CHAMBER HILL

INSIGHTS

MedPAC Discusses Medicare Payment Adequacy for Physicians, Hospitals, and Other Providers

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On December 7, 2023, the Medicare Payment Advisory Commission (MedPAC) held the first day of its December meeting. MedPAC covered payments and payment adequacy for physicians, hospitals, hospice, and dialysis services. Links to PDF copies of the different presentations can be found in the title section of each session below.

PHYSICIANS

MedPAC opened with a discussion regarding Medicare payments to physicians under the physician fee schedule. MedPAC staff shared how MedPAC measures payment adequacy based on beneficiaries' access to care, quality of care, clinicians' revenues and costs. Generally, MedPAC found Medicare beneficiary access to care was similar or better than access among those with private insurance. Additionally, MedPAC noted similar rates of clinicians accepted patients with Medicare and private insurance. MedPAC also found that the total number of clinicians billing under the fee schedule has been increasing but rates varied depending on the specific type of clinician. MedPAC also found that clinician encounters per fee-for-service (FFS) beneficiary increased by 3.1% in 2022.

MedPAC uses ambulatory care-sensitive hospitalizations and emergency department visits to measure quality of care, and MedPAC staff shared that there are variations in this data based on geography. MedPAC staff shared that patient experience scores were relatively stable. MedPAC was indeterminate in measuring quality of care. MedPAC staff found that spending per Medicare beneficiary increased by 2.8% in 2022. It also found that the ratio of private insurance to Medicare rates rose a little. MedPAC also found median compensation for physicians increased by 9% and 5% for advanced practice providers in 2022. MedPAC also found the Medicare Economic Index (MEI) growth rate reached a peak in 2022; however, MedPAC expects MEI growth to slow down.

The MedPAC staff presentation ended with a description of MedPAC's March 2023 physician fee schedule recommendations. The first of these recommendations is to update the base payment rate for 2024 by half of the projected MEI rate increase. The second recommendation is to create add-on payments for fee schedule services provided to low-income beneficiaries. Specifically, the recommendation is for a 15% add-on for primary care clinicians and 5% for non-primary care clinicians.

In this session, commissioners had questions about how MedPAC data on access and quality was

collected. Some commissioners also asked about using more objective measures of access and quality instead of subjective measures. There was also a robust discussion about the use of physician salaries in measuring clinicians' revenues and costs. Specifically, one commissioner brought up concerns that this is unrelated to the physician fee schedule and concerns that it seemed like physicians are being unfairly targeted. However, another commissioner thought it was fair to include physician salary in the measurement. Multiple commissioners also expressed concerns about consolidation within health care. Another topic of discussion among commissioners in this session was the appropriateness of the recommended base payment update and add-on payments. Some commissioners also discussed the need to do more to incentivize teams-based care.

HOSPITALS

The afternoon session began with a discussion of Medicare payment adequacy for hospitals. MedPAC staff shared that they measure payment adequacy based on access to care, quality of care, access to capital, and FFS Medicare payments and costs. MedPAC generally found access to care was positive but that quality of care and access to capital was mixed. MedPAC found that hospitals' FFS Medicare margin reached a record low and that there was a negative median FFS Medicare margin among relatively efficient hospitals. MedPAC recommended a record high update for the inpatient prospective payment system and outpatient prospective payment system. Specifically, the recommendations include the current law update plus 1%, a redistribution of existing Medicare safety net payments created by the commission using the Medicare Safety-Net Index (MSNI), and a $2 billion addition to MSNI pool.

Commissioners' questions began by asking about data. Specifically, questions were asked about data on social risks of patients in hospitals and about staffing. Questions were also asked about various aspects of hospital financing including the calculation of uncompensated care, the 340B program, and investment loss. Other commissioners asked about the use of the term "relatively efficient" to describe hospitals and what that meant. There were also questions about the different kinds of hospitals that receive payment under Medicare. Another topic of discussion centered around the differences between reimbursement for hospitals vs physicians. A MedPAC staff member shared that the commission makes these decisions based on separate data and that the criteria is not the same.

HOSPICE

The afternoon session continued with a discussion of hospice payment adequacy. In measuring Medicare payment adequacy for hospice care, MedPAC staff found that access to care, access to capital, and FFS Medicare payments and costs were all positive. MedPAC staff shared that quality scores for the Medicare hospice program are stable. MedPAC staff also shared findings that there is a significant amount of spending by hospice enrollees on nonhospice items. MedPAC staff outlined a few different policy approaches to address this finding. These included administrative approaches (such as creating a more concrete definition of related services), a bundled payment approach (where unrelated services would

be included in the hospice benefit with a higher base rate), and a payment penalty approach (where a penalty could apply to hospice providers with patients who have relatively high nonhospice spending).

Much of the commissioners' discussion time was focused on the pros and cons of the different policy approaches to addressing the high spending on nonhospice services. Although there seemed to be some interest in exploring these approaches, there were also concerns raised about the different approaches. For example, there were concerns that bundling could threaten small hospice providers. There were also concerns about the possibility of limiting the ability of Medicare hospice beneficiaries to maintain a quality of life within the program. A number of commissioners also expressed concerns about quality ratings for hospice providers. It was clear that there was a desire to see quality ratings improve on the whole.

DIALYSIS

In its of measure payment adequacy for dialysis service, MedPAC staff found access to care and access to capital were positive, that quality of care was stable, and FFS Medicare payments and costs were mixed.

The commissioners' discussion focused on a few key topics. For example, questions were asked about how dialysis providers interact with Medicare Advantage plans. There were also questions asked about horizontal and vertical integration and consolidation among dialysis providers. Other questions touched on the payment for medication in dialysis and the length of time that beneficiaries spend in the program and how long it would take to implement cost-saving or quality-improvement measures.

We trust you found this summary useful. Please reach out to us with any questions.