**MedPAC March 2023 Report to Congress**

**Chapter 1: Context for Medicare payment policy**

This first chapter highlights key national trends in health care spending for the country as a whole and for the Medicare program. MedPAC highlights the issues surrounding the solvency of the Medicare Trust Fund. To keep the HI Trust Fund solvent over the next 25 years, the Medicare Trustees estimate that the Medicare payroll tax would need to be raised immediately from its current rate of 2.9 percent to 3.66 percent or Part A spending would need to be permanently reduced by 16.9 percent. Alternatively, some combination of smaller spending reductions and smaller tax increases could be pursued. One of the most powerful ways that the Medicare program can control spending growth is by setting prices.

*National health care spending has grown faster than GDP*

In 2022, national health care spending is estimated to have grown by 4.6 percent, which was driven by continued high demand for health care services and price growth caused by high inflation. By 2024, more historical spending trends are expected to return, with national health care spending growing faster than GDP.

*Medicare spending is projected to double in the next 10 years*

Over the last 10 years, spending per Medicare beneficiary has grown more slowly than spending per privately insured enrollee. Medicare’s Trustees project that Medicare spending will grow in 2023 through 2030 by more typical rates of about 6 percent to 7 percent per year. These rates will result in Medicare spending doubling over the next 10 years, rising from $875 billion in 2021 to $1.8 trillion in 2031.

The two factors driving Medicare’s spending growth are the projected increase in the number of beneficiaries, which is expected to grow by a little more than 2 percent per year, as the baby-boom generation continues to age into Medicare, and the projected increase in the volume and intensity of services delivered per beneficiary.

Medicare spending grew by a relatively modest 3.6 percent in 2020. Total Medicare spending increased in 2020, despite a decrease in spending in traditional FFS Medicare, because capitated payments to Medicare Advantage (MA) plans were set before the COVID-19 pandemic began and assumed pre-pandemic utilization trends would continue in 2020, and because rapid growth in beneficiary enrollment in these private plans continued in 2020.

Medicare spending then grew at an accelerated rate in 2021, as patients resumed care. The suspension of a 2 percent payment sequester and a temporary 3.75 percent increase to clinician payment rates also contributed to spending growth in 2021. Medicare spending is estimated to have grown at a more typical rate in 2022 (7.5 percent) as the 2 percent sequester was reinstated and patient demand for health care services eased.

*Recommendation: MedPAC did not make any formal recommendations in this chapter.*

The MedPAC June Report to Congress typically offers broad recommendations aimed at restructuring the way Medicare’s payment systems work. For example, MedPAC has recommended incorporating value-based insurance design into FFS Medicare’s benefit design and changing the formula used to set payments for MA plans.

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

As required by law, the Commission annually makes payment update recommendations for providers paid under Medicare’s traditional fee for service (FFS) payment systems. To help determine the appropriate base payment rate for a given payment system in 2024, MedPAC generally first considers whether payments are adequate for relatively efficient providers in 2023. MedPAC will also examine the most recent available data on beneficiaries’ access to care, the quality of care, and providers’ access to capital. Lastly, they consider anticipated policy and cost changes to project Medicare payments and providers’ costs for 2023.

*Beneficiaries’ access to care*

The first part of the Commission’s approach to developing payment updates is to assess the adequacy of current Medicare payments. Access to care is an important indicator of the willingness of providers to serve Medicare beneficiaries and the adequacy of Medicare payments. In March and April 2020, the MedPAC found that many elective procedures were delayed or canceled, and many beneficiaries chose not to visit providers’ offices and health care facilities because of the risk of contracting COVID-19.

*Quality of Care*

Medicare payment systems created little or no incentive for providers to spend additional resources on improving quality. MedPAC cannot draw conclusions about the relationship of quality measures to Medicare payment adequacy because the indicators reflect circumstances unique to the PHE.

*Providers’ access to capital*

Widespread ability to access capital throughout a sector may reflect the adequacy of Medicare payments. One indicator of a sector’s access to capital is its all-payer profitability, reflecting income from all sources.

*Considering anticipated payment and cost changes in 2023*

The Commission’s payment update recommendations for 2024 reflect the most recent inflation and other data from 2021, preliminary data from 2022, and projections for 2023.

*Recommending how Medicare payments should change in 2024*

In considering updates, the Commission makes its recommendations for 2024 relative to the 2023 base payment as defined in Medicare’s authorizing statute. The Commission takes into consideration payment differentials across sectors and make sure the relative update recommendations for the sectors do not exacerbate existing incentives for providers to choose a site of care based on payment considerations. The difficulty of harmonizing payments across sectors to remove inappropriate incentives illustrates one weakness of FFS payment systems specific to each provider type and highlights the importance of moving beyond FFS to more global and patient-centric payment systems.

*Consistent payment for the same service across settings*

The report highlighted MedPAC’s view that Medicare should pay the same amount for the same service, even when it is provided in different settings. Since, Medicare’s payment systems were developed independently and have had different update methodologies, payments for similar services can vary.

MedPAC continues to look for opportunities to develop policies that create incentives for providing high-quality care efficiently across providers and over time.

**Chapter 3: Hospital inpatient and outpatient services**

*Recommendation:* ***For fiscal year 2024, the Congress should update the 2023 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent.***The current-law updates to payment rates for 2024 will not be finalized until summer 2023. CMS’s third-quarter 2022 forecasts would result in the IPPS operating base payment rate and OPPS base rate increasing by 2.9 percent and the IPPS capital base payment rate increasing by 2.4 percent.

The MedPAC provided an update of hospital inpatient and outpatient services using the most recent inflation and other data from 2021, preliminary data from 2022, and projections for 2023. In 2021, the FFS Medicare program and its beneficiaries paid general acute care hospitals $182.5 billion for inpatient and outpatient services under the IPPS and OPPS, including $8.3 billion in uncompensated care payments and $16.4 billion for separately payable drugs. In 2021, most of the hospital payment adequacy indicators remained positive or improved, although substantial variation continues across hospitals. In 2022, input cost increases for hospitals were higher and more volatile than in recent years.

*Beneficiaries’ access to care*

MedPAC found that beneficiaries maintained good access to hospital inpatient and outpatient services, but some hospitals faced occupancy and staffing constraints. An equal amount of acute care hospitals opened and closed in both fiscal years 2021 and 2022. The number of hospitals opening was steadier from 2017 through 2022, ranging from 8 to 18 openings. The number of closures was substantially below the levels in 2019 (46) and 2020 (25) and comparable with levels in 2017 and 2018. Rural hospitals often face the greatest challenges with declining admissions, in part due to rural beneficiaries increasingly bypassing their local hospitals to seek care at urban hospitals. However, as the Rural Emergency Hospital (REH) designation began on January 1, 2023, some rural hospitals in financial distress may choose to convert to REHs rather than cease providing all services.

*Quality of care*

MedPAC stated that the quality of care was mixed relative to 2019. The trend analysis excludes 2020 quality characteristics due to results reflecting temporary changes caused by the COVID-19 pandemic. Fee-for-service beneficiaries’ risk adjusted hospital mortality rate increased due do deaths from COVID-19. Fee-for-service beneficiaries’ risk adjusted hospital readmission rate improved. MedPAC reported that patient experience results remained high, but most declined by 1-4 percentage points across the surveyed categories.

*Providers’ access to capital*

MedPAC reports a record high all-payer operating margin for IPPS hospitals of 8.7 percent in 2021. There was substantial variation in margins across hospitals. Preliminary 2022 all-payer operating margin data were mixed relative to pre-pandemic levels, but most hospitals continued to have strong access to bond markets.

*Medicare payments and providers’ costs*

From 2020 to 2021, IPPS hospitals’ Medicare margin increased, with the median Medicare margin among relatively efficient hospitals becoming positive when including Medicare’s share of federal relief funds and increasing from negative to break-even when excluding these funds. IPPS hospitals’ Medicare margin increased in 2021 to -6.2% including federal relief funds and -8.3% excluding federal relief funds. The median Medicare margin for relatively efficient hospitals increased to 1 percent, which is near break-even exclusive of federal relief funds. MedPAC projects that hospitals’ Medicare margins in 2023 will be lower than in 2021, in part due to growth in hospitals’ input costs exceeding CMS forecasts used to set Medicare payment rate updates as well as the expected expiration of PHE payment changes and funds. MedPAC anticipates the reduction in net revenue to be partially offset by reductions in hospitals’ costs related to COVID-19 and the statutory 0.5 percent increase to inpatient operating payments. The IPPS hospitals’ Medicare margin is estimated to decrease in 2023 to -10 percent and that the median Medicare margin for relatively efficient hospitals will decrease to modestly below break-even, similar to pre-pandemic levels.

*Supporting Medicare safety-net hospitals*

The recommended update to IPPS and OPPS payment rates of current law plus 1 percent may not be sufficient to ensure the financial viability of some Medicare safety-net hospitals with a poor payer mix. Medicare already provides substantial safety-net funding to hospitals, but there are several problems with the way Medicare distributes these funds, including omitting a hospital’s Medicare share from its funding formulas in favor of subsidizing Medicaid payments, making supplemental payments only for inpatient services, and having an uncompensated care payment formula that favors hospitals with few FFS Medicare patients.

*Recommendation: In fiscal year 2024, the Congress should:*

* ***Begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI);***
* *Add $2 billion to the MSNI pool;*
* *Scale fee-for-service MSNI payments in proportion to each hospital’s MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and*
* *Pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.*

While most hospitals will see increases in Medicare revenue from the proposed additional $2 billion in Medicare safety-net spending, there are some hospitals that will see reductions. Material reductions could occur for hospitals that currently receive high Medicare uncompensated care payments but serve relatively few FFS Medicare patients. To mitigate this, the Congress could phase in the policy for all hospitals over a set period of time. Alternatively, a stop-loss policy could be implemented so that no hospital would experience changes (positive or negative) in Medicare payments of more than 5 percent in any one year due to the transition to the MSNI. Both approaches would also allow time for the hospitals facing the most substantial revenue reductions to try to augment revenues from existing sources and request additional financial support from state and local governments, as warranted. To the extent that these hospitals have high-cost structures, a transition also would allow time to improve efficiencies.

**Chapter 4: Physician and other health professional services**

*Recommendation:* For calendar year 2024, the Congress should update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the Medicare Economic Index.

*Recommendation*: The Congress should enact a non-budget-neutral add-on payment, not subject to beneficiary cost sharing, under the physician fee schedule for services provided to low-income Medicare beneficiaries. These add-on payments should equal a clinician’s allowed charges for these beneficiaries multiplied by:

* 15 percent for primary care clinicians and
* 5 percent for non–primary care clinicians.

*Overall Trends and Patient Access*

In this Chapter, MedPAC recognized that in 2021 and 2022, most physician payment adequacy indicators remained positive or improved, but clinicians’ input costs grew at rates not seen for many years. Results of the Commission’s annual survey showed that Medicare beneficiaries generally report better access to clinician services than privately insured individuals. The report also stated that the over the last several years, there has been a rapid increase in the number of advanced practice registered nurses and physician assistants as well as an increase in the number of specialists, but a decline in the number of primary care physicians. Patients in the survey report more problems obtaining a new primary care physician than a new specialist.

The number of clinician encounters did not return to pre-pandemic levels in 2021, but average spending per beneficiary in 2021 was higher than 2019. Between 2019 and 2021, allowed charges per beneficiary increased by 6.1% for evaluation and management (E&M) services and 4.8% for treatments, but decreased by 10.3% for tests, 7.3% for anesthesia services, 6.9% for major procedures, 2.4% for imaging services and 1.5% for other procedures. The change in total spending per unit between 2019 and 2021 was largely attributed to E&M services which grew by 10.3% whereas changes per unit of service in other service categories experienced small growth or declined in 2021. This E&M increase was largely due to increases in Medicare payment rates for a small number of E&M services that account for a large portion of spending. These increases in valuation for E&M services were offset by reducing rates for all fee schedule services, which at least partly explains the reductions in spending per unit of service for other services.

*Physician Compensation*

MedPAC reported that as in previous years, compensation for primary care physicians remained much lower than for specialists in 2021. The report specifically lists radiology as the specialty with the highest median compensation ($482,000), followed by nonsurgical, procedural specialties ($441,000) and surgical specialties ($441,000). Median compensation for primary care physicians was $264,000.

MedPAC examined the relationship between compensation and practice ownership due to the growth in hospital employment of physicians, but did not find a consistent relationship between practice ownership and compensation. Variations in compensation depended more on the compensation method (e.g. salaried vs. productivity-based compensation).

*Input Costs for Clinicians*

The Medicare Economic Index (MEI) measures the average annual price change for the market basket of inputs used by clinicians to furnish services, after adjusting for economy-wide productivity. The MEI includes physician compensation and physicians’ practice expenses (e.g. non-physician staff compensation, rent, equipment and professional liability insurance). CMS recently updated the MEI’s cost categories using data on physician offices from 2017 from the Census Bureau’s Services Annual Survey and data from other sources. Between 2010 and 2022, the MEI increased by 23%, well above the 6% cumulative increase in annual updates to physician fee schedule payment rates while volume and intensity of clinician services delivered each year has increased.

CMS projects continued high growth in clinicians’ input costs in the next few years, with the MEI currently projected to grow by 3.9% in 2023 and by 2.9% in 2024. Therefore, MedPAC recommended that for calendar year 2024, the Congress should update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the Medicare Economic Index. The report indicated that the Commission was concerned that clinicians may not be able to absorb the projected cost increases at current payment levels. The Commission acknowledged that the Consolidated Appropriations Act, 2023 provides a temporary increase to base payment rates of 1.25 percent in 2024, which will expire after 2024. The Commission’s recommendation is a permanent update that would be built into subsequent years’ payment rates as opposed to a temporary update.

*Supporting Medicare Safety-net Clinicians*

The Commission has undertaken a body of work to examine safety-net providers and develop ways that the Medicare program can best support their mission. The MedPAC identified safety-net providers as those that disproportionately serve (1) low-income Medicare beneficiaries who are less profitable to care for than the average beneficiary, or (2) uninsured patients or patients with public insurance who are not materially profitable to treat. The combination of lower revenues and potentially higher treatment costs can put a financial strain on safety-net clinicians and make it more difficult for low-income beneficiaries to access needed care.

MedPAC found that certain clinicians treat a large share of low-income beneficiaries. For example, nurse practitioners (NPs) highest share of allowed charges associated with LIS beneficiaries. The share of specialist physicians’ allowed charges associated with LIS beneficiaries varied substantially among specialists. Among the top 20 specialist physician specialties, nephrologists had the highest share with 49 percent, and dermatologists had the lowest share with 6 percent.

A new Medicare safety-net add-on payment for clinicians treating beneficiaries with low incomes. Given that lower revenues and potentially higher treatment costs may create financial strain on clinicians who care for beneficiaries with low incomes and may make it difficult for such beneficiaries to access needed care, the MedPAC Commission supports instituting a new Medicare safety-net (MSN) add-on payment for clinicians who treat LIS beneficiaries. The Commission states that clinicians should receive add-on payments based on a percentage of allowed charges for physician fee schedule services furnished to LIS beneficiaries. The Commission supports options that would provide a higher add-on percentage for services furnished by primary care clinicians than for services furnished by non–primary care clinicians. For primary care clinicians the add-on should equal 15 percent of fee schedule–allowed charges for

LIS beneficiaries, while the add-on for other clinicians should equal 5 percent of allowed charges.

**Chapter 11: The Medicare Advantage program: Status report**

In 2022, the Medicare Advantage (MA) program included 5,261 plan options offered by 182 organizations, enrolled about 29 million beneficiaries, and paid MA plans $403 billion (excluding part D drug payments). The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program. MedPAC believes that beneficiaries should be able to choose among Medicare coverage options since some may prefer to avoid the constraints of provider networks and utilization management by enrolling in the traditional FFS Medicare program, while others may prefer to seek the additional benefits and alternative delivery systems that private plans provide.

*Enrollment, plan offerings, and extra benefits*

Substantial growth in MA plan enrollment, availability, and rebates indicates an increasingly robust MA program. Enrollment in MA has more than doubled since 2013. As of 2022, 49 percent of eligible Medicare beneficiaries are now in MA plans, and all indications suggest that the majority of those eligible will be enrolled in MA in 2023. For 2023, the average beneficiary has access to 41 plans sponsored by 8 organizations, and rebates that finance extra benefits are the highest in the program’s history. The average MA plan enrollee has access to over $2,350 in extra benefits annually that FFS enrollees cannot access without purchasing additional health insurance coverage or paying for the services on an out-of-pocket basis.

*Medicare payments to plans*

The growth and availability of MA plans has occurred without overall savings to the Medicare program. Total Medicare payments to MA plans in 2023 (including rebates that finance extra benefits) are projected to be $27 billion higher than if MA enrollees were enrolled in FFS Medicare. Payments to MA plans (including the impact of coding intensity but ignoring any favorable selection) average an estimated 106 percent of projected FFS spending. MA benchmarks, the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits, continue to be well above projected FFS spending levels. In 2023, MA benchmarks averaged an estimated 109 percent of projected FFS spending (including quality bonuses but not accounting for MA coding), 1 percentage point above the level in 2022. Bids fell to a record low of 83 percent of projected FFS spending.

*Risk adjustment and coding intensity*

Medicare payments to MA plans are specific to each enrollee, based on a plan’s payment rate and an enrollee’s risk score. MA plans have a financial incentive to ensure that their providers record all possible diagnoses because those diagnoses raise an enrollee’s risk score and result in higher payments to the plan. By law, CMS reduces MA risk scores across the board to make them more consistent with FFS coding. In 2021, the adjustment reduced MA risk scores by 5.9 percent, resulting in MA risk scores that were still about 4.9 percent higher than they would have been if MA enrollees had been treated in FFS Medicare. In 2021, those higher scores resulted in $17 billion in excess payments to MA plans, and MedPAC projects that the amount will reach $23 billion in 2023 (if MA coding remained the same as in 2021). The Commission continues to find that coding intensity varies significantly across MA plans and that increasing diagnostic coding allows some plans to offer more extra benefits, thereby attracting more enrollees and undermining plan incentives to improve quality and reduce costs.

The Commission previously recommended changes to MA risk adjustment that would exclude diagnoses collected from health risk assessments (which currently rely on unverified enrollee-reported data), use two years of diagnostic data, and apply an adjustment to eliminate any residual impact of coding intensity. The Commission reports that nearly two-thirds of MA coding intensity could be due to use of diagnoses from chart reviews and health risk assessments, and that these two mechanisms are a primary factor driving coding differences among MA plans. These recommendations have not been incorporated.

*Quality in MA*

The current state of quality bonus program (QBP) reporting in MA is such that the Commission can no longer provide an accurate description of the quality of care across MA plans. Under the coronavirus PHE, CMS relaxed quality reporting rules for 2020, boosting 2022 star ratings for many plans and generating a windfall for some plans. Star ratings subsequently dropped in 2023 when quality reporting returned to pre-PHE rules. Also, beneficiaries lack good information on the quality of care provided by MA plans in their local market, limiting their ability to make informed choices among plans. Beneficiaries enrolled in MA do not know how their plan’s quality compares with quality in FFS Medicare. Findings are sufficiently mixed on patient experience and outcomes that the Commission cannot conclude that MA plans systematically provide better quality over FFS.

*Mandated Report on MA*

The Consolidated Appropriations Act of 2023 mandated that the Commission submit a report that compares MA and FFS per enrollee spending for at least the last five years for which data are available. The Act specified that the Commission’s analysis use the FFS spending method used to calculate MA benchmarks and to compare MA payments with beneficiaries enrolled in both Part A and Part B. The Commission used their long-standing prospective method of comparing MA payments with FFS spending from 2004 through 2023 and supplement this analysis with a retrospective method using the available data on actual MA payments and FFS spending (both claims and nonclaims payments) from 2016 through 2019. Their prospective and retrospective methods yielded very similar results: both found that MA payments were higher than FFS spending from 2016 through 2019. It is noted that these analyses for the year 2020 would not yield similar results because CMS’s projection of FFS spending, MA bids and risk score projections were overestimated during the first year of the coronavirus pandemic.