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

Washington, DC, June 13, 2024—Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2024 *Report to the Congress: Medicare and the Health Care Delivery System*. Each June, as part of its mandate from the Congress, MedPAC reports on improvements to Medicare payment systems, issues affecting the Medicare program, and changes to health care delivery and the market for health care services. This year's report covers the following topics:

| Approaches for updating clinician payments and incentivizing participation in alternative payment models. For many years, the Commission has found that beneficiary access to clinician services has been as good as, or better than, that of privately insured individuals. Nevertheless, the Commission is concerned about whether payments to clinicians under current-law updates will remain adequate in the future. Clinicians' input costs, as measured by the Medicare Economic Index (MEI), are expected to increase by an average of 2.3 percent per year from 2025 through 2033. Meanwhile, beginning 2026, payment rates made under the Medicare physician fee schedule (PFS) will increase by 0.75 percent per year for qualifying clinicians participating in advanced alternative payment models (A-APMs) and by 0.25 percent for all other clinicians—far below the expected growth in the MEI. This gap between the growth in clinician input costs and updates to PFS payment rates could, over time, create incentives for clinicians to reduce the number of Medicare beneficiaries they treat or stop participating in Medicare entirely. In this chapter, the Commission considers two approaches that would update PFS payment rates based on some measure of inflation. The first approach would update the practice expense portion of the fee schedule payment rates by the hospital market basket, adjusted for productivity. The second approach would update total fee schedule payment rates by the MEI minus 1 percentage point. The second approach would be simpler to implement than the first, would not lead to different rate increases among clinicians in different specialties, and would reduce or eliminate the need for policymakers to revisit fee schedule update policy in the near future to provide separate increases to the work portion of fee schedule payments. The Commission finds the features of the second approach more desirable and will continue to develop this option in the future. Because the Commission is also concerned about the sunset of participation bonuses for clinicians in A-APMs after 2026, the chapter also discusses considerations for extending the bonus for a few more years to support participation in A-APMs.

| Provider networks and prior authorization in Medicare Advantage. As discussed in this chapter, Medicare Advantage (MA) plans can shape the services and providers that enrollees can access by using provider networks and utilization management tools such as prior authorization. These tools have the potential to promote more efficient care; however, misapplication of these tools could lead to delays or denials of needed care. CMS requires MA plans to demonstrate the

adequacy of their networks for 29 provider types and 13 facility types, which they review for each new MA contract and on a triennial audit cycle thereafter. Prior authorization requirements can vary by service type and by plan, which can impact beneficiaries with certain conditions and some provider types and specialties more than others. In our analysis of data from 2021, we found that MA plans made about 37.5 million prior authorization determinations, or about 1.5 determinations per enrollee. Overall, about 95 percent of prior authorization requests had fully favorable decisions. The percentage of adverse prior authorization decisions varied across the largest MA organizations, with negative determination rates ranging from 3 percent to 12 percent. Providers or beneficiaries requested that MA plans redetermine 11 percent of negative prior authorization decisions in 2021. Eighty percent of those requests had fully favorable decisions. Nonetheless, prior authorization has been identified as a major source of provider administrative burden and can become a health risk for patients if it results in needed care being delayed or denied.

| Assessing data sources for measuring health care utilization by Medicare Advantage enrollees: Encounter data and other sources. Since 2012, MA plans have been required to submit to Medicare a record of each encounter that MA enrollees have with a health care provider. Complete and accurate encounter data could be used to provide more rigorous oversight of Medicare’s payments to MA plans—which reached \$455 billion in 2023—and to ensure that the Medicare beneficiaries enrolled in an MA plan (now more than half of eligible beneficiaries) receive the full Medicare benefit. Lessons learned from MA encounter data could inform improvements to MA payment policy, facilitate comparison with traditional (fee-for-service (FFS)) Medicare, and generate new policy ideas that could be applied across the entire Medicare program. In this chapter, the Commission assesses the relative completeness of MA encounter data and other data sources that contain information about MA enrollees’ use of services. We find that encounter data completeness has incrementally improved since 2017 for some services but there remain important shortcomings. We also find that the information plans submit to CMS through separate reporting processes is not internally consistent and that there are technical factors that limit our ability to use the data to identify underreporting of encounter data. In our comparison of encounter data and Healthcare Effectiveness Data and Information Set® (HEDIS®) data, we found that HEDIS hospitalization data differed substantially from encounter data. Our analysis of bid data and encounter data also showed discrepancies. Among bids that could be compared with encounter data, utilization rates based on encounter data were within 5 percent of the rates reported in plan bids for less than 40 percent of bids, comprising less than half of enrollees in the analysis. Encounter-based rates for inpatient and skilled nursing facility services were more than 5 percent below the bid-based rate for roughly one-third of bids analyzed (about 20 percent to 30 percent of enrollees in our analysis), suggesting that encounter data remain incomplete, particularly for some organizations.

| Paying for software technologies in Medicare. Many types of clinical software are becoming increasingly available to providers. In this chapter, we discuss Medicare’s coverage of and payments for certain types of software that are used to diagnose or treat an illness or injury without being part of a hardware medical device. We discuss algorithm-driven software (called software-as-a service or SaaS by CMS) that helps practitioners make clinical assessments, such as software that detects diabetic retinopathy, and prescription digital therapeutics (PDTs), which are prescribed by clinicians and typically administered by patients on a mobile phone, tablet, or smartwatch to diagnose or treat an illness or injury, such as software that provides cognitive behavioral therapy. Since 2018, FFS Medicare has covered and paid for SaaS in inpatient and outpatient hospital settings and in clinician offices. However, FFS Medicare generally does not cover PDTs because the Medicare statute lacks a separate benefit category for PDTs and the

technology is not consistent with FFS Medicare's definition of durable medical equipment (the Medicare benefit category that covers medical equipment and supplies used to treat beneficiaries' illness or injury in their residence). A key issue facing FFS Medicare is how the program should pay for SaaS. Paying appropriately will mean finding a balance between promoting access to new technologies that meaningfully improve the diagnosis or treatment of beneficiaries and ensuring affordability for the Medicare program and the beneficiaries and taxpayers who finance it. For SaaS that is covered in hospital inpatient and outpatient settings, packaging payment into larger payment bundles gives providers flexibility in the provision of care and incentives for efficiency. By contrast, paying separately for software technologies can limit the competitive forces that generate price reductions among like services and may lead to providers overusing the technologies to increase revenue. For SaaS that is covered and paid for under the various FFS Medicare fee schedules (e.g., physician fee schedule, DME fee schedule), in which the program generally pays for each service furnished, Medicare currently has few pricing tools that would help strike a balance between maintaining incentives for innovation and ensuring affordability.

| Considering ways to lower Medicare payment rates for select conditions in inpatient rehabilitation facilities. Payments to inpatient rehabilitation facilities (IRFs) are high relative to the cost of care, with Medicare margins exceeding 10 percent for the past 20 years. The Commission has recommended since 2009 that the Congress reduce the aggregate level of FFS payments to IRFs. In this chapter, the Commission considers three more targeted ways to lower Medicare's FFS payment rates for beneficiaries with select conditions in lieu of an across-the-board reduction to payments: lower IRF rates to the amount paid to SNFs, lower IRF payment to equal the average of their currently reported costs of care, and lower IRF payment rates based on a blend of current rates and rates that equal the average of their currently reported costs of care. We focused on lowering payment rates for clinical conditions that CMS concluded do not typically require intensive rehabilitation. In assessing whether a targeted approach would be a reasonable way to lower IRF payments, the Commission encountered several issues. First, the list of conditions that do not typically require intensive rehabilitation is imperfect at identifying beneficiaries who require IRF-level care. Second, we found that there was little difference in stay-level of profitability for conditions that do not typically require intensive rehabilitation and those that do. Third, unmeasured differences in the patients treated in IRFs and SNFs hampered our ability to draw conclusions about whether equalizing payments across the two settings for some patients would be appropriate. Taken together, these factors persuaded the Commission that there was not evidence sufficient to suggest that we should modify our standing recommendation to lower payment rates for all cases.

| Medicare's Acute Hospital Care at Home program. For many years, hospitals and payers have experimented with providing acute hospital care through a modified benefit, referred to as "hospital at home" (HAH), which provides acute care in a beneficiary's home rather than a traditional stay in a hospital. In this chapter, the Commission assesses the experience to date of hospitals and beneficiaries in the FFS Medicare Acute Hospital Care at Home (AHCAH) program and reviews considerations for Medicare policy. CMS reported that, as of April 2024, about 23,000 AHCAH discharges have occurred (including both Medicare and Medicaid beneficiaries) and 328 hospitals have been approved to participate. However, past experience suggests that many approved hospitals may not have implemented programs. In the Commission's interviews with hospitals participating in AHCAH, hospitals noted challenges in getting their programs started. Hospitals also described experiences with beneficiaries declining AHCAH care, citing beneficiary lack of familiarity with the model. Interviewees also reported that beneficiaries receive fewer services (such as physician consults and laboratory tests) during an AHCAH stay than during a

conventional inpatient stay. Nevertheless, the cost per unit of service may be higher due to the additional costs and inefficiencies of providing care to patients in their homes. Whether AHCAH can provide value to beneficiaries and the Medicare program—through better outcomes and reduced Medicare expenditures for follow-on care—will require further study.

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.