



American College of Radiology Summary of March 2022 Medicare Payment Advisory Commission (MedPAC) Report

Chapter 1: Context for Medicare Payment Policy

This chapter examined both the short and long-term implications for the Medicare program in terms of spending. In the short-term, the Medicare program is facing the impacts of the COVID-19 pandemic on beneficiaries, and in the long-term, Medicare's Hospital Insurance Trust Fund will become insolvent by 2026 or 2027. Medicare's annual spending is projected to double between 2020 and 2030 due to growth in the volume and intensity of services provided to beneficiaries and a growth in the number of beneficiaries.

Short-term Context: Coronavirus Pandemic

Medicare beneficiaries face disproportionately high mortality rates from COVID-19 compared to younger age groups. Furthermore, the pandemic has had a disproportionate effect on non-White individuals, and mortality rates for Black, Hispanic, and Native American people are at least double the rates for White Americans.

Medicare beneficiaries' access to care was largely maintained through the pandemic, although many beneficiaries temporarily delayed care. Diagnostic and screening tests were among the most common types of care that Medicare beneficiaries reported delaying or foregoing due to the pandemic.

Telehealth has become a normal part of healthcare and nearly half of Medicare beneficiaries surveyed in the MedPAC's annual telephone survey reported using telehealth at least once in the past year. Patient satisfaction with the telehealth services was high, but approximately half of telehealth users indicated a preference for returning to in person visits when the pandemic ends.

The report discusses the impact of the pandemic on the healthcare workforce, including a decline in the number of nursing staff and impacts to providers' revenues. With Provider Relief Fund payments and forgivable loans through the Paycheck Protection Program, the MedPAC believes that the pandemic will not have a long-term financial impact on the Medicare program; however, the Commission recognizes that the ongoing effects on provider revenues are not yet fully understood.

Long-term Context

Actuaries expect national health care spending to increase at an average annual rate of 2.4 percent from 2019 to 2028. The largest driver of personal health care spending increases is rising prices, which is partly a result of expected acceleration in economy-wide inflation. The second largest driver of national spending growth is growth in the use and intensity of services per patient.

Unlike in the private health care sector, price growth is not expected to drive Medicare's increasing spending over the next 10 years because it can set prices. Therefore, Medicare's increase in projected spending is driven by the increasing number of beneficiaries and the increasing volume and intensity of services delivered per beneficiary. As enrollment is out of the program's control, the MedPAC opines that one way to slow Medicare spending growth is to shift care from high-cost to lower-cost clinical settings. Another option is reducing quantity of services used by beneficiaries, specifically low-value care ("services with little or no clinical benefit or that have more risk of harm than potential benefit"). The report notes that CMS has tested some alternative payment models to incentivize more efficient use of services with mixed results. Finally, Medicare Advantage payment reforms may be needed.

In a discussion on price growth in the private sector, the MedPAC indicates that a key driver of higher prices in the private sector is provider market power. The report notes increasing rates of hospital and physician group consolidation and opines that providers consolidate in order to gain leverage in contract negotiations. A 2022 report from the Congressional Budget Office concluded that providers do not raise negotiated prices with private insurers in order to offset lower prices paid by Medicare and Medicaid. The MedPAC raises a concern that over time, if Medicare rates fall far enough below commercial rates, providers will have incentive to focus on patients with commercial insurance, creating pressure to increase Medicare payment rates and/or impact Medicare beneficiaries' access to care.

The affordability of health care for Medicare beneficiaries

Beneficiary spending on Medicare premiums and cost sharing for services and prescription drugs constituted 23 percent of the average Social Security benefit in 2021, an increase of 9 percent in the past 20 years. Disparities exist in the populations of Medicare beneficiaries that report trouble affording care. Despite the burden of cost sharing on beneficiaries, the MedPAC believes that cost sharing can be beneficial to the program by deterring overuse of services; however, only 11 percent of Medicare beneficiaries do not have any other type of healthcare coverage.

Medicare spending trends

The MedPAC points to the new Alzheimer's drug Aduhelm as an example of a drug that can have a significant impact on overall Medicare spending. Between 2009 and 2019, changes in prices for Part B drugs were the largest contributing factor to the spending on Part B drugs. The Commission is beginning a new analysis examining drug pricing in order to make future recommendation.

Trends in beneficiaries' morbidity and mortality

Prior to the COVID-19 pandemic, over the past few decades, there has been little change in the leading cause of death in the U.S., with heart disease and cancer first and second. Recent research indicates that COVID-19 was the third leading cause of death in most months of 2020 and was the leading cause of death in late 2020 through early 2021. With the availability of vaccines, COVID-19 fell to the seventh leading cause of death by June 2021.

Disparities among Medicare beneficiaries

The MedPAC has identified disparities in life expectancy related to race and ethnicity. In addition, demographic characteristics are also associated with different care experiences.

Alternative Payment Models (APMs)

Medicare has tried to slow its growth in spending through APMs, which give providers financial incentives to deliver care more efficiently. The most prominent APMs are population-based payment models (accountable care organizations) episode-based models, and advanced primary care models. Models typically run 3-6 years, and while the impact of the models is still being analyzed, any savings have been modest. Despite this, the Commission still believes that with some improvements, APMs could achieve greater success.

Past MedPAC Recommendations

The MedPAC has made recommendations for restraining Medicare spending growth including:

- Make payments site neutral
- Improve the accuracy of payments and increase payments to primary care providers
- Strengthen Medicare's payment systems to address rising drug prices and costs
- Scrutinize claims more closely to reduce overutilization, fraud and abuse
- Encourage better integration with Medicaid
- Modify beneficiary cost sharing to incentivize high-value care
- Collect more complete and accurate Medicare Advantage data
- Incentivize improving population-based outcomes

Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare

This chapter provided an overview of how the MedPAC assesses payment adequacy and did not include any specific recommendations.

The MedPAC is required by law to make annual payment update recommendations for providers paid under the Medicare fee-for-service payment systems. The Commission believes that temporary "shocks" to the healthcare system, such as those caused by the COVID-19 pandemic, are best addressed through "targeted temporary funding policies" rather than permanent changes to all providers. The Commission also acknowledges that the COVID-19 pandemic made it more difficult to assess Medicare's payment adequacy as many of the indicators used were directly or indirectly impacted by the PHE. The MedPAC does not believe that changes in the capacity and supply of providers during the pandemic are an indicator of inadequate Medicare payment rates.

The report discusses that there are sometimes significant differences in payment (80 percent or more) for similar services across different healthcare settings. The Commission believes that basing payment on the rate in the most efficient setting would save money for Medicare and reduce patient cost sharing, but recognizes that this is a complex issue. Building off of previous site neutral payment recommendations, the Commission will continue to study other services that

are provided in multiple sites of care to potentially recommend additional site neutral payment policies. The Commission will continue to look for opportunities to develop policies that create incentives for providing high-quality care efficiently.

Chapter 3: Hospital inpatient and outpatient services

Recommendation: Under current law, the Medicare hospital base payment rates are projected to increase by 2.5 percent for IPPS and 2.0 for OPSS in 2023. **For fiscal year 2023, the Congress should update the 2022 Medicare base payment rates for acute care hospitals by the amount specified in current law.** The Commission believes this recommendation will be enough to maintain beneficiaries' access to care and keep payment rates close to the cost of delivering high-quality care efficiently.

The MedPAC provided an update of hospital inpatient and outpatient services. The most recent complete data from 2020 was used to create this chapter. The report noted that they considered the effects of COVID-19 public health emergency (PHE), and that the effects are best addressed through targeted temporary funding policies rather than permanent changes. The MedPAC noted that any additional needed financial support should be targeted to affected hospitals.

In 2020, the MedPAC found that between hospital inpatient and outpatient services, there was a total spend of \$172.6 billion. The MedPAC report found that 4.8 million beneficiaries had 7.5 million inpatient stays in the 3,100 short-term acute care hospitals paid under the Hospital Inpatient Prospective Payment System (IPPS) in 2020. In the same year, 18.2 million beneficiaries made 78.1 million visits to the 3,600 hospitals providing outpatient services under the Hospital Outpatient Prospective Payment System (HOPPS).

Beneficiary Access

While the variable effects of the public health emergency continued in fiscal year 2021 and will continue to some extent in 2022, the MedPAC anticipates that, in aggregate, indicators of beneficiaries' access to care will remain positive. Inpatient stays per capita declined 11.5 percent across fiscal year 2020, and outpatient stays per capita fell 17.4 percent. Volumes took a large downturn in March followed by a partial rebound in the summer as patients and providers continually postponed care because of the COVID-19 pandemic. The MedPAC report showed that short-term acute care hospitals continued to have significant excess inpatient capacity with an aggregate occupancy rate of 62 percent in 2020, similar to the 64 percent rate in 2019.

Hospital Closures

The number of hospital closures declined substantially in fiscal years 2020 and 2021, falling from 46 in 2019 to 25 in 2020 and 10 in 2021. This is likely due to the increased federal financial support provided to hospitals during the PHE. Of the 10 hospitals that closed in fiscal year 2021, the majority were small; 8 of the 10 had 100 or fewer beds. Six were in metropolitan areas and 4 were in rural areas.

Medicare Margins

The Medicare margin at IPPS hospitals decreased from -8.7 percent in 2019 to -12.6 percent in 2020. The median Medicare margin among relatively efficient hospitals fell from -1 percent to -3 percent, when excluding federal relief funds. The MedPAC also reported a Medicare margin including a portion of relief funds of -8.5 percent and reported the median margin for relatively efficient hospitals to be 1 percent. The MedPAC cautiously projects IPPS hospitals' Medicare margin in 2022 to be -10 percent excluding relief funds and -9 percent including them. In 2020, both IPPS and OPSS payments per inpatient stay and costs per stay grew faster than in prior years, but costs grew faster than payments. Congress and CMS have authorized and enacted several hospital payment policies to increase payments for inpatient care during the PHE, including temporary suspension of Medicare sequestration, a 20 percent increase to IPPS payments for beneficiaries diagnosed with COVID-19, and new COVID-19 treatments add-on payment (NCTAP).

Mandated report on the Bipartisan Budget Act of 2018 changes

The Bipartisan Budget Act (BBA) of 2018 temporarily modified the eligibility criteria for the low-volume hospital (LVH) payment adjustment for fiscal years 2019 through 2022, mandating that hospitals with fewer 3,800 all-payer inpatient stays be eligible for the LVH adjustment. The law also required that the Commission evaluate and report on the effects of this LVH policy change. The MedPAC found that this change resulted in a 5 percent increase in low-volume hospitals from 2018 to 2021. The MedPAC also noted a 22 percent increase in annual LVH payments across 2019 and 2020 as compared to the annual average from 2010 to 2018, including a 19 percent increase from 2018 to 2019. Before and after the BBA modifications, low-volume hospitals had a higher Medicare margin but lower all-payer total margin than other hospitals. LVHs' inpatient Medicare margin was about 7 percentage points higher than other hospitals.

Chapter 4: Physician and other health professional services

***Recommendation:* For calendar year 2023, the Congress should update the 2022 Medicare payment rates for physician and other health professional services by the amount determined under current law.**

The MedPAC notes that the analysis in this chapter is based on 2020 claims data, the most recent available for review. That said, the Commission notes that it has considered the effects of the COVID-19 pandemic on its indicators and whether those effects are likely to be temporary or permanent. The MedPAC believes that the long term impacts of the pandemic vary significantly across clinicians and are therefore best addressed through targeted temporary funding policies rather than a permanent change to all clinicians' payment rates in 2023 and beyond.

The MedPAC concluded that despite the current COVID-19 public health emergency, beneficiaries' access to clinician services is comparable to prior years. This information was based on survey of Medicare beneficiaries over the age of 65 in mid-2021. It is important to note that the report states that non-elderly Medicare beneficiaries reported being less satisfied with their quality of care than elderly beneficiaries, there significant disparities in care experiences

between racial or ethnic groups and White beneficiaries, individuals with lower income had worse care experiences, few differences were noted in the care experiences between rural and urban beneficiaries, and elderly beneficiaries of different ages had comparable care experiences.

More individuals experienced problems finding a new primary care provider than a new specialist, which has been an ongoing issue for years among Medicare beneficiaries and the privately insured. The number of clinicians had been growing since 2015, but held steady in 2020, while the enrollment of Medicare beneficiaries continued to grow, increasing the ratio of clinicians to beneficiaries. The mix of clinicians also changed between 2015 to 2020, as the number of primary care physicians plateaued and the number of specialists increased steadily. From 2015 to 2019, prior to the pandemic, there had been an average 1.3 percent increase per year in the total number of clinical encounters per beneficiary. However, as a result of the pandemic, there was a sharp decline (11.1 percent) in 2020.

The Commission reports that quality of care provided by clinicians is difficult to assess, but the difficulties were exacerbated by the effects of the pandemic. The report focuses on the 2020 results for the quality measures, but they may only “reflect temporary changes in the delivery of care and data limitations unique to the PHE rather than trends in the quality of care provided to beneficiaries.” The results were not used to inform the Commission’s conclusion as to whether the overall quality has improved, worsened, or remained the same.

After growing an average 2 percent per year between 2015 to 2019, Medicare’s allowed charges (i.e., payments to providers, including beneficiary cost sharing) for clinician services per beneficiary fell by 10.6 percent in 2020 due to postponed care during the PHE. Among broad service categories, allowed charges for evaluation and management services fell 9.4 percent, while imaging services fell by 11.4 percent, major procedures fell by 9.9 percent, other procedures fell by 12 percent, tests fell by 14.1 percent, and anesthesia fell by 14.1 percent.

Medicare spending on clinician services in 2020 was \$8.7 billion lower than in 2019, but it is yet unclear whether the decline continued into 2021. With Congress’ tens of billions of dollars in support federal relief funds during the pandemic, there was a 5.4 percent growth in national spending on clinician services in 2020 (up from a 4.2 percent growth in 2019). The MedPAC estimates that clinicians received more than \$17 billion through the Provider Relief Fund and up to \$18 billion in forgiven loans through the Paycheck Protection Program in 2020 and 2021.

The MedPAC reports that median physician compensation from all payers across all specialties continued to grow in 2020, rising by 1 percent. The Commission points out that median compensation in 2020 remained much lower for primary care physicians than for many other specialists. The report states that this underscores concerns about the mispricing of fee schedule services and its impact on primary care. The sentiment is that even with the recent increase in payment for evaluation and management office/outpatient visits, more should be done to improve the fee schedule’s accuracy and increase reimbursement for primary care services.

The Medicare Access and CHIP Reauthorization Act of 2015 mandates no update for clinicians for 2023. The report states that they expect the volume and revenue to rebound to prepandemic levels or higher by 2023 as a result of the billions of dollars in relief funds provided by Congress.

Prior to the PHE, CMS paid for telehealth services under the physician fee schedule only if services were provided via two-way audio and video communication. During the PHE, CMS waived the requirement, as not all beneficiaries had the capability to participate. In the March 2021 report, the Commission presented a policy option where CMS would continue to temporarily cover some telehealth services for a limited time period (one to two years after the expiration of the PHE) if the agency determined there is potential for clinical benefit. In this time, policymakers would gather evidence on the impact of telehealth services to determine whether they should continue to pay for certain telehealth services (including audio-only communications) permanently. Since CMS is unable to use claims data to assess the impact of many audio-only telehealth services, the Commission is recommending that CMS require clinicians to use a claims modifier to identify all audio-only telehealth services. This is how audio-only telehealth services for mental health conditions and substance use disorders are currently being reported.

The Commissioner's Prior Work to Improve the Accuracy of Physician Fee Schedule Payments and Increase Payments for Primary Care

The Commission has a long-standing interest in ensuring accurate payment for primary care services such as ambulatory evaluation and management (E&M). The report states that these E&M services have been historically underpriced in the physician fee schedule and that certain other specialties are able to increase their service volumes (and payments) more easily than primary care clinicians, leading to substantial disparities in compensation. The amount of work required for a service is measured by its work relative value unit (RVU), which is based on an assessment of time and intensity relative to other services. The MedPAC states that some services such as imaging and tests may gain efficiencies over time as a result of improved technology or technique, reducing the amount of work required; however, the work RVUs for these services are not decreased. The argument made is that ambulatory E&M services do not lend themselves to efficiency gains, as they require a clinician's time. As a result of budget neutrality rules, the report states that ambulatory E&M visits have become passively devalued over time as other services become overvalued.

In 2011, the Commission recommended that Congress direct the Secretary to regularly collect data on service volume and work time from a cohort of efficient practices. These data would be used to calculate the amount of time the clinician worked in a week or month and compared to the time estimates in the physician fee schedule for the services billed by the clinician during that time period. The purpose of this analysis would be to determine whether the time estimates and RVUs in the fee schedule are accurate. Congress has not adopted this recommendation.

In 2015, the Commission recommended that Congress implement a per beneficiary payment for primary care clinicians, replacing the expired Primary Care Incentive Payment (PCIP) program, which had provided a 10 percent bonus payment on physician fee schedule payments for certain E&M visits provided by primary care clinicians. Funding for this per beneficiary payment would come from reducing payment rates in the fee schedule except for the ambulatory E&M visits, with the goal of rebalancing the fee schedule toward primary care clinicians while maintaining budget neutrality. Congress has not adopted this recommendation.

In the June 2018 Commission report to Congress, they recommended a budget-neutral approach to rebalance the physician fee schedule by increasing payment rates for ambulatory E&M services and reducing payment rates for other services. This led CMS to increase the RVUs for E&M office/outpatient visits in 2021 and to offset the increase in these rates by reducing the rates for all physician fee schedule services. Congress intervened and raised the 2021 payment rates for all fee schedule services by 3.75 percent and delaying implementation of a new add-on code for E&M office/outpatient visits for three years. Congress also increased 2022 payment rates by 3 percent; however, these increases will expire in 2023 and the rebalancing of the fee schedule will take effect.

The Commission also explored ideas to increase the number of physicians who choose to practice primary care. In the June 2019 Commission report, they suggested incentives such as a scholarship or loan repayment program for physicians who provide primary care to Medicare beneficiaries. In November 2019, other ideas such as testing alternative payment models that support primary care on a national basis instead of only in certain regions and creating new billing codes for comprehensive geriatric assessments and fall risk assessments were presented. It was also suggested exposing residents to high-functioning community-based primary care practices by, for example, requiring residency programs to have geriatric rotations could lead more residents to select primary care.

The Coronavirus Public Health Emergency and the Commission's Payment Adequacy Assessment for Physician and Other Health Professional Services

The report mentions the damaging impacts of the pandemic—the tragic effects on beneficiaries, the material effects on patient volumes, costs, and profitability, as well as the physical and mental health of the health care workforce—while stating that it is not clear when it will end. The PHE has also affected the Commission's payment adequacy factors, the most recent data being from 2020. While it is important to analyze the 2020 data to assess beneficiaries' access to care, quality of care, and Medicare's payments and providers' costs, it is more difficult to interpret than usual.

The Commission reiterates the belief that as the effects of the COVID-19 pandemic are temporary and vary significantly across clinicians, they are best addressed through targeted temporary funding policies, and that only permanent effects of the pandemic will be factored into any recommendations for changes in Medicare base payment rates.

Expansion of Telehealth During the Public Health Emergency

Telehealth coverage was expanded during the PHE, giving providers broader flexibility to furnish services to beneficiaries while decreasing risk of COVID-19 exposure. Medicare spending for telehealth grew from \$59 million in 2019 to over \$4.2 billion in 2020.

The volume of telehealth visits varied by specialty. There was mixed feelings from clinicians about telehealth—some appreciated the flexibility and convenience while others felt that better quality of care was provided in person. The report states that clinicians believe that telehealth

will remain a permanent part of the health care landscape and that a combination of in-person and telehealth services would be ideal in the future.

Quality of Care is Difficult to Assess

The difficulty in assessing quality of care was compounded by the effects of the PHE on providers and beneficiaries for 2020. The results may reflect temporary changes unique to the PHE rather than trends in quality of care.

The report includes background information about the MedPAC's 2018 recommendation that the MIPS program be eliminated and replaced with a "voluntary value program" in which clinicians would receive increases or decreases to their payment rates based on their performance on a uniform set of measures assessing outcomes, patient experience and value.

The Commission uses quality metrics that rely on risk-adjustment models that use performance from previous years to predict beneficiary risk. Since COVID-19 is a new diagnosis that is not captured in the current risk-adjustment models, the report does not draw conclusions about the overall quality of care.

Medicare Payments and Providers' Costs

The MedPAC states that overall physician compensation continued to increase despite a decline in Medicare's total allowed charges for clinician services for 2020. Median compensation in 2020 for primary care physicians was much lower than for physicians in other specialties.

In 2020, commercial payment rates for PPOs were 138 percent of Medicare FFS rates for clinician services, compared with 136 percent in 2019. The gap between private payer rates and Medicare reimbursement rates has grown in recent years. Despite this, the vast majority of clinicians continue to participate in the Medicare program. The MedPAC believes greater consolidation of physician practices and hospitals' acquisition of physician practices may be a reason for increasing private payer reimbursement rates as larger physician groups have greater leverage to negotiate higher rates.

While the MedPAC does not believe beneficiaries' access to clinician services is at risk in the near term, in the long run, if private payers do not restrain the growth in clinicians' payment rates, eventually the difference between private insurance rates and Medicare rates could grow so large that some clinicians would have an incentive to focus primarily on patients with private insurance instead of Medicare patients.

The MedPAC also analyzed physician compensation data from SullivanCotter's 2019 Physician Compensation and Productivity Survey. From 2016 to 2019, median compensation across all specialties grew at an average annual rate of 2.5 percent, then grew by 1 percent during 2020. Median compensation for primary care physicians increased by 0.8 percent, while radiology remained the same (0 percent change). Radiology was identified in the report as the specialty with the highest median compensation (\$475,000), followed by nonsurgical, procedural specialties (\$442,000), and surgical specialties (\$430,000). Median compensation for primary

care was reported at \$250,000. The report states that underpricing of ambulatory E&M services in the fee schedule contributes to the income disparity and the decline in the number of primary care physicians in the U.S.

In 2021, CMS substantially increased the work RVUs for E&M office/outpatient visits. This action was supported by the Commission as an important step toward addressing the devaluation of these services and reducing the disparity in compensation between primary care and certain specialists, which could increase the supply of primary care physicians.

Shifts in billing from freestanding offices to hospitals reduce fee schedule-allowed charges but raise overall Medicare spending

The report includes a sidebar section about shifts in billing from freestanding offices to hospitals and the overall impact on Medicare spending. In recent years, the number of services billed in hospital outpatient departments (HOPD) has been increasing while the number of services provided in freestanding offices has declined. The MedPAC estimates that in 2019, the Medicare program spent \$1.4 billion more than it would have if payment rates for E&M office/outpatient visits in HOPDs were the same as freestanding office rates. Beneficiary cost sharing is also higher in the HOPD setting.

To address this increased spending, the MedPAC has recommended adjusting payment rates in the OPSS so that Medicare pays the same amount for E/M services in the HOPD as freestanding offices.

Chapter 12: The Medicare Advantage program: status report and mandated report on dual-eligible special needs plans

This chapter provided an overview of the Medicare Advantage program and MedPAC did not include any specific recommendations to Congress.

The MedPAC provided an update on the Medicare Advantage program. MedPAC found that in 2021, 186 organizations offered 4,778 plan options to nearly 27 million enrolled beneficiaries, and MA plans were paid an estimated \$250 billion excluding part D drug payments.

Enrollment

The MedPAC found that the average Medicare beneficiary has a choice of 36 plans, and the average MA plan enrollee has access to \$2,000 in extra yearly benefits. The share of eligible Medicare beneficiaries enrolled in MA rose from 37 percent in 2018 to 46 percent in 2021; if this upward trend continues, the majority of eligible Medicare beneficiaries will be enrolled in MA by 2023.

Plan availability

The MedPAC reported that access to MA plans remains high in 2022. For 2022, the average plan is expected to provide Medicare Part A and B benefits for 15 percent less than FFS Medicare

spending, and nearly all plans are expected to provide Medicare benefits for less than the cost of FFS Medicare.

Plan payments & rebates

The PHE has had a significant impact on Medicare beneficiaries. In 2022, Medicare payments to MA plans have increased because of the expectation that deferred care would raise utilization above pre-pandemic levels. MedPAC reported that MA rebates in 2022 are a record high at \$164 per enrollee per month on average, a 17 percent increase from 2021. MedPAC used the most recent data available from 2020 to show that MA plans reported margins that averaged 6.5 percent, excluding Part D drug margins.

Mandated report: Comparing the performance of D-SNPs and other plans that serve dual-eligible beneficiaries

The Bipartisan Budget Act (BBA) of 2018 permanently authorized dual-eligible special needs plans (D-SNPs) which limit their enrollment to beneficiaries who receive both Medicare and Medicaid, with more stringent requirements beginning in 2021. The BBA also mandated that the Commission periodically compare the performance of different types of D-SNPs and other plans that serve dually enrolled beneficiaries. MedPAC found that although 94 percent of beneficiaries live in a county where at least one D-SNP is available, there is geographic variation in availability of more highly integrated plans. They also reported differences in the type of dual-eligible beneficiaries enrolled, and whether they qualified for full or partial benefits. Partial-benefit dual eligible beneficiaries tend to have somewhat better health and lower costs than full-benefit beneficiaries. MedPAC noted that there are challenges with assessing performance and measuring quality, reiterating the 2020 recommendation to enact a new MA value incentive program.

Chapter 14: Mandated report: Designing a value incentive program for post-acute care

The Consolidated Appropriations Act, 2021, requires the MedPAC Commission to report on a prototype value-based payment program under a unified prospective payment system (PPS) for post-acute care (PAC) services and analyze the impacts of the prototype's design. The PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). The MedPAC found that there is significant patient overlap between the separate settings, with each setting having its own prospective payment system.

Elements of a value incentive program for post-acute care

The MedPAC Commission presents key design elements for a PAC VIP but does not provide specific model details. The report highlights that prior to implementation of a PAC value incentive program (VIP), payment systems would need to be aligned. Table 14-10 in the March Report to Congress, summarizes the key elements of a PAC VIP that would serve as a starting point for policymakers.

The MedPAC Commission design for PAC VIP would need to adjust payments based on provider performance on a small set of measures tied to clinical outcomes, patient experience, and resource use. The MedPAC Commission also stated that policymakers would need to define the reliability standards for measure results and determine which strategies would ensure reliable results for as many providers as possible. This would require CMS to select a set of performance measures that captures differences across providers appropriately.

As discussed in previous MedPAC meetings, the report stated the PAC VIP would need use a simple scoring system but advised policymakers would need to decide whether a provider should meet a minimum performance standard before it earns performance points that translate into a reward.

The chapter highlights the need to account for differences in patients' social risk factors using a peer-grouping mechanism. This would require policymakers to define and measure patient populations' social risk to establish peer groups, as well as how many groups would be required to meaningfully differentiate providers.

Implementing a PAC VIP

Implementing a PAC VIP would involve many steps and would be a multiyear process. The first step would require first a PAC PPS be implemented and CMS would need to align regulatory requirements across the separate systems that currently exist. The MedPAC highlighted the need additional measures to accurately measure functional status and of patient experience. Additionally, there would be difficulty in developing accurate risk adjustment across the different settings. The report states CMS should test various area-level measures for their potential use in accurately accounting for differences in the social risk of individual patients.

The Commission did not make any formal recommendations but continued to build upon previous Commission recommendations on value incentive programs.