters. MedPAC considers beneficiaries' access to quality care, providers' access to capital and Medicare payments compared to provider costs when assessing payment adequacy and recommending payment updates.

Background
MedPAC states in the chapter background, "Appropriate payment begins with base payment rates that reflect the costs of efficiently delivering care to the average beneficiary, followed by adequate adjustments for differences in cost due to market-, service-, and patient-level variations. Payment policy can also be a mechanism for encouraging improvements in quality of care, ensuring access for beneficiaries, and pursuing other policy objectives such as ensuring program integrity.".

MedPAC addresses the effect of the COVID-19 pandemic on providers and notes that though the most pronounced effects of the pandemic have passed, it continues to monitor the health care landscape for residual impacts of the pandemic on access, quality and costs. Most notably, expansion of telehealth services began by necessity during the public health emergency (PHE), but demand for telehealth services has continued beyond the end of the PHE.

The Commission's principles for assessing payment adequacy
MedPAC states, "Payment rates should be sufficient to provide high quality care for beneficiaries but not exceed the level necessary to do so.". The Commission also considers whether payments may need to be redistributed within or across sectors to address patient access to quality care in certain areas (e.g. rural and underserved areas). MedPAC uses a combination of administrative data, surveys, and other sources to inform its assessments, aiming to incorporate as many high-quality data sources as possible.

Beneficiary access to quality care is a key indicator of payment adequacy. MedPAC considers provider capacity and staffing, service volume, and FFS Medicare margins as measures of access using claims and survey data. Provider shortages, long wait times, and difficulty maintaining staffing levels can indicate inadequate payment rates while rapid increases in utilization may indicate that reimbursement rates are higher than necessary. MedPAC believes that technological changes may increase capacity and reduce costs. The Commission does not necessarily believe that closure of facilities is indicative of inadequate payment but may be a correction of excess capacity.

MedPAC has a strong focus on beneficiary access to high quality care and as such does not believe that simply increasing payments through a standard update for all providers incentivizes quality improvement initiatives. Over the last ten years, quality improvement programs have been implemented in the Medicare payment systems, however, development of large numbers of quality measures has caused confusion and increased burden on providers to report on these quality measures. The Commission is also concerned that many of the measures do not meaningfully focus on beneficiary outcomes.

The Commission recognizes complexities in determining payment adequacy stating, "Our assessment of the relationship between FFS Medicare's payments and providers' costs is complicated by differences in providers' efficiency, responses to changes in payment incentives, the introduction of new technologies, and cost reporting accuracy.". Determining "true" costs of caring for Medicare beneficiaries is difficult, particularly since private sector payments also influence providers. MedPAC recognizes, for example, that hospitals may shift costs onto private insurers to offset Medicare losses, however, the Commission believes that this may disincentivize providers from operating more efficiently. Consolidation of providers gives them more leverage to negotiate higher private sector payment rates.

Anticipated payment and cost changes in 2024
To estimate payments, MedPAC first applies the annual payment updates specified in law for 2023 and 2024 to base data (2022 for most sectors). It then models the effects of other policy changes that will affect the level of Medicare payments in 2024. To estimate 2024 costs, inflation and historical cost growth are considered. The Commission's judgments about payment adequacy, policy changes in the intervening years, and expected cost changes result in an update recommendation for each FFS payment system. The recommendations in this report may call for an increase, a decrease, or no change relative to the 2024 base payment.

It is important to note that MedPAC recommendations are not implemented unless Congress or the Secretary of Health and Human Services change law and/or regulations to do so.

Chapter 3: Hospital inpatient and outpatient services

Beneficiaries' access to care
Indicators of beneficiaries' access to hospital inpatient and outpatient care were generally positive. The number of inpatient beds at general ACHs remained steady at nearly 650,000, hospitals had available capacity, and hospital employment has rebounded above the levels in the immediate pre-pandemic period. There was a slight decrease in the net supply of hospitals in 2023, with 18 closures and 11 new opened hospitals. The volume of both inpatient and outpatient services per FFS Medicare beneficiary declined from 2021 to 2022, which reflects shifts in the setting where the care was provided and declines in COVID-19 care rather than a decrease in beneficiary access to hospital care. Historically, some services have shifted from freestanding physician offices to hospital outpatient departments, where payment rates are higher. The Commission reiterates their assertion regarding site neutral policies: that Medicare should not pay more for services provided in a high-cost setting when it is safe and appropriate to provide those services in a lower-cost setting when doing so does not pose a risk to access.

Quality of care
In 2022, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved relative to pandemic highs, falling to the level in 2019 (8.1 percent). FFS Medicare beneficiaries' risk-adjusted readmission rate also improved, to 14.7 percent, slightly lower than the rate in 2021 and about a percentage point better than the rates in the immediate pre-pandemic period. However, most patient experience measures remained below pre-pandemic levels by several percentage points. The Commission has repeatedly stated that Medicare's hospital quality programs should be redesigned and consolidated to encourage hospitals to provide high quality care.
Providers' access to capital

Hospitals' FFS Medicare marginal profit on IPPS and OPPS services declined from 2021 to 2022, but remained positive at 5 percent in aggregate, indicating that hospitals with available capacity continued to have a financial incentive to provide hospital care to FFS beneficiaries. The all-payer operating margin varied across hospital types, with for-profit hospitals' margins remaining above

pre-pandemic levels and nonprofits' falling below. Hospitals' borrowing costs increased in 2022 and 2023, but by less than the general market.

FFS Medicare payments and providers' costs
There was a record decline in hospitals' FFS Medicare margin due to higher-than-expected inflation, the decline in federal coronavirus relief funds, the reinstatement of sequestration on Medicare patients, the decrease in uncompensated care payments, and increased high-cost outlier inpatient stays. In 2022, the FFS Medicare program and its beneficiaries spent nearly $180 billion on IPPS and OPPS services at general ACHs, including $7.1 billion in uncompensated care payments made under the IPPS and $19.1 billion for separately payable drugs. FFS beneficiaries' cost-sharing liability totaled 7 percent of hospital inpatient payments and 17 percent of outpatient payments.

Recommendation: For fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1.5 percent. The current-law updates to payment rates for 2025 will not be finalized until summer 2024, but CMS's third-quarter 2023 forecasts are currently projected to increase the IPPS and OPPS base rates by slightly less than 3 percent.
In addition, Congress should:

- Begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI);
- Add $4 billion to the MSNI pool;
- Scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and
- Pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.

Chapter 4: Physician and other health professional services
Medicare's PFS pays for about 8,000 medical services provided across a variety of care settings. These services include office visits, surgical procedures, imaging, and tests and are delivered in physician offices, hospitals, nursing homes, and other settings. The clinicians who are paid to deliver these services include not only physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) and other types of health professionals. In 2022, Medicare and its beneficiaries paid $91.7 billion for fee schedule services provided by almost 1.3 million clinicians, accounting for just under 17 percent of spending in Medicare's FFS program. The MedPAC conducted their annual survey of Medicare beneficiaries reported access to care that was comparable with, or better than, that of privately insured people.

Assessment of payment adequacy
Medicare beneficiaries continued to report access to care that is comparable with, or better than, that of privately insured people. The share of clinicians accepting Medicare is high and comparable with the share accepting private insurance. The composition of the clinician workforce continues

to change, with the number of APRNs and PAs growing rapidly, the number of specialists growing at a more modest rate, and the number of primary care physicians slowly declining. The number of clinician encounters per FFS beneficiary has increased over time, with faster growth from 2021 to 2022 (3.1 percent) compared with the average annual growth rate from 2017 to 2021 (0.7 percent).

Clinicians do not submit annual cost reports to CMS, so MedPAC is unable to calculate their profit margins from delivering services to Medicare beneficiaries. Instead, MedPAC relies on indirect measures of how FFS Medicare payments compare with the costs of providing services. MedPAC find that updates to fee schedule payments have grown more slowly than clinicians' input cost growth but increases in the volume and intensity of services furnished by clinicians have resulted in higher physician fee schedule spending per FFS beneficiary. Physicians' compensation has increased at rates like the general rate of inflation, which may be partially due to growth in private insurance payment rates and to growth in the volume and intensity of services clinicians have furnished per FFS beneficiary over time.

From 2021 to 2022, physician fee schedule spending per FFS beneficiary grew for most types of services. Among broad service categories, growth rates were 2.2 percent for evaluation and management services and 3.0 percent for imaging. In 2022, spending on clinician services by FFS Medicare and its beneficiaries was $1.1 billion lower than it was in 2021. This decline represents a 1.2 percent decrease in fee schedule spending and is attributable to a 3.9 percent decline in the number of beneficiaries enrolled in FFS Medicare, Medicare Advantage has enrollment has continued to increase.

In 2022, private health insurance preferred provider organization (PPO) payment rates for clinician services were, on average, 136 percent of FFS Medicare's payment rates, up from 134 percent in 2021. Compensation and productivity data indicate that, while clinicians who work in hospital-owned practices do not necessarily earn more than those working in clinician-owned practices, they do tend to see fewer patients and bill for fewer services.

Between 2021 to 2022, median compensation for physicians grew by 9 percent and the median compensation for advanced practice providers (e.g., nurse practitioners, PAs) grew by 5 percent. Clinicians' costs, as measured by the Medicare Economic Index (MEI), grew by 1 percent to 2 percent per year for several years before the coronavirus pandemic. MEI growth then increased to 2.5 percent in 2021 and to 4.6 percent in 2022. However, MEI growth is expected to moderate: It is projected to be 4.1 percent in 2023, 3.1 percent in 2024, and 2.6 percent in 2025, although these projections are subject to change. These expected increases in clinicians' input costs are larger than the increases in FFS Medicare payment rates scheduled under current law.

Under current law, PFS rates are expected to decline in 2025, due to the expiration of the 1.25 percent pay increase that will apply in 2024 only and a 0 percent update scheduled for 2025. Given recent high inflation, cost increases could be difficult for clinicians to continue to absorb. Based on many of MedPAC indicators current payments to clinicians appear to be adequate.

Recommendation

The Congress should:

- for calendar year 2025, update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the Medicare Economic Index; and
- enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.

MedPAC estimates that the combination of the recommended update and safety-net policies would increase fee schedule revenue for the average clinician by 3 percent. The effects would differ by specialty, with fee schedule revenue increasing by an estimated 5.7 percent, on average, for primary care clinicians and by an estimated 2.5 percent, on average, for other clinicians.

Chapter 12: The Medicare Advantage program: Status report

In 2023, the Medicare Advantage (MA) program included 5,635 plan options offered by 184 organizations, enrolled about 31.6 million beneficiaries, and paid MA plans an estimated $455 billion (not including Part D drug plan payments). The majority of Medicare beneficiaries are now enrolled in MA plans. Enrollment in MA is highly concentrated at the local level and increasingly concentrated at the national level. The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the FFS Medicare program, and MedPAC strongly supports the inclusion of these private plans in the Medicare program.

Medicare payments to plans

Medicare spends an estimated 22 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, which translates to a projection of $83 billion in 2024. Payments to MA plans average an estimated 122 percent of what Medicare would have expected to spend on those same beneficiaries if they had FFS Medicare. MedPAC is concerned that the higher payments to MA are being subsidized by the taxpayers and beneficiaries who fund the program, as increased MA payments lead to an increase in Part B premiums for all beneficiaries (a projected increase of $13 billion in 2024). Aggregate Medicare payments to MA Plans have always been substantially higher than what estimated spending would have been in FFS Medicare.

Risk adjustment and coding intensity

Medicare payments to MA plans are specific to each enrollee, based on a plan's payment rate and an enrollee's risk score. MA plans have a financial incentive to ensure that their providers record all possible diagnoses because those diagnoses raise an enrollee's risk score and result in higher payments to the plan. Higher MA payments due to coding differences have been under scrutiny for more than a decade. MedPAC estimates that in 2022, MA risk scores were about 18 percent higher than scores for similar FFS beneficiaries due to higher coding intensity, and their projection for 2024 is 20 percent higher. CMS has the authority to control the reduction of MA risk scores to make them more consistent with FFS coding but will implement the minimum adjustment of 5.9 percent for 2024, making the risk scores about 13 percent higher than under FFS Medicare. Uncorrected MA coding intensity has increased payments to plans by an estimated $124 billion through 2022 and is projected to generate nearly $94 billion more in 2023 and 2024.

MedPAC reiterated their previous recommendations from the March 2016 report to the Congress to replace the existing mandatory minimum coding intensity adjustments with a three-part approach:

- develop a risk adjustment model that uses two years of FFS and MA diagnostic data,
- exclude diagnoses that are documented only on health risk assessments, and then
- apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

Quality in MA

In 2024, 23.3 million beneficiaries (¾ of MA enrollees) were enrolled in a plan that received a quality bonus increase to its benchmark, translating to $15 billion in additional program spending. MedPAC has long been concerned about the flaws within the current MA quality bonus program, stating that it does not currently provide a reliable basis for beneficiaries to evaluate quality across plans. The Commission maintains that the program does not effectively promote high-quality care, referencing the recommendation from its June 2020 report to Congress to replace the current quality bonus program. The Commission plans to include more details in future chapters on MA quality and access to care, outlining their approach and empirical analysis of MA plan performance.

Chapter 13: Estimating Medicare Advantage coding intensity and favorable selection

MedPAC presents their estimations of the effects of higher coding intensity and favorable selection of enrollees into MA on the amount Medicare pays to MA plans relative to what the program would have paid if the enrollees were covered under FFS Medicare.

Estimating Medicare Advantage coding intensity

MedPAC has revised their original cohort method to account for differences in Medicaid eligibility between MA and FFS beneficiaries as well as remove the restriction requiring continuous enrollment in either MA or FFS in the years prior to 2021. This led to higher estimates of coding intensity compared to their original method. MedPAC also revised the Demographic Estimate of Coding Intensity (DECI) method developed by Kronick and Chua, which reduced the previous coding intensity estimate.

The Commission has decided to adopt the revised DECI method to estimate the impact of coding intensity due to it being a more comprehensive approach, producing larger estimates of coding intensity in each year with smaller differences in the estimates for earlier years and larger differences in more recent years.

Estimating Medicare Advantage favorable selection

Research suggests that beneficiaries' risk scores don't fully account for spending differences between MA and FFS populations. Favorable selection into MA occurs when beneficiaries with lower actual spending relative to their risk score tend to enroll in MA. It is the extent to which risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans. Favorable selection in MA tends to increase when lower-spending enrollees remain in MA longer and higher-spending enrollees leave MA plans.

MedPAC used the same analytic framework from their June 2023 report to Congress, but with some technical improvements. Their revised methodology estimates that the effects of favorable selection increased program spending by 6 percent in 2017, rising to 9 percent in 2019 and 13 percent in 2021. The Commission will implement further revisions as they conduct sensitivity analyses of certain aspects of their method.

HEADQUARTERS
1892 Preston White Drive
Reston, VA 20191
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W.
Suite 910
Washington, DC 20004
202-223-1670

CENTER FOR RESEARCH AND INNOVATION
50 South 16th St., Suite 2800
Philadelphia, PA 19102
215-574-3150

ACR INSTITUTE FOR RADIOLOGIC PATHOLOGY
1100 Wayne Ave., Suite 1020
Silver Spring, MD 20910
703-648-8900