MEDPAC | Medicare Payment Advisory Commission

TESTIMONY

Improving payment accuracy in the Medicare program

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Statement of
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Committee on Energy and Commerce
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Summary

The Medicare Payment Advisory Commission's (MedPAC's) work focuses on ensuring that beneficiaries have access to high-quality care and that Medicare is a good steward of taxpayer dollars. The Commission does not identify or track improper payments as part of its work. This testimony focuses on areas where Medicare payments can be changed to improve the value associated with the Medicare program.

- Medicare Advantage (MA) plan payments are partly based on diseases recorded on claims for MA enrollees, which gives plans an incentive to record more diagnoses which increase their payments. This contributed to MA payments far above what would be spent if MA enrollees were in fee-for-service (FFS). Reforms to the risk adjustment system are called for.
- In our annual assessment of payment adequacy for several categories of post-acute care (PAC), we found that FFS Medicare payments for PAC services are substantially higher than providers' costs and that quality and access to care and capital were stable. This suggests modest reductions in some PAC payments would be appropriate.
- Payment rates for ambulatory services in FFS Medicare often differ across care setting, which increases total Medicare spending and beneficiary cost sharing without significant improvement in patient outcomes. MedPAC has recommended aligning payments across sites for some services.
- Medicare allows nurse practitioners and physician assistants to bill under the provider number of a supervising physician, a practice known as "incident to" billing. The "incident to" billing rules prevent identification of clinicians who treat beneficiaries and inhibit Medicare's ability to identify and support clinicians furnishing primary care. MedPAC has recommended eliminating incident to billing.

Introduction

Chair Rodgers, Chair Griffith, Ranking Member Pallone, Ranking Member Castor, and distinguished Committee members, my name is Michael Chernew, and I am the Chair of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be with you today to discuss the Commission's work on improving payment accuracy in the Medicare program.

MedPAC is a small congressional support body established by the Balanced Budget Act of 1997 (P.L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. As part of our work, the Commission examines Medicare's payment systems for services provided through the traditional fee-for-service (FFS) program and for health plans in both the Medicare Advantage (MA) program and the Part D prescription drug benefit.

Three principles guide the Commission's work: (1) payments should be sufficient to support beneficiary access to high-quality health care in an appropriate clinical setting; (2) payments should reflect efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary; and (3) payments should give providers incentives to supply appropriate and equitable care. In all our efforts, the Commission follows a deliberative, analytic process to provide the Congress with thoughtful, empirically based information and advice on Medicare.

MedPAC seeks to provide information about relevant Commission work that may be helpful as the Committee works to ensure that Medicare patients have access to care and that taxpayer funds are being spent wisely. In this testimony, I will discuss the Commission's recent work and recommendations in several areas:

- Diagnostic coding in Medicare Advantage,
- FFS payment rates for post-acute care (PAC) services,
- Aligning FFS payment rates across ambulatory settings, and
- Increasing transparency by eliminating "incident to" billing in certain cases.

Before I begin, I would like to note that the term "improper payments" has a specific statutory definition that is used in work that other agencies have done on the issue. Other federal agencies, like the Department of Health and Human Services and the Government Accountability Office are responsible for identifying and tracking improper payments. Those responsibilities fall outside of MedPAC's scope. Instead, our work focuses on ensuring beneficiaries' access to care and on improving the accuracy and adequacy of Medicare's payments to providers and health plans to promote efficient use of Medicare's resources. Nonetheless, we recognize that some of our recommendations, if implemented, may indirectly affect improper payments.

Diagnostic coding in Medicare Advantage

The MA program allows beneficiaries enrolled in both Part A and Part B of Medicare to receive benefits from private plans rather than from the traditional FFS program. MA plans provide Part A and Part B coverage, and most plans also provide Part D drug coverage. Medicare Advantage plans receive a fixed payment from CMS that is based on a benchmark (related to estimated FFS spending) in the areas they serve and a bid the plan submits, which reflects its expected costs of covering Medicare benefits. Importantly, the payment to a plan is adjusted for estimates of the expected effects on spending of the health status and demographics of the beneficiaries the plan enrolls. If

plans bid lower than the benchmark, as most do, they can keep a share of the difference, known as a rebate. The rebate must be used to finance extra benefits to plan enrollees. These extra benefits can include reduced cost sharing for Part A and Part B services; reductions in Part B and Part D premiums; and coverage of supplemental benefits such as dental, vision, and hearing benefits. These extra benefits have been attractive to many beneficiaries, and MA enrollment has grown rapidly in recent years. In 2023, 52 percent of eligible beneficiaries were enrolled in MA plans.

Despite its growing popularity, the expansion of MA is also a cause for concern. Private plans that accept full risk have been available in Medicare since the mid-1980s, but they have never generated aggregate savings for the program, at least in part because of how they are paid. We estimate that in 2024 Medicare will spend approximately 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare. The higher payments for beneficiaries in private plans, combined with the growing enrollment in MA, are major factors driving growth in Medicare spending and putting financial pressure on the Medicare program.[1]

The Commission contends that, under the right policies, MA plans could serve as vehicles to manage spending and improve the quality of care more effectively than the fragmented FFS system. Although MA plans have the potential to provide good value for the program, the policies that govern how MA plans are paid are flawed and prevent that value from materializing.

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[1] For more information on our comparisons of MA and FFS spending and our analysis of MA coding intensity, see Chapter 12 and Chapter 13 in our March 2024 report to the Congress, available at https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/.

One particular area of concern is the system used to adjust payments for differences in demographics and health status, which is based on a risk score computed from MA claims but calibrated using diagnoses coded on FFS claims. Specifically, in both MA and FFS Medicare, claims include both procedure and diagnosis codes; however, most FFS Medicare claims are paid using only procedure codes, which offers little incentive for providers to record more diagnosis codes than necessary to justify providing a service. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses because adding new diagnoses (provided they are used in the MA risk-adjustment system) raises an enrollee's risk score and results in higher payments to the plan. Two significant vehicles that plans use to identify new diagnoses are chart reviews (which document diagnoses not captured on claims and which do not exist in FFS Medicare) and health risk assessments (which can be plan-initiated and sometimes rely on unverified enrollee-reported data).

Coding differences do not necessarily imply MA plans are coding inappropriately (though some may be). The coding differences may reflect MA plans capturing more diagnoses than FFS providers, potentially because MA plans have an incentive to report every diagnosis for an enrollee and because FFS providers may be more likely to focus on more significant diagnoses that are a primary reason for a visit. Research has shown that some FFS beneficiaries have chronic conditions that are not consistently captured. For example, conditions like kidney failure or paraplegia may drop off FFS claims in some years—suggesting that not all diagnoses are reported consistently in FFS Medicare. Furthermore, whistleblowers and the Department of Justice allege that some MA plans have submitted fraudulent diagnoses for risk adjustment. There are no data available to precisely parse the share of higher MA coding intensity due to these or other reasons;

however, we estimate that about half of higher MA coding intensity could result from use of diagnoses from chart reviews and health risk assessments and that these two mechanisms are primary factors driving coding differences among MA plans. Importantly, because the risk-adjustment model that CMS uses to pay MA plans is calibrated on FFS claims, relatively higher MA coding intensity—regardless of the reason—increases payments to MA plans above FFS spending.

We estimate that, in 2022, MA risk scores were about 11 percent higher than they would have been if MA enrollees had been enrolled in FFS Medicare. (That figure accounts for a reduction of 5.9 percent that CMS makes to risk scores to partly offset the effects of coding intensity). Coding intensity is thus the largest single factor contributing to the higher Medicare spending in MA compared to FFS. We have also found that coding intensity varies significantly across MA plans; for example, among the eight largest MA insurers, we have found a 15 percentage point variation in coding intensity. Higher coding intensity allows some plans to offer more extra benefits—and attract more enrollees—than other plans, a dynamic that distorts the nature of plan competition in MA.

The Commission has recommended making several changes to the MA risk-adjustment system that would reduce coding intensity. Those changes include not using diagnoses collected from health risk assessments, using two years of MA and FFS diagnostic data (the current model uses one year of data), and applying an adjustment to MA risk scores to address the residual impact of coding intensity. The Commission expects that its recommendations would not only reduce Medicare spending, but also improve equity across MA insurers by reflecting that some plans coded more intensively than others. More broadly, when reforming Medicare's payments to MA plans, the Commission has

urged the Congress to achieve an appropriate balance of benefits for enrollees, payment adequacy for plans, and responsible use of taxpayer dollars that fund the program.

FFS payment rates for post-acute care services

A core part of MedPAC's statutory mission is to assess whether payments in FFS Medicare are adequate to achieve access to high-quality care for Medicare beneficiaries and efficient use of program resources, and to advise the Congress on what steps to take if payments are too low or too high. Every year, the Commission makes recommendations to the Congress about how Medicare payment rates should be updated in the coming year based on that assessment. Our analysis takes into account evidence on beneficiaries' access to care, the quality of care that providers deliver, and the costs providers incur in delivering that care. We use the best available data to examine indicators of payment adequacy and reevaluate any assumptions from prior years, to make sure our recommendations accurately reflect current conditions. We apply the same criteria across settings, but because data availability, baseline conditions, and expected future changes may vary, our recommended updates for each sector are not formulaic.

Our most recent recommendations, which were included in our March 2024 report to the Congress, pertain to payment updates for 2025. As part of that work, we examined the adequacy of Medicare's payment rates for three types of PAC services: skilled nursing facilities (SNFs), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs). These providers collectively offer important recuperation and rehabilitation services to Medicare beneficiaries. About 40 percent of beneficiaries with hospital stays receive PAC services after they have been discharged; beneficiaries can also receive some PAC services, particularly home health, without a prior hospital stay. In 2022, FFS Medicare spent a total of about $54 billion on these services.

Across all three PAC sectors, we found that beneficiaries have adequate access to care, quality-of-care indicators appear to be stable, and providers have sufficient access to capital. However, we also found that FFS Medicare payments for PAC services are substantially higher than providers' costs. We estimate that, in 2024, the margins on FFS Medicare payments will be 16 percent for SNFs, 18 percent for home health, and 14 percent for IRFs.

Based on our analysis, the Commission recommended that (for 2025), the Congress reduce 2024 payment rates for:

- SNFs by 3 percent,
- HHAs by 7 percent, and
- IRFs by 5 percent.[2]

The high aggregate Medicare margins for these providers have been a longstanding concern for the Commission. For example, we have found that the margins in all three PAC settings have consistently been high (often well over 10 percent) for more than 15 years. A common theme is that the aggregate Medicare margin increased substantially soon after each setting's prospective payment system was implemented, indicating that the initial base rates for each setting were set too high and that providers rapidly adjusted to the new payment rules.

[2] For more information on our most recent analyses of payment adequacy in PAC settings, see Chapter 6 (skilled nursing facilities), Chapter 7 (home health agencies), and Chapter 8 (inpatient rehabilitation facilities) in our March 2024 report to the Congress, available at https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/.

Importantly, these providers, particularly SNFs, serve other market segments, most notable Medicaid and, while our focus is on appropriate Medicare payment, policy makers may consider the broader sector context. Nevertheless, over the years, the Commission has made a series of recommendations to either eliminate statutory payment updates for PAC providers, reduce current payment rates for PAC providers, or both. The persistence of these high margins underscores the need for policymakers to regularly monitor and update FFS Medicare payment rates to ensure that Medicare funds are being spent wisely while ensuring that beneficiaries have access to care.

Aligning FFS payment rates across ambulatory settings

A persistent problem in FFS Medicare is that the payment rates for a service can vary depending on the setting where care is delivered. For example, payment rates for the same service often differ across three ambulatory settings: hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding clinician offices. These payment differences encourage arrangements among providers, such as consolidation of physician practices with hospitals, that result in care being billed from settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without significant improvement in patient outcomes. From 2015 to 2021, for example, the volume of chemotherapy administration in freestanding clinician offices (the ambulatory setting for which payment rates are usually lowest) fell 14 percent, while the volume in HOPDs (the ambulatory setting for which payment rates are usually highest) climbed 21 percent.

In general, the Commission has maintained that Medicare should base payment rates on the resources needed to treat patients in the most efficient, clinically appropriate setting. If the same service can be safely provided in different settings, a prudent purchaser

should not pay more for that service in one setting than another. This principle suggests that—for services that are safe and appropriate to provide in a lower-cost setting—Medicare should adjust rates paid for services delivered in higher-cost settings to more closely align with the rates paid in lower-cost settings. However, Medicare should be selective about which services should have payment rates aligned across settings, because many ambulatory services cannot be safely or appropriately provided in freestanding offices in the majority of circumstances. Such services are typically complex procedures or services related to emergency care. In these instances, discretion should be used and the payment rates in each of the ambulatory settings should be left unchanged to ensure that hospitals are adequately reimbursed to maintain access to those services.

The Commission examined the feasibility of aligning FFS payment rates across the three ambulatory settings by analyzing services that are reimbursed under the outpatient prospective payment system (OPPS) when provided in HOPDs. Under the OPPS, services with similar clinical attributes and costs are grouped into ambulatory payment classifications (APCs). The OPPS has a total of 169 distinct APCs for services (there are additional APCs for drugs and devices). Some of those services can also be provided in a freestanding clinician office, where they are reimbursed under the physician fee schedule, or in an ASC, where they are reimbursed under the ASC fee schedule.

Of the 169 APCs, we determined that HOPDs had the highest volume for 103 APCs, clinician offices had the highest volume for 57 APCs, and ASCs had the highest volume for 9 APCs. The 66 APCs that were most often provided outside of HOPDs could be promising candidates for aligning payment rates. For example, for services that are most commonly provided in clinician offices, the OPPS and ASC payment rates could be aligned with the

generally lower payment rates under the physician fee schedule. Similarly, for services that are most commonly provided in ASCs, the OPPS payment rates could be aligned with the lower ASC payment rates.

Based on this analysis, in 2023 the Commission recommended that the Congress more closely align payment rates across ambulatory settings for services that can be safely and appropriately provided in all settings and when doing so does not pose a risk of access.[3] The services we identified as candidates for payment rate alignment could differ from the services that CMS would select for alignment because CMS could use a different approach to identify those services and their selection would be informed by clinicians and other stakeholders through notice-and-comment rulemaking or similar processes. In addition, a well-functioning system of aligning payment rates should ensure that hospitals receive adequate financial support to maintain access to emergency care and standby capacity by paying more than the aligned payment rates for services that are provided as part of an emergency department visit.

These recommendations alone would not reduce Medicare spending in the short term because current law requires that changes to OPPS and ASC payment rates be implemented on a budget-neutral basis. As a result, payment alignment would reduce payment rates for some APCs and increase them for other APCs. However, aligning payment rates for select services would reduce incentives for providers to make site-of-

[3] For more information, see Chapter 8 of our June 2023 report to the Congress, available at https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf.

care decisions based on financial rather than clinical factors, which could eventually result in lower aggregate spending.

Increasing transparency by eliminating "incident to" billing in certain cases

High-quality primary care is essential for creating a coordinated health care delivery system. Primary care services—such as ambulatory evaluation and management services—are provided by physicians and other health professionals, such as nurse practitioners (NPs) and physician assistants (PAs). Although the Commission has concerns about the supply of primary care physicians, the number of advanced practice registered nurses (APRNs) and PAs has increased rapidly and is projected to continue to do so in the future. (NPs are one type of APRN.) Medicare beneficiaries rely on APRNs and PAs to provide an increasingly substantial share of their medical services.

APRNs and PAs are graduate-level trained clinicians who predominantly work in collaboration with or under the supervision of physicians to deliver care to patients. In addition, state governments have steadily increased NPs' and PAs' scopes of practice, meaning that these clinicians have an increasing amount of authority and autonomy.

Medicare lets NPs and PAs bill under the provider number of a supervising physician if certain conditions are met, a practice known as "incident to" billing. Medicare pays for services at 100 percent of the fee schedule rate when a service provided by an NP or PA is billed "incident to" and 85 percent of the fee schedule rate when the NP or PA bills for the service using their own provider number. We have conducted analyses that suggest a substantial share of the services provided by NPs and PAs to Medicare beneficiaries are billed on an "incident to" basis.

Medicare also collects little up-to-date information regarding the specialty in which NPs and PAs practice. While NPs and PAs have historically been concentrated in primary care, a large share of NPs and PAs do not work in primary care, and more recent patterns suggest that NPs and PAs are increasingly practicing in specialty fields.

Given the growing role of NPs and PAs and their shift away from primary care, the "incident to" billing rules and lack of specialty data obscure important information on the clinicians who treat beneficiaries and inhibit Medicare's ability to identify and support clinicians furnishing primary care. Therefore, MedPAC has recommended that (1) the Congress eliminate "incident to" billing for APRNs and PAs and require them to bill the Medicare program directly, and (2) the Secretary refine Medicare's specialty designations for APRNs and PAs. These recommendations are designed to improve transparency around the provision of services billed under the Medicare program and improve policymakers' ability to target resources toward primary care.[4] The Commission has made separate recommendations that would support Medicare beneficiaries' access to primary care, and would continue to assess the adequacy of Medicare's payments to clinicians as part of our annual update work.[5]

Conclusion

The Medicare program plays a vital role in providing health care coverage for elderly individuals and many individuals with disabilities. The program's payment systems are often complex, and the issues I have discussed today are examples of the different types

[4] For more information, see Chapter 5 of our June 2019 report to the Congress, available at https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf.
[5] For more information, see Chapter 4 of our June 2024 report to the Congress, available at https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch4_MedPAC_Report_To_Congress_SEC.pdf.

of reforms that policymakers periodically need to make to these payment systems, such as refinements to risk adjustment systems, aligning payment rates with providers' costs, ensuring that payments encourage providers to deliver care in lower-cost settings, and providing more accurate information about the mix of providers that deliver primary care. The recommendations that the Commission has made in these (and other) areas aim to improve the value of the program for taxpayers and beneficiaries while ensuring that beneficiaries have appropriate access to care.