MEDPAC | Medicare Payment Advisory Commission

TESTIMONY MATERIALS

Responses to questions for the record for the hearing entitled: What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors

Paul B. Masi, M.P.P.
Executive Director
Medicare Payment Advisory Commission

Submitted to the:
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

December 1, 2023

On October 19, 2023, the Subcommittee on Health of the Energy and Commerce Committee convened a hearing at which Paul B. Masi, Executive Director of the Medicare Payment Advisory Commission (MedPAC), testified about improving patient access to care and reducing provider burden. Following the hearing, Representative Earl "Buddy" Carter and Representative Lori Trahan submitted questions for the record to MedPAC. This document provides MedPAC's responses.

MedPAC is dedicated to providing independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. We hope the Committee Members find the information provided in our responses helpful, and we welcome the opportunity to provide any additional resources that can be used by the Committee to ensure Medicare patients have good access to care and to reduce provider burden.

The Honorable Earl "Buddy" Carter

Question: I saw at MedPAC's last meeting that you all plan to examine the role of generic drugs in Medicare Part D. Don't you think that MedPAC should wait until the IRA price controls are implemented in 2026? Otherwise, I fear that MedPAC's recommendations will be useless for Members of this committee.

Answer: In our October public meeting, the Commission discussed future analyses of beneficiary utilization of and spending for generic drugs in Medicare Part D. This work will provide the Congress and Commissioners with a better understanding of how the market for generic drugs operates and implications for beneficiary cost sharing. The majority of Part D enrollees primarily use generic drugs, and low-priced generics have played an important role in reducing cost sharing for patients at the pharmacy counter. At the same time, studies suggest there may be wide variation in the prices of generic drugs, with some Medicare beneficiaries facing prices that are higher than if they paid cash. The Commission is analyzing the factors that affect this trend. Our work on this topic is at an early stage, and we are not contemplating recommendations at this time.

Question: From your perspective, how has the lack of an inflationary update impacted access for Medicare beneficiaries?

Answer: Low updates to physician fee schedule payment rates do not appear to have negatively affected Medicare beneficiaries' access to clinician services. During most of the last two decades, the Commission has determined that payment rates under Medicare's physician fee schedule have been adequate to support Medicare beneficiaries' access to clinician services. The Commission has based this conclusion on several important findings about access to care: survey data suggest that beneficiary access to clinician care is comparable to or better than access for privately insured individuals; most beneficiaries report good access to clinician services in our annual focus groups with beneficiaries and clinicians; the share of clinicians who accept Medicare is comparable to the share who accept private health

insurance; the number of encounters beneficiaries have with clinicians, an indirect measure for access to care, has continued to grow; and longer-term measures of access to clinician care also remain positive, with interest in becoming a physician remaining high.

Some stakeholders continue to worry about whether clinician payments will remain adequate in the future. Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), clinician payment rates will not be increased in 2025, and relatively low annual updates are scheduled for 2026 and beyond. At its October 2023 public meeting, the Commission began to consider whether changes to MACRA's scheduled updates are needed. As we do every year, the Commission will reassess the adequacy of Medicare's payments for clinician services with updated information during our December and January public meetings.

Question: Does your data show which specialties are getting the biggest cuts and if access to those specialties has decreased?

Answer: MedPAC has not reported on the net effects of the recent changes to payment under the physician fee schedule. We do not have evidence that the changes in payment rates have negatively affected beneficiary access to care furnished by specialists. In our 2022 survey of Medicare beneficiaries and privately insured individuals, fewer Medicare beneficiaries reported problems finding a specialist, compared with privately insured individuals. We also find that the number of specialists billing fee-for-service (FFS) Medicare has consistently grown over time, including in 2021, indicating that these providers had sufficient incentive to serve Medicare beneficiaries. The Commission will continue to monitor these measures and others for signs that beneficiaries are experiencing increased difficulty accessing care from specialists.

Question: Does your data reflect how many practices cap the number of Medicare patients they want to see or have to cap ancillary staff as a result of the payments going down?

Answer: We are not aware of a data source that reports the number of practices that cap the number of Medicare patients they want to see. Several national surveys find that the share of providers that report accepting new Medicare patients is comparable to the share that report accepting new privately insured patients. For example, the 2021 National Ambulatory Medical Care Survey found that among the 94 percent of nonpediatric office-based physicians who reported accepting new patients, 89 percent reported accepting new Medicare patients and 88 percent reported accepting new privately insured patients.[1] Across clinicians in our focus groups, most were accepting new patients, including Medicare patients.

[1] Schappert, S. M., and L. Santo, Department of Health and Human Services. 2023. *Percentage of office-based physicians accepting new Medicare, Medicaid or privately insured patients in the United States: National Ambulatory Medical Care Survey, 2021*. Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/data/namcs/2021-P3P4-NAMCS-Provider-Data-Dictionary-COVID-Dashboard-RDC-Researcher-Use-508.pdf.

Question: Is MedPAC planning to do any work highlighting the importance of nonphysician providers in Medicare? As you know, pharmacists play a critical role in caring for and counseling patients. Do you plan to devote a MedPAC chapter to the critical role of nonphysician providers in caring for Medicare beneficiaries? This is not just pharmacists; the nurses and nurse practitioners matter too.

Answer: The Commission appreciates the growing role of clinicians other than physicians in caring for Medicare beneficiaries, including pharmacists, advanced practice registered nurses (APRNs), and physician assistants (PAs), among others. In its annual March reports to the Congress, the Commission has documented a rapid increase in the number of APRNs (a group that includes nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and certified nurse midwives) and PAs. In addition, the Commission has found that certain groups of Medicare beneficiaries, including rural and low-income beneficiaries, are more reliant on such clinicians to access care. Because of their growing importance, in its June 2019 report to the Congress, the Commission recommended that (1) Congress require APRNs and PAs to bill the Medicare program directly, eliminating "incident to" billing for services they provide, and (2) the Secretary refine Medicare's specialty designations for APRNs and PAs. These recommendations were designed to give the Medicare program a fuller accounting of the breadth and depth of services provided by APRNs and PAs and to improve policymakers' ability to target resources toward primary care. In addition, in its June 2023 report to the Congress, the Commission noted the growing importance of nurse practitioners and licensed clinical social workers in treating Medicare beneficiaries with behavioral health conditions.

Relative to other types of providers, the Medicare program has limited data on the volume and type of care furnished by pharmacists. However, when possible, the Commission has recognized pharmacists' important role in the health care delivery system. For example, in its June 2021 report to the Congress, the Commission highlighted pharmacists' key role in enabling Medicare beneficiaries to have access to vaccines. Pharmacists can register with Medicare as "mass immunizers" and thereby bill Part B for influenza, pneumococcal, and COVID-19 vaccinations. In 2019, the Commission found that "mass immunizers" administered the highest share of influenza vaccines (48 percent) and the second highest share of pneumococcal vaccines (31 percent) for FFS Medicare beneficiaries. The Commission also noted that most states have expanded pharmacists' scope of practice over time. As states allow pharmacists to furnish care with a greater amount of independence and as the data allow, the Commission will continue to monitor the role pharmacists play in caring for Medicare beneficiaries.

The Honorable Lori Trahan

Question: When recommending home health reimbursement cuts, has MedPAC considered workforce shortages and the ability of home health agencies to attract and retain staff?

Answer: MedPAC recognizes that the ability to attract and retain staff is important for ensuring access to quality home health care for beneficiaries. Many factors affect the market for home health agency staff, which include ensuring that Medicare's payments provide adequate resources to staff appropriately. In general, FFS Medicare payments have exceeded costs by more than 16 percent since 2001, and FFS Medicare margins in 2021 were 24.9 percent, the highest level since the home health prospective payment system was initiated. High Medicare payments place strain on the program's finances and increase Part B premiums for beneficiaries. These high margins led the Commission to conclude in our March 2023 report to the Congress that HHAs would still have adequate funds to retain and attract staff even if payment levels were reduced. We understand that some home health agencies may face financial challenges because of payment rates from non-FFS Medicare payors. However, because of high margins on FFS Medicare payments, FFS Medicare is not contributing to those challenges. Additionally, using FFS Medicare overpayments as a policy tool to account for inadequate payments from other payors would not promote good value of Medicare's resources for the taxpayers and beneficiaries who finance the program.

Question: Is MedPAC concerned that these cuts to home health agencies will further limit patient access to home health care and exacerbate capacity challenges that many hospitals are experiencing?

Answer: The share of beneficiaries that receive home health care following a hospital discharge remains above 2019 levels, indicating that access for Medicare beneficiaries is comparable to prepandemic levels. We recognize that some hospitals continue to experience capacity challenges. However, given the relatively high Medicare margins for home health care services, Medicare payment rates are not contributing to those challenges. The Commission will continue to annually assess access to home health care for FFS Medicare beneficiaries, including those who require posthospital care.

Question: How should I be thinking about developing a definition of an "essential hospital" such that it includes hospitals treating the most vulnerable patients?

Answer: The Medicare program should provide adequate support to ensure access to high-quality hospital care for Medicare beneficiaries. Because caring for low-income Medicare beneficiaries can require more resources than caring for commercially insured patients and higher-income Medicare beneficiaries, MedPAC created a Medicare Safety-Net Index (MSNI) that is based on three factors: the share of a hospital's patients that are Medicare beneficiaries, the share of Medicare beneficiaries that receive the Part D low-income subsidy, and the share of the hospital's revenue that is spent on uncompensated care. In our March 2023 report to the Congress, we recommended that Medicare payment rates increase as the MSNI increases. For example, a hospital that treats a higher share of low-income Medicare patients would receive a higher payment rate under the MSNI for each Medicare service than a hospital in the same city that cares for higher-income beneficiaries with the same diagnoses. The Commission contends that this

approach of having the safety-net payments follow the patients is a better way to target scarce Medicare resources to support hospitals that treat large shares of vulnerable Medicare patients.