MEDPAC

Advising the Congress on Medicare issues

Considering current law updates to Medicare's payment rates for clinicians

Geoff Gerhardt, Brian O'Donnell, Rachel Burton

October 5, 2023

Considering payments under the Medicare physician fee schedule

- Annual assessments of payment adequacy indicate beneficiary access is similar to the commercially insured
- Modest updates have helped to restrain increases in Medicare spending, beneficiary premiums, and cost-sharing payments
- Some have raised concerns about current-law approach to updates
  - Current-law updates are not tied to inflation, which has been higher than in recent history
  - Gap between projected inflation and updates may negatively affect clinician participation in Medicare and beneficiary access to care in the future
- Bonus payments for A-APM participants are set to expire, which may reduce participation in these models

Note: A-APM (advanced alternative payment model).

Presentation roadmap

1. Background
2. The impact of inflation on the adequacy of payment rates
3. Growth in the volume and intensity of services clinicians deliver
4. Wide variation in payment rates based on where a service is delivered
5. Overvaluation of many services
6. Incentives to participate in advanced alternative payment models

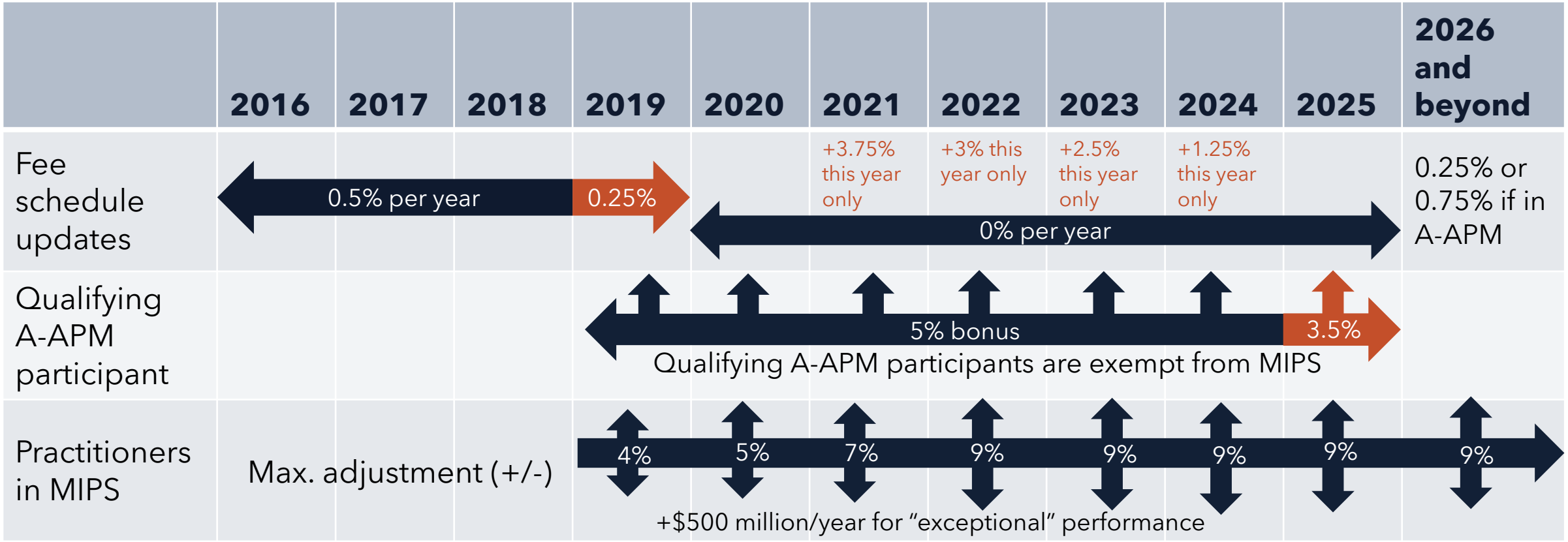
Background

Medicare's approach to setting and updating clinician payment rates has evolved over time

Customary, prevailing and reasonable (CPR)	Volume performance standard (VPS)	Sustainable growth rate (SGR)	Medicare Access and CHIP Reauthorization Act (MACRA)
Payment rates based largely on charges submitted by clinicians	Payment rates based on resource-based relative value units	Changed formula used to calculate spending targets	Replaced formula-based updates with specified updates
Payment rates increased when submitted charges increased	Inflation-based updates adjusted by comparing growth in actual spending to spending target growth rate	Inflation-based updates adjusted by comparing *cumulative* actual spending to *cumulative* spending target	Includes incentives for clinicians to join A-APMs
			MIPS for clinicians not in an A-APM

Note: A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System).

MACRA provides specified updates to payment rates, payment adjustments, and A-APM bonuses



Note: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System). MIPS adjustments to payment rates can be positive, neutral, or negative.

Source: MedPAC analysis of MACRA and subsequent legislation.

Lessons learned from update approaches

- Physician fee schedule has built-in incentives to increase volume and intensity
- Payment adjustments intended to incentivize more efficient care are likely to be ineffective if applied at the national level
- Spending target mechanisms can lead to highly variable and unpredictable updates
- Specifying fixed updates means rates cannot respond automatically to changing conditions

Measures of beneficiary access to care and provider participation have been stable

- MedPAC surveys indicate Medicare beneficiaries' access to care is equal to, or better than, privately insured population
  - Satisfaction rates with time required to get an appointment are similar; Medicare beneficiaries have fewer problems finding a new physician
  - Other surveys show similar findings
- The supply of clinicians billing Medicare is growing
  - Nearly all clinicians who bill the fee schedule accept Medicare's payment rates as payment in full

Source: Annual beneficiary survey, Medicare Current Beneficiary Survey, Medical Expenditure Panel Survey, National Health Interview Survey, and Medicare Part B claims.

Other measures indicate that Medicare's payment rates have generally been adequate

- Number of clinician encounters per FFS beneficiary continues to grow
- Number of applicants to medical schools has increased over time
- Clinicians' compensation has grown faster than inflation
- MedPAC has recommended carrying out updates specified by MACRA except in 2023, when it recommended update equal to half of MEI
- Given that payment adequacy indicators have been stable, MedPAC could take "watchful waiting" approach to future updates

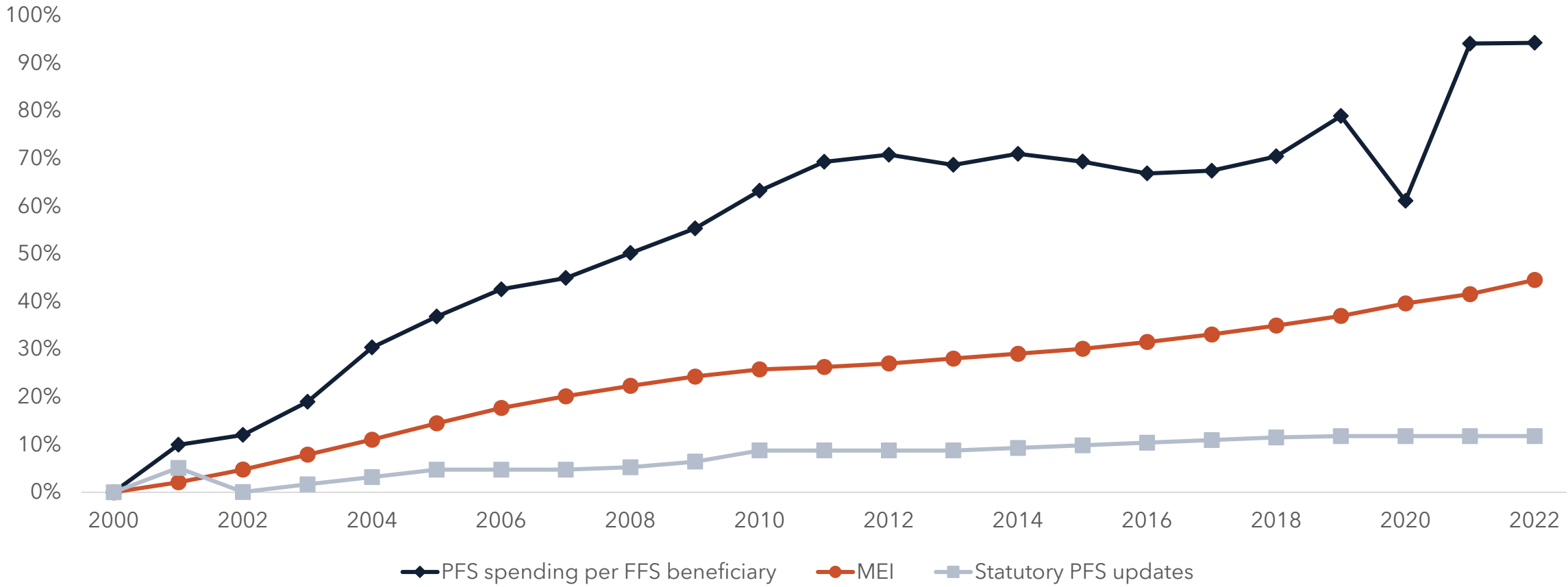
Note: FFS (fee-for-service), MACRA (Medicare Access and CHIP Reauthorization Act of 2015), MEI (Medicare Economic Index).
Source: MedPAC analysis of Medicare Part B claims and data from Association of American Medical Colleges.

The impact of inflation on the adequacy of payment rates

Measuring inflation with the Medicare Economic Index

- The Medicare Economic Index (MEI) measures the weighted average price change for various inputs involved in furnishing clinician services
  - Clinician compensation (47.5%)
  - Practice expenses (52.5%)
- We analyzed how MEI growth has compared with past fee schedule updates and how projected MEI growth compares with projected payment updates

MEI growth was larger than annual payment updates, but fee schedule spending per beneficiary outpaced both measures, 2000-2022



Note: MEI (Medicare Economic Index), PFS (physician fee schedule), FFS (fee-for-service), MIPS (Merit-based Incentive Payment System), A-APM (advanced alternative payment model). The MEI values used in the figure reflect the market basket increases published in the fee schedule final rule each year. This simulates how payment rates would have increased if the MEI was used to update PFS rates. MIPS adjustments, A-APM participation bonuses, and payment increases of 3.75 percent in 2021 and 3.0 percent in 2022 are not included in the figure since they are one-time payments not built into subsequent years' payment rates.

Source: MedPAC analysis of Medicare regulations and Trustees' reports.

MEI growth is projected to slow but exceed fee schedule updates by more than it did in the past

- MEI growth:
  - Averaged 1.7 percent per year for two decades before COVID-19 pandemic
  - Began accelerating in 2021, reaching an annual growth rate of 4.5 percent
  - Is projected to moderate but remain slightly above the levels experienced during much of the past two decades (e.g., ~2.5 percent from 2025 to 2030)
- Annual payment updates:
  - 0 percent in 2025
  - 0.25 percent or 0.75 percent per year thereafter
- Gap between projected MEI growth and updates is projected to be slightly larger from 2025 to 2030 than it was in the past

Note: MEI (Medicare Economic Index).

Should changes in inflation be factored into annual fee schedule updates?

- Full MEI updates have not been necessary to maintain access to care
- The gap between projected MEI growth and fee schedule updates is projected to be slightly larger in the future than in the past two decades
- Payment-rate increases that are directly specified in law can become disconnected from the growth in the cost of running a clinician practice
- Commission could consider exploring updating fee schedule rates based on some portion of input cost inflation
- Higher updates increase Medicare spending, beneficiary premiums, and cost-sharing

Note: MEI (Medicare Economic Index).

Growth in the volume and intensity of services clinicians deliver

Volume and intensity of services furnished has increased substantially over time

- Relative to other types of providers, clinicians have a larger degree of control over the volume and intensity of services they furnish
- The structure of the fee schedule creates an incentive to increase the volume and intensity of services furnished
- Consistent with that incentive, the volume and intensity of fee schedule services has increased over time
  - E.g., from 2000 to 2017, the cumulative per beneficiary growth in volume and intensity of imaging services was 75 percent
  - Growth in volume and intensity could represent increases in patient complexity and/or other factors (e.g., changes in coding behavior)

Should mechanisms to control volume and intensity growth be included in the annual update process?

1. Explicit mechanisms to lower payment-rate updates if spending growth exceeds spending targets
   - Employed as part of VPS and SGR as tools to limit national Medicare expenditures
   - Do not provide individual clinicians with an incentive to practice efficiently
2. MACRA framework: modest updates paired with value-based payment arrangements (e.g., A-APMs)
   - Limits Medicare expenditures (through modest payment updates)
   - In theory, promotes efficient provision of care; in practice, evidence is mixed

Note: VPS (volume performance standard), SGR (sustainable growth rate), MACRA (Medicare Access and CHIP Reauthorization Act of 2015), A-APM (advanced alternative payment model).

Wide variation in payment rates based on where a service is delivered

Different updates across payment systems can exacerbate payment differentials across settings

- Medicare often pays more when services are paid under the OPPS
- Different updates can increase payment differences across payment systems
  - From 2001 to 2023, the average annual hospital market basket increase was 2.7 percent compared with 0.5 percent for the fee schedule
- May contribute to vertical consolidation and care being billed under the higher-paid OPPS

Note: OPPS (outpatient prospective payment system).
Source: MedPAC analysis of Medicare regulations.

Should fee schedule updates address differences in payment rates across settings?

- Implement Commission's standing site-neutral recommendations
  - Reduce OPPS rates for certain services to ensure Medicare sets rates based on the resources needed to treat patients in the most efficient setting
- Commissioners also could consider updates that promote site-neutral payments
  - E.g., the practice expenses paid under the fee schedule could be updated by the growth in the hospital market basket, less a productivity adjustment
  - Such a policy would promote parity in how practice expenses are updated under the OPPS and fee schedule

Note: OPPS (outpatient prospective payment system).

Overvaluation of many services

Particularly strong evidence of overvaluation of surgical services relative to other services

- Study of 1,350 procedures involving anesthesia found they took 27% less time to conduct than Medicare's billing codes assumed
  - MedPAC previously recommended:
    - 2006: Create panel of experts to identify overvalued codes, review suggested code values
    - 2011: Collect data on clinician work time, service volume, practice expenses; revalue codes
- Study of global surgical codes found the number of postoperative visits provided by billing clinicians is lower than Medicare's codes assume:
  - 4% of postoperative visits assumed in 10-day global surgical codes are provided
  - 38% of postoperative visits assumed in 90-day global surgical codes are provided
- The Commission could consider further action on this issue

Source: Crespin et al. 2022. Variation in estimated surgical procedure times across patient characteristics and surgeon specialty. *JAMA Surgery* 157, no. 5; MedPAC's Oct. 14, 2011 letter to the Congress; MedPAC's March 2006 report to the Congress; Crespin et al. 2021. *Claims-based reporting of post-operative visits for procedures with 10- or 90-day global periods: Updated results using calendar year 2019 data*. https://www.cms.gov/files/document/rand-cy-2019-claims-report-2021.pdf.

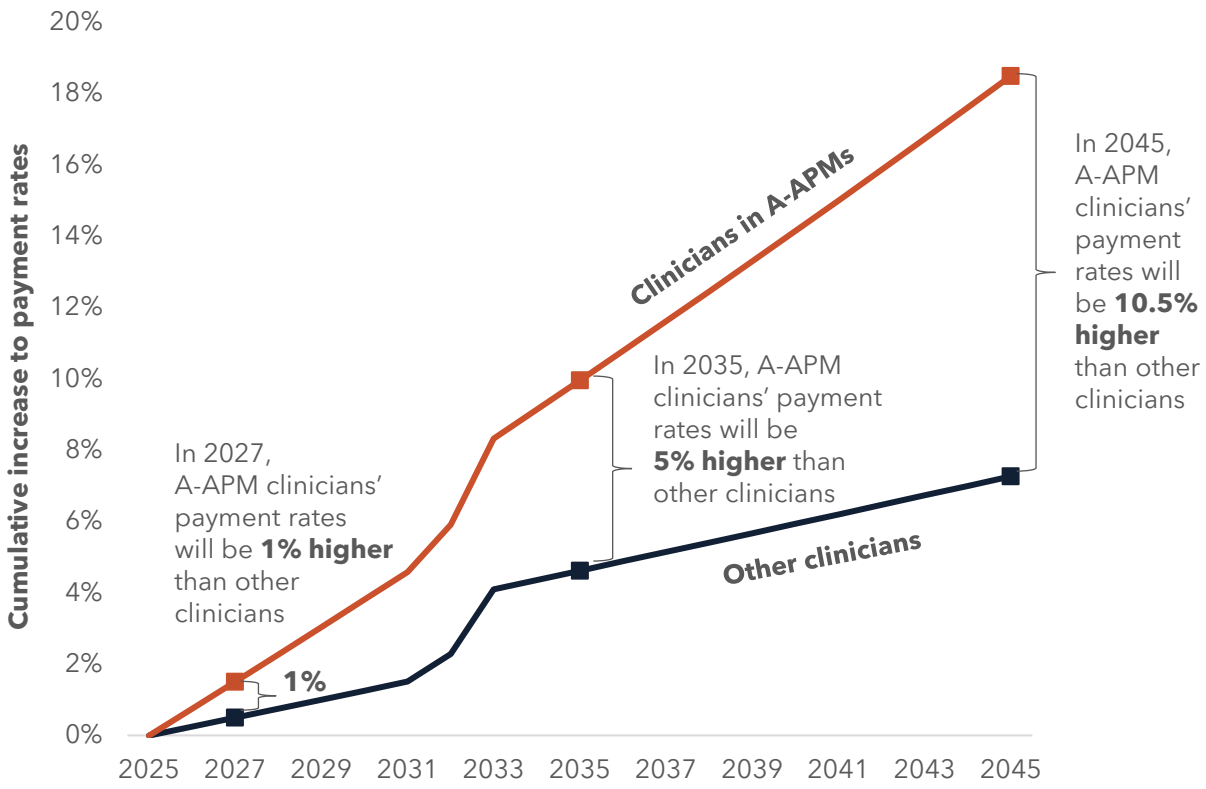
Incentives to participate in advanced alternative payment models

A-APM participation is incentivized under current law through a bonus and then higher updates

- MACRA incentivizes A-APM participation through:
  - A-APM participation bonus (2019-2025)
  - Higher updates to payment rates (2026-on)
  - Exemption from MIPS
- To date, the A-APM participation bonus (5%) has always been larger than the highest MIPS adjustment (under 2%)
- Unclear whether A-APM participation bonus has increased participation in A-APMs, since there are also other costs and benefits to weigh
- Stakeholders claim that the expiration of the A-APM participation bonus could cause some top-performing clinicians to exit A-APMs for MIPS

Note: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System).

Should differential updates for clinicians in A-APMs vs. other clinicians be eliminated?



Note: A-APM (advanced alternative payment model). Graph shows updates to fee schedule payment rates specified in law, including the end of a 2% percent sequester (i.e., reduction) in 2032. Graph does not show CMS's annual budget neutrality adjustments to the fee schedule's conversion factor.

- The difference between payment rates for clinicians in A-APMs vs. other clinicians:
  - Small in the 2020s
  - Large in the 2040s and onward
- Large differences in payment rates may be untenable if A-APMs not available to all clinicians

Should the A-APM participation bonus be extended after 2025?

- If MIPS is retained: Could consider extending the A-APM bonus
  - Could prevent certain clinicians from exiting A-APMs for MIPS
- If MIPS is eliminated (as MedPAC recommended in 2018): Bonus may not be needed
  - Unclear that bonus (median: $1,500) is deciding factor in A-APM participation
  - Bonus not available in some geographic areas, medical specialties, etc.
  - Bonus increases Medicare spending (by $650M/year)
  - Yet, bonus might keep some clinicians in A-APMs
- If bonus is retained, could consider restructuring it

Note: MIPS (Merit-based Incentive Payment System), A-APM (advanced alternative payment model).
Source: CMS. 2023. Advanced alternative payment model (APM) incentive payments for 2023; MedPAC. 2018. "Moving beyond the Merit-based Incentive Payment System," in *Report the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Discussion

Discussion

Are changes needed to Medicare's default fee schedule updates to ensure adequate payments OR should we continue "watchful waiting" and revisit as needed?

If the Commission wants to pursue reforming current law:

1. Incorporate some portion of inflation into default updates?
2. Incorporate some limit on spending growth?
3. Consider updates that promote site-neutral payments?
4. Restructure or eliminate A-APM bonus? Eliminate differential updates?

MEDPAC

Advising the Congress on Medicare issues

Medicare Payment Advisory Commission

meetingcomments@medpac.gov

www.medpac.gov

@medicarepayment