American College of Radiology™

MedPAC June 2024 Report to Congress Detailed Summary

The Medicare Payment Advisory Commission (MedPAC) released their June 2024 Report to Congress on June 13, 2024. The MedPAC is an independent congressional agency that advises the United States Congress on various issues affecting the Medicare program. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and report to the Congress. MedPAC's mission is to preserve beneficiaries' access to high-quality care, control Medicare spending growth, and provide sufficient payment for efficient providers.

Chapter 1: Approaches for updating clinician payments and incentivizing participation in alternative payment models

The MedPAC Commission considered two approaches for updating fee-for-service (FFS) Medicare's PFS payment rates to adequately for cost growth and to ensure Medicare beneficiaries maintain access to clinician services. The MedPAC expressed concerns about whether payment updates under current law will remain adequate in the future.

Payment rates are set to be flat in 2025, and, starting in 2026, payment rates 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. Further, 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, exceeding the growth in PFS payment rates. This gap could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat or stop participating in Medicare entirely. Additionally, MedPAC remains concerned about the growing differential between FFS payment rates when a service is billed in a freestanding clinician office versus a hospital outpatient department (HOPD).

MedPAC is also concerned about the upcoming sunsetting of participation bonuses for clinicians in A–APMs after 2026. To date, the A–APM participation bonus, currently set at 5 percent of a clinician's Medicare payments for fee schedule services, has always been larger than the highest adjustment available through the Merit-based Incentive Payment System (MIPS), helping to incentivize clinicians' participation in A–APMs. After 2026, A–APM participation bonuses will be eliminated in favor of the differential payment updates for clinicians depending on whether they are in an A–APM.

Alternative approaches to updating PFS payment rates

The MedPAC has considered two different approaches to update fee schedule rates based on a portion of changes in input cost inflation. One approach would be to update the practice expense portion of fee schedule payment rates by the hospital market basket,

adjusted for productivity. This approach would attempt to address current differences in updates between the PFS and the hospital outpatient prospective payment system (HOPPS). Currently, PFS payment rates are updated by statutorily specified percentages that are not linked to cost growth, while OPPS rates are updated by the hospital market basket. This approach defers consideration of automatic annual updates to the work component of fee schedule payments, but periodic updates to the work component of payments could still occur. Under this approach, services for which practice expenses represent a large share of the total payment would see larger updates compared with services for which practice expenses represent a small share of the total payment. As a result, certain specialists like radiation oncologists, vascular surgeons, interventional radiologists, and dermatologists would receive larger updates than primary care providers, behavioral health clinicians, and certain other types of specialists. MedPAC found that to it would be important to pair this update approach with efforts to revalue fee schedule services to reduce inaccuracies in payment rates.

The second approach discussed would update total fee schedule payment rates, including payments for both practice expense and clinician work, by the MEI (which includes a productivity adjustment) minus 1 percentage point. This approach could also include an update floor equal to half of MEI to avoid updates that are very low or negative. This approach would reflect the fact that PFS updates have averaged around MEI minus 1 percentage point for the previous two decades. This approach would update payment rates for all codes by the same factor in a given year, so the percentage updates would be the same across different services and specialties. To improve payment accuracy for services with high practice expenses and to limit incentives for vertical consolidation, this approach could be paired with efforts to rebase the MEI using more recent data, change the treatment of practice expenses under the fee schedule for services performed in facilities, or other reforms.

The Commission finds the features of the second approach more desirable and will continue to develop this policy option in the future.

Maintaining incentives to participate in A–APMs
Under current law, clinicians in A–APMs receive a participation bonus worth 5 percent of their Medicare payments for fee schedule services from 2019 through 2024, a bonus worth 3.5 percent of these payments in 2025, and a bonus worth 1.88 percent of these payments in 2026. The MedPAC has discussed extending the bonus as one way to incentivize clinicians to participate in A–APMs rather than the MIPS program. Ideally, the A–APM participation bonus in addition to payments received directly through an A–APM would exceed the top MIPS adjustment. The MedPAC has also discussed restructuring the A–APM participation bonus to be based on a percentage of a clinician's Medicare payments for fee schedule services for FFS Medicare beneficiaries in A–APMs. In combination with this

change, policymakers could eliminate the requirement that a certain share of a clinician's payments or patients be in an A–APM to qualify for the bonus. Restructuring the bonus in this way would allow bonus payments for clinicians who participate in A–APMs but currently fail to qualify for the bonus. The number of clinicians who qualify for the A–APM participation bonus has been increasing steadily since it first became available in 2019, but the number remains a minority of clinicians, about one in five clinicians who billed FFS Medicare received the bonus in 2023.

Chapter 2: Provider networks and prior authorization in Medicare Advantage

Provider Network Adequacy

Medicare Advantage beneficiaries receive care from "in network" providers who have agreed to furnish covered services to plan members at specific payment rates. CMS sets network adequacy standards for MA contracts and verifies contracts' compliance using a three-year review cycle. To properly assess adequacy, plans' provider directories must be accurate, yet plans have very little recourse if providers do not update their information regularly. In 2021, CMS audited about 25 percent of MA contracts, and CMS denied more than half of the subsequent requests for adequacy exceptions.

Beginning in 2024, contracts applying for new or expanded services will receive a 10% reduction in the required number of beneficiaries within travel time and distance standards in their service area. New plans can utilize letters of intent cosigned by the MA organization and provider organizations to negotiate contracts to initially demonstrate network adequacy. These new plans must then secure a signed contract by the beginning of the applicable contact year to fully comply. Also starting in 2024, plans are expected to demonstrate adequacy on the timeliness and communication competencies of providers.

Prior Authorizations

MA plans can require enrollees to obtain prior authorization to access certain services, a practice that is not used to the same degree in fee-for-service Medicare. MA plans must follow Medicare's national and local coverage policies. CMS annually audits a sample of MA denials to determine whether they were appropriate, and MA contracts are required to report the number of determinations and reconsiderations for services requested by enrollees and the outcomes of those reviews.

In 2023, nearly all MA enrollees were in plans that required prior authorization for some categories of services. In 2021, MA plans made about 37.5 million prior authorization determinations, or about 1.5 determinations per enrollee. MedPAC found that overall, 95 percent of prior authorization requests had fully favorable decisions. Although only a small percentage of requests have been denied, the Office of Inspector General (OIG) audits suggest that many denied requests should have been approved. CMS recently finalized several regulatory changes that address concerns surrounding the prior authorization

process, such as requiring more transparency around MA organizations' internal coverage criteria and better communication of rationales for denied requests.

Chapter 3: 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 provider. MedPAC finds that analyzing MA encounter data can be used to provide more rigorous oversight of Medicare's payments to MA plans, which reached $455 billion in 2023. Analyzing the encounter data ensures that MA beneficiaries receive full Medicare benefits.

Despite data completeness incrementally improving from 2017 to 2020 and 2021 data, MedPAC's findings of generally incomplete data continue to demonstrate the need for policy action to improve data collection. MedPAC assessed the variation in data completeness across and within MA contracts and found wide ranges of completeness across service sectors. The share of contracts submitting at least one record for all service categories increased from 80 percent in 2015 to 96 percent in 2020. The Commission also compared bid data with encounter data and found discrepancies between the two sources with additional analysis needed. Incomplete reporting of encounter data continues to limit their utility in monitoring, learning from, and improving the MA program.

The Commission's 2019 recommendations to Congress, which have not yet been adopted, would address the shortcomings of MA encounter data:

- Establish thresholds for the completeness and accuracy of MA encounter data
- Evaluate MA plans' submitted data and provide feedback to organizations, including comparisons to external data sources
- Apply a withhold to plan payments, which could be refunded to MA organizations that meet those thresholds
- Institute a mechanism for direct submission of provider claims to Medicare administrative contractors as a voluntary option

Chapter 4: Paying for software technologies in Medicare
In this Chapter, the MedPAC reviewed the FDA's process for clearing Software as a Medical Device (SaMD), examined Medicare's current coverage process and payments for medical device software under the payment systems for Part A and Part B services, and discussed issues that policymakers should keep in mind when considering payment for medical software in FFS Medicare.

Many types of clinical software are increasingly available to providers. These software products incorporate artificial intelligence (AI), which uses algorithms or models to

perform tasks and exhibits behaviors such as learning, making decisions, and making predictions. A subset of AI known as machine learning uses computer algorithms to learn through data to perform a task without being explicitly programmed; this type of AI has become a part of a growing number of medical devices.

MedPAC discussed software that performs functions that often categorize it as a medical device, a software that is used for one or more medical purposes that diagnose or treat an illness or injury without being part of a hardware medical device. The FDA classifies these technologies as SaMDs, for the purposes of this chapter MedPAC classifies them into two categories:

- Software as a service (SaaS), which is algorithm-driven software that is either cleared or approved by the FDA to help practitioners make clinical assessments, including decision support intervention software, clinical risk modeling, and computer-aided detection.
- Prescription digital therapeutics (PDTs), which are software products that (1) receive market authorization (i.e., are either cleared or approved) by the FDA to manage or treat an injury or disease; (2) are prescribed by clinicians; (3) are typically administered by patients on a mobile phone, tablet, smartwatch, or similar technologies; and (4) primarily use software to diagnose or treat an illness or injury.

MedPAC uses the terms SaaS and PDT when discussing issues related to Medicare's coverage and payment. One of the key issues facing the FFS Medicare program is how medical software that is generally separate from the medical device should be paid for. For the hospital inpatient and outpatient PPSs and the end-stage renal disease PPS, the MedPAC has supported larger payment bundles because they give providers flexibility in the provision of care and incentives to use the most cost-efficient methods. Conversely, paying separately for software technologies can discourage providers from demanding lower prices for AI technologies and lead to overuse. Unfortunately, for the various FFS Medicare fee schedules 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.

MedPAC will continue to deliberate on appropriate payment for software technologies under FFS Medicare.