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MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT TO CONGRESS ON MEDICARE PAYMENT POLICY

Washington, DC, March 15, 2024—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2024 *Report to the Congress: Medicare Payment Policy*. The report presents MedPAC's recommendations for updating provider payment rates in traditional fee-for-service (FFS) Medicare for 2025 and for providing additional resources to acute care hospitals and clinicians who furnish care to Medicare beneficiaries with low incomes. The report reviews the status of ambulatory surgical centers (ASCs), the Medicare Advantage (MA) program (Medicare Part C), and the Part D prescription drug program (Medicare Part D). It also includes a chapter describing our methods for estimating coding intensity and favorable selection in the MA program. Lastly, the report satisfies two congressional mandates: one to review special needs plans for beneficiaries dually eligible for Medicare and Medicaid and another on a new provider designation, rural emergency hospitals.

While the public health emergency (PHE) related to the coronavirus pandemic officially expired on May 11, 2023, the Commission recognizes that the pandemic has had tragic effects on beneficiaries, as well as damaging impacts on the nation's health care workforce, as clinicians and other health care workers have faced burnout and risks to their health and safety.

The Commission is acutely aware of how wider economic volatility in the wake of the PHE has affected providers' financial status and patterns of Medicare spending. Input cost growth exceeded payment updates for most health care sectors in 2022 and 2023, a deviation from the historical trend that placed strain on many providers. Within that context, the Commission evaluates available data to assess whether FFS Medicare payments, in aggregate, are sufficient to ensure access to care for Medicare's beneficiaries and support the efficient delivery of care. In this report, we make recommendations aimed at supporting access to high quality care for Medicare beneficiaries while giving providers incentives to constrain their cost growth and thus help control program spending.

| Fee-for-service payment rate update recommendations. MedPAC's payment update recommendations, which we are required by law to submit each year, are based on an assessment of payment adequacy for each provider type that examines beneficiaries' access to and use of care, the quality of the care they receive, the supply of providers and their access to capital, and providers' costs and Medicare's payments.

MedPAC recommends a higher-than-current-law FFS payment update in 2025 for acute care hospitals and physicians and other health professional services; the current law payment update for outpatient dialysis providers; eliminating the payment update for hospice providers; and payment reductions for three post-acute care sectors (skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities).

To maintain adequate access to care for all Medicare beneficiaries, we also recommend that the Congress establish safety-net add-on payments for clinician services furnished to FFS Medicare beneficiaries with low incomes, with higher add-on payments for primary care clinicians. We estimate that the recommended safety-net add-on policy would increase the average clinician's fee schedule revenue by an additional 1.7 percent. When combined with our above-current-law update for the physician fee schedule (a 1.3 percent update), we estimate the average clinician would receive 3 percent higher Medicare payments. For hospital services, we also recommend redistributing existing disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI); adding \$4 billion to the MSNI pool; scaling fee-for-service MSNI payments in proportion to each hospital's MSNI and distributing the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and paying commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and excluding these payments from MA benchmarks.

Part D. About 78 percent of Medicare beneficiaries (more than 51 million beneficiaries) participated in private Medicare drug plans in 2023. Beneficiaries continue to have broad choice among plans in 2024. Plan sponsors offered 3,507 conventional MA plans with prescription drug benefits (MA-PDs) and 1,306 MA-PDs tailored to specific populations (special needs plans, or SNPs). In 2024, plan sponsors are offering 709 prescription drug plans (PDPs), the fewest since the program began. In 2022, total Part D expenditures were \$117.3 billion. Plan enrollees paid \$15.4 billion of that amount in plan premiums for basic benefits. Beyond program spending, enrollees also paid \$18.5 billion in cost sharing and \$9.9 billion in premiums for enhanced benefits.

Since its inception in 2006, Part D has changed in important ways. Generic drugs account for nearly 90 percent of the prescriptions filled, while a relatively small share of prescriptions for high-cost biological products and specialty medications accounts for a mounting share of spending. In 2022, about 482,000 enrollees filled a prescription for which a single claim was sufficient to put them into the catastrophic phase of the Part D benefit, up from just 33,000 enrollees in 2010. Medicare's cost-based reinsurance continues to be the largest and fastest growing component of Part D spending, totaling \$56.8 billion, or about 56 percent of the total. As a result, the financial risk that plans bear, as well as their incentives to control costs, has declined markedly. The value of the average basic benefit that is paid to plans through the capitated direct subsidy has plummeted in recent years. However, in 2024, as a result of legislative and regulatory changes, we see a reversal in the trend toward higher reinsurance payments: direct subsidy payments increased to an average of nearly \$30 per member per month, while average reinsurance payments are expected to decline to about \$90 per member per month.

In 2020, the Commission recommended substantial changes to Part D's benefit design to limit enrollee out-of-pocket spending; realign plan and manufacturer incentives to help restore the role of risk-based, capitated payments; and eliminate features of the current program that distort market incentives. In 2022, the Congress passed the Budget Reconciliation Act of 2022 (BRA), which included numerous policies related to prescription drugs; one such provision is a redesign of the Part D benefit with many similarities to the Commission's recommended changes. The policies adopted in the BRA have begun to be implemented, with more changes coming over the next several years that will likely alter the drug-pricing landscape. The Commission will continue to monitor the effects of the redesign.

Medicare Advantage. Overall, plan and beneficiary participation indicate an increasingly robust MA program. The Commission strongly supports the inclusion of private plans in the Medicare program. Beneficiaries should be able to choose among Medicare coverage options since some may

prefer to avoid the constraints of provider networks and utilization management by enrolling in the traditional FFS Medicare program, while others may prefer the additional benefits and alternative delivery systems that MA plans can provide.

In 2023, the MA program included 5,635 plan options offered by 184 organizations, enrolled about 31.6 million beneficiaries (52 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$455 billion (not including Part D drug plan payments). In 2024, the average Medicare beneficiary has a choice of 43 plans (offered by an average of 8 organizations), and the average enrollee in a conventional MA plan has \$2,142 in extra benefits available from the plan annually. The average rebate amount, which finances extra benefits, has more than doubled since 2018 among conventional plans and, in 2024, accounts for 17 percent of payments to MA plans.

Each year, the Commission estimates the effects on Medicare spending when a beneficiary enrolls in MA relative to FFS. In the past, the Commission has acknowledged that favorable selection can affect that estimate but had not assessed its magnitude. Over the past year, the Commission has produced an estimate of how favorable selection affects Medicare's spending and includes the estimate in its comparison of spending in this year's report. Favorable selection can occur when beneficiaries with actual spending that is lower than what their risk scores predict disproportionately subsequently enroll in MA as opposed to remaining in FFS. When accounting for favorable selection of enrollees in MA and higher MA coding intensity, we estimate that Medicare spends approximately 22 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected \$83 billion in 2024. The Commission estimates that coding intensity (accounting for roughly 13 percentage points) and favorable selection (accounting for roughly 9 percentage points) comprise nearly all of that difference. The Commission acknowledges that a portion of these increased payments to MA plans are used to provide more generous supplemental benefits and better financial protection for MA enrollees. However, the benefits from MA's higher cost relative to FFS are subsidized by the taxpayers and beneficiaries who fund Medicare, and they increase fiscal strain on the program. The Commission estimates that Part B premiums, paid by all Medicare beneficiaries, will be about \$13 billion higher in 2024 because of higher MA spending.

The Commission remains committed to including private plans in the Medicare program and allowing beneficiaries to choose among Medicare coverage options, including the alternative delivery systems that private plans can provide. However, the current payment system requires reform. Over the past several years, the Commission has made several recommendations to improve the program. These recommendations call for the Congress and CMS to make reforms to address imbalances related to coding intensity, replace the quality bonus program, establish more equitable benchmarks, and improve the completeness of encounter data.

| Estimating Medicare Advantage coding intensity and favorable selection. To promote transparency of its work, the Commission includes a chapter on methods used to estimate MA coding intensity and favorable selection. These are challenging analytic issues, and the Commission will continue to refine these estimates in future work. We continue to conduct sensitivity analyses of certain aspects of our method, particularly related to how our analysis deals with regression to the mean and attrition of beneficiaries from MA cohorts.

Coding intensity. In its advance notice for 2019 MA payment rates, CMS requested comment on adopting an alternative method for calculating the MA coding adjustment factor, including the Commission's "cohort method" and the demographic estimate of coding intensity (DECI) developed by other researchers. Previously, the Commission's cohort method estimated the impact of higher coding intensity on MA risk scores by comparing changes in MA and FFS risk scores over time for

cohorts of beneficiaries with similar age, sex, and MA or FFS enrollment length. For this report, we revised our method to account for differences in Medicaid eligibility between MA and FFS beneficiaries (which has changed significantly since we first developed our method) and to remove a restriction requiring continuous enrollment in either MA or FFS. These model improvements produced higher estimates of coding intensity compared with our original cohort method.

We also estimated coding intensity using the DECI method. We found that by (1) applying this method to complete enrollment, demographic, and risk-score data; (2) accounting for differences in Medicaid eligibility between MA and FFS beneficiaries; and (3) constraining new Medicare enrollees to have no coding intensity (because their “new enrollee” risk scores are based only on demographic factors and are not influenced by diagnostic coding), the DECI method yielded estimates of coding intensity that were very similar to our revised cohort method (within 1.5 percentage points for all years 2008 through 2021). This gives us greater confidence that our analysis of coding intensity is producing reasonable estimates.

Favorable selection. Favorable selection in MA causes payments to plans to be systemically greater than what Medicare would have spent on those beneficiaries had they remained in FFS. Seeking to both estimate the extent of higher payments that result from favorable selection and incorporate a discussion of favorable selection into our annual March report to the Congress, the analysis described in Chapter 13 maintains the same analytic framework that we used in our June 2023 report but makes four key technical improvements. In our updated analysis, we continue to estimate that favorable selection resulted in Medicare payments that were substantially higher for MA enrollees than if those same beneficiaries were in FFS.

| Mandated report: Dual-eligible special needs plans. The Bipartisan Budget Act of 2018 mandated that the Commission periodically study the performance of MA dual-eligible special needs plans (D-SNPs) and other types of plans that serve dual-eligible beneficiaries. This is our second report under the mandate.

For this analysis, we compare plans’ performance using quality measures that plans report as part of the Healthcare Effectiveness Data and Information Set® (HEDIS®) and patient experience data that plans collect using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) beneficiary survey.

We found that these data sources provide limited insight into the relative performance of D-SNPs because most HEDIS measures are not tied to clinical outcomes and because HEDIS and CAHPS scores on many measures are fairly similar across plan types. MA plans perform better on some measures than Medicare-Medicaid Plans (MMPs), which are demonstration plans that operate outside the MA program, but those differences could reflect structural differences between the two types of plans. These findings are consistent with our first mandated report and with other Commission analyses that have examined the difficulties of assessing the quality and performance of MA plans.

| Mandated report: Rural emergency hospitals. The Consolidated Appropriations Act, 2021 (CAA) created a new designation, the rural emergency hospital (REH), for rural communities to help maintain access to emergency care. Long-running declines in inpatient volume have diminished the impact of Medicare’s inpatient-centric support for rural hospitals. REHs do not furnish inpatient care, but must meet several other criteria, including having an emergency department that is staffed 24/7 and a transfer agreement with a Level I or Level II trauma center. They are paid fixed monthly payments from Medicare (approximately \$270,000 per month, totaling \$3.2 million per year in 2023), in addition

to rates of 105 percent of standard outpatient prospective payment system rates for emergency and outpatient services.

The CAA also mandated that the Commission review payments to REHs as part of the March report beginning in 2024. Because this program began in 2023, complete REH claims data are not yet available. Therefore, our work provides context on the evolution of Medicare's support for rural hospitals, gives background on the REH designation and hospitals that have converted to REHs, and describes our 2023 site visits to (prospective) REHs to understand their experiences and decision-making processes.

In our review, we found 21 hospitals converted to REHs in 2023. Before converting, these hospitals often furnished a low (and declining) volume of inpatient care, received enhanced payments from Medicare, were located relatively close to other hospitals, and had financial difficulties. The REH designation has allowed rural communities to overcome financial difficulties and retain local access to emergency and outpatient services in places that cannot support a full-service hospital.

The Commission will continue to monitor the new REH designation, including analyzing REH claims data when they become available, and consider possible modifications in the future.

The full report is available at MedPAC's website (<http://www.medpac.gov>).

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The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.