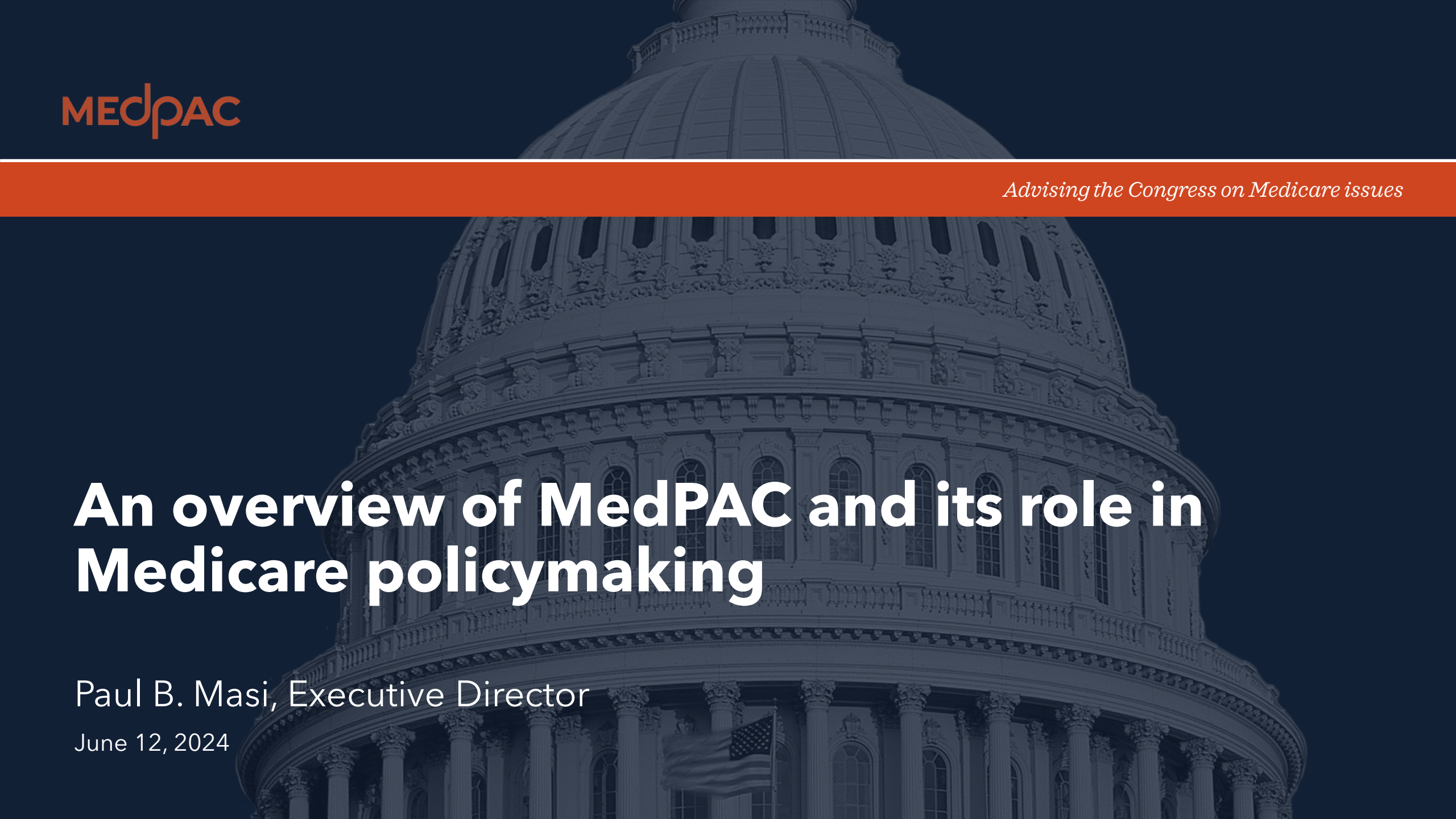


MEDPAC

Advising the Congress on Medicare issues

An overview of MedPAC and its role in Medicare policymaking

Paul B. Masi, Executive Director

June 12, 2024

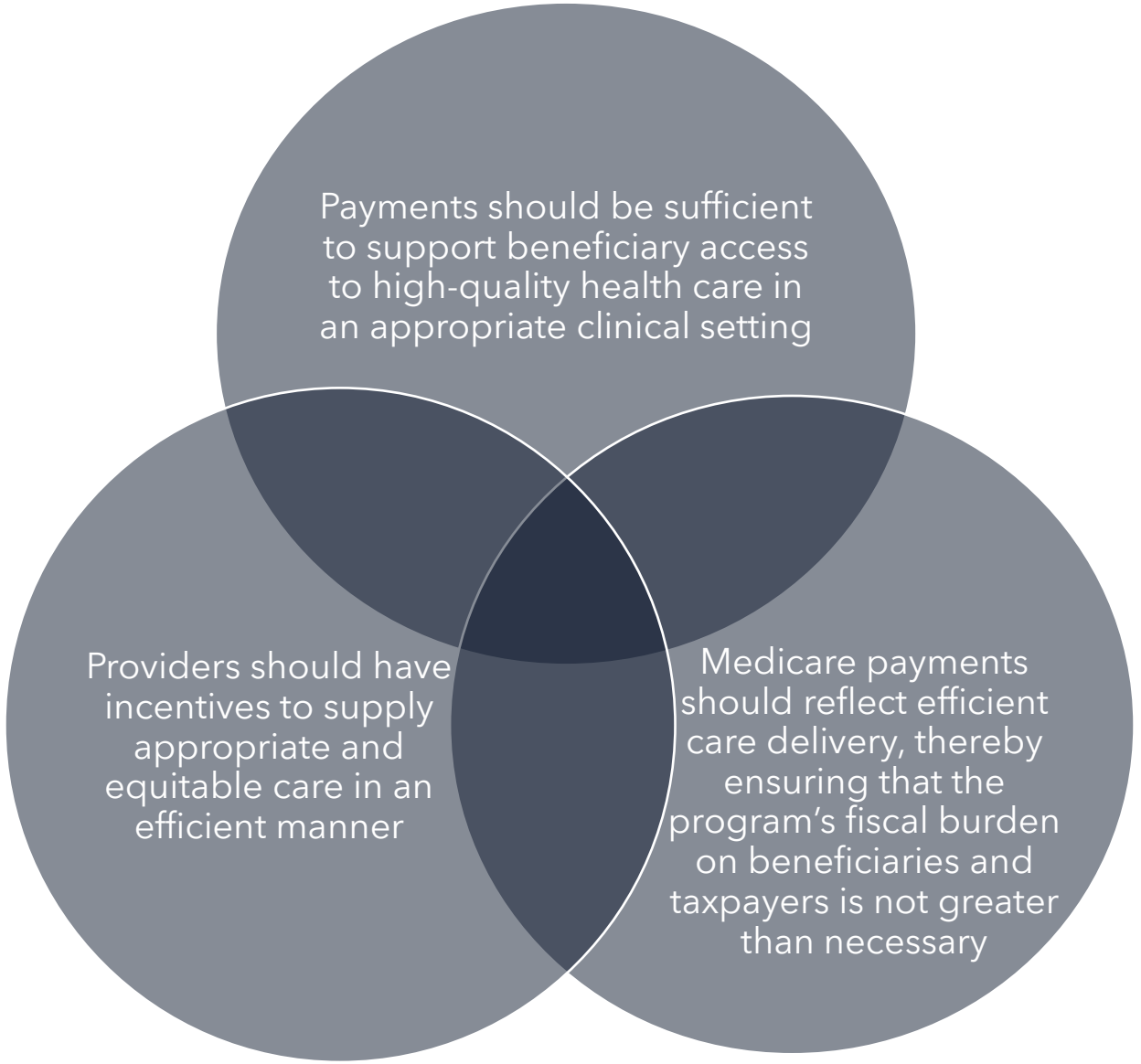
MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- 17 Commissioners selected by the Comptroller General of the Government Accountability Office (GAO) for experience and subject matter expertise
  - Include providers, payers, researchers, beneficiary-focused individuals
  - Serve 3-year terms, can be reappointed
- Commissioners supported by 25-30 analysts; most staff analysts are experts in their fields
- Seven public meetings during the year
  - Staff present analyses informed by site visits, focus groups with beneficiaries and providers, expert panels, input from stakeholders, quantitative analyses

Transparency in MedPAC's work

- Commission meetings are open to the public and webcast
- Full meeting transcript publicly available on MedPAC's website
- Presentations are available through webcast and MedPAC's website
- Public comments are disseminated to commissioners and available on MedPAC's website
- Other publications on MedPAC's website include reports, comment letters, testimony, press releases, data books, payment basics, contractor reports, and recommendations
- Publish analytic agenda for the upcoming year

MedPAC's principles of Medicare payment



MedPAC's annual agenda is determined by multiple factors

- Statutory requirements
- Congressional interest (formally or informally)
- Commissioner interest (in consultation with the Chair)
- Staff

MedPAC staff meet with a variety of stakeholders

- Staff take most meeting requests
- Important part of what we do:
  - Critical to understand real-world policy implications
  - Prior to making recommendations, important to recognize a broad perspective
- Stakeholder meetings provide staff with:
  - Data
  - Understanding of stakeholder's experience
  - Policy perspectives

How MedPAC assesses payment adequacy for fee-for-service providers

MedPAC's annual analysis of the adequacy of FFS Medicare's payments

- By statute, required to make recommendations each year in our March report focused on **fee-for-service (FFS) Medicare.**
- Principles:
  - Payments should be sufficient to support beneficiary access to high-quality care
  - Providers should have incentives to supply appropriate care
  - Good stewards of taxpayer dollars
- Framework
  - Access to care (e.g., utilization, survey results, focus groups)
  - Quality of care (e.g., quality indicators)
  - Access to capital (e.g., financial statements)
  - Medicare payments and costs (e.g., margins, where feasible)

Recommendation is not formulaic, different factors matter more (or less) across sectors

Note: MedPAC publications are the definitive reference source for all analyses and results.

Summary of hospital payment adequacy indicators, 2022

Beneficiaries' access to care

- Number of inpatient beds steady at ~650,000
- 67% of all inpatient beds occupied, in aggregate
- Volume declines reflect shifts in care
- 2022 FFS Medicare marginal profit: 5%

Mostly positive

Quality of care

- FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved
- FFS beneficiaries' risk-adjusted hospital readmission rate improved
- Patient experience measures declined

Mixed

Access to capital

- Demand for hospital bonds remained strong
- 2022 all-payer operating margin: 2.7%
- Rating agencies have mixed outlooks for nonprofits in 2024

Mixed

FFS Medicare payments and costs

- 2022 FFS Medicare margin: -11.6%
- 2022 FFS Medicare margin for relatively efficient hospitals: ~-2%
- Projected margin to increase in 2024 due to one-time $9 billion 340B remedy payments

Mostly negative

Based on our payment adequacy analysis, in March 2024, the Commission recommended:

For fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amounts specified in current law plus 1.5 percent.

In addition, the Congress should:

- begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI)
- add $4 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
- pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks

Note: MedPAC publications are the definitive reference source for all analyses and results.
Source: MedPAC March 2024 Report to the Congress.

Trends in Medicare inpatient psychiatric services

Declining IPF use by Medicare FFS beneficiaries but longer lengths of stay

	Average annual change	
	2017-2019	2019-2021
IPF stays per 1,000 FFS beneficiaries	-5.7%	-15.4%
Medicare spending (in billions)	-4.4%	-12.2%
Average length of stay (in days)	1.4%	4.6%
Medicare payment per stay	2.2%	7.5%

- IPF interviewees consistently noted that the lack of appropriate discharge options led to prolonged lengths of stay

Note: Note: IPF (inpatient psychiatric facility), FFS (fee-for-service.
Source: MedPAC analysis of FFS claims data from CMS.

By law, treatment in freestanding IPFs is subject to a lifetime limit of 190 days

- Enacted in 1965 when IPF care was mostly provided by state-run freestanding facilities
  - Limit does not apply to hospital-based IPFs (60% of IPF stays) or general acute care hospitals
- Nearly 50,000 beneficiaries were near or had reached the 190-day limit in 2022
- 1,100 beneficiaries reached the limit between 2022 and 2023 (data not shown)

Number of Medicare beneficiaries who reached or neared the lifetime limit, 2022

	Reached limit	Within 15 days of limit	Total
FFS	24,470	5,930	30,400
MA	12,780	3,990	16,770
Total	37,250	9,920	47,170

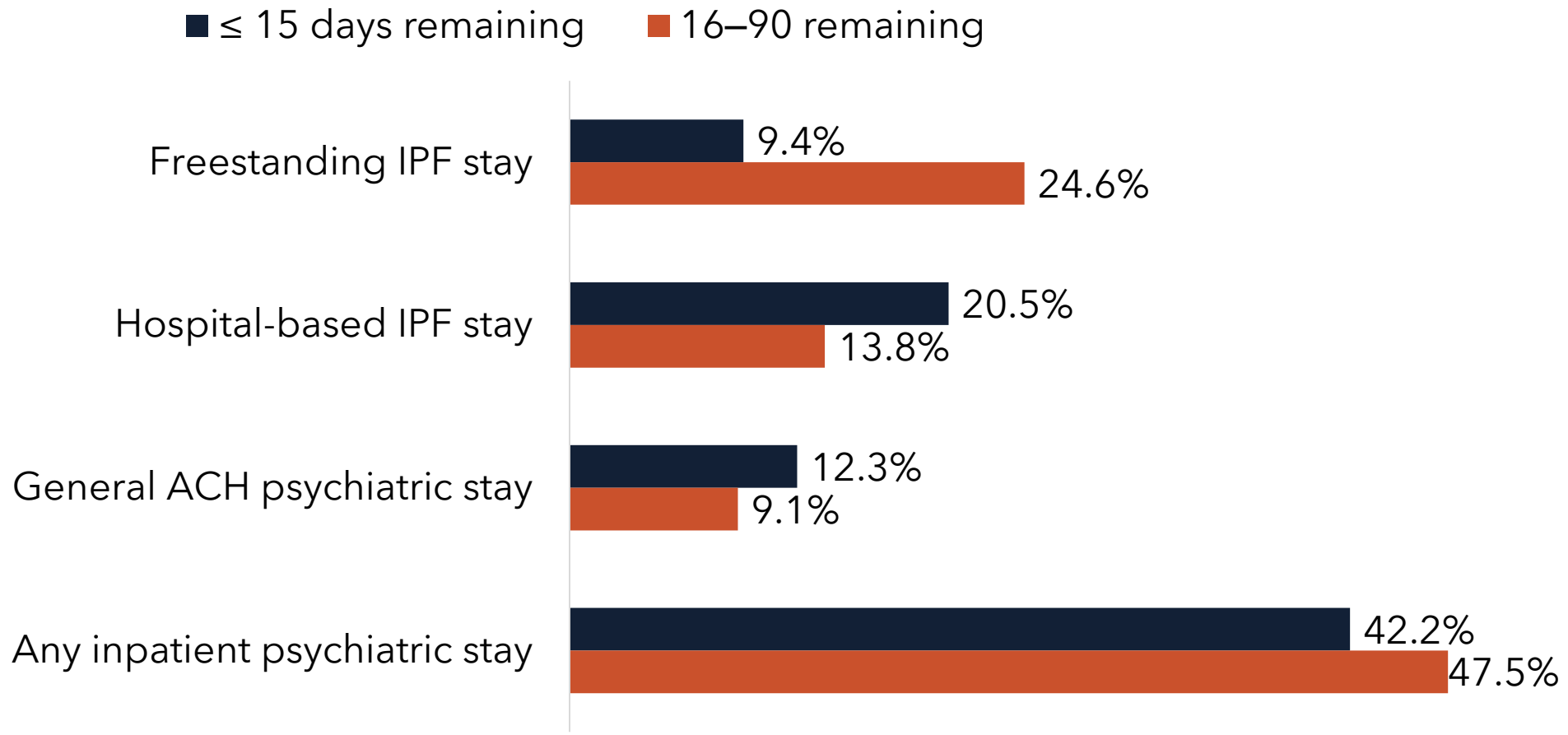
Note: IPFs (inpatient psychiatric facilities), FFS (fee-for-service), MA (Medicare Advantage).
Source: Medicare enrollment data from CMS for 2022 and 2023.

Beneficiaries who exhaust the 190 days may have some additional coverage through MA or Medicaid

- Over 400 MA plans (9% of all plans) offered additional IPF coverage as a supplemental benefit in 2022
  - 3.6% of MA enrollees who neared or reached the limit were in these plans
- Limited Medicaid IPF coverage for adults younger than age 65 (the "IMD exclusion")
  - 54% of Medicare beneficiaries who neared or reached the limit were dually eligible and under age 65
  - Many states use Section 1115 waivers and other exceptions to provide coverage

Note: MA (Medicare Advantage), IPF (inpatient psychiatric facility), IMD (Institutions for Mental Diseases). The "IMD exclusion" refers to the prohibition of matching federal funds for Medicaid payment of inpatient treatment for individuals aged 21 to 64 in an IMD. IMDs are hospitals, nursing facilities, or other institutions with more than 16 beds primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. "Section 1115 waivers," which must be approved by CMS, enable states to conduct demonstrations or pilot projects that improve programs for Medicaid populations.
Source: MA plan benefit package data from 2022; Congressional Budget Office. (2023). *Budgetary Effects of Policies to Modify or Eliminate Medicaid's Institutions for Mental Diseases Exclusion; KFF "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State",* 2024.

FFS beneficiaries at or nearing the limit were less likely to have a Medicare-covered inpatient psychiatric stay, 2022

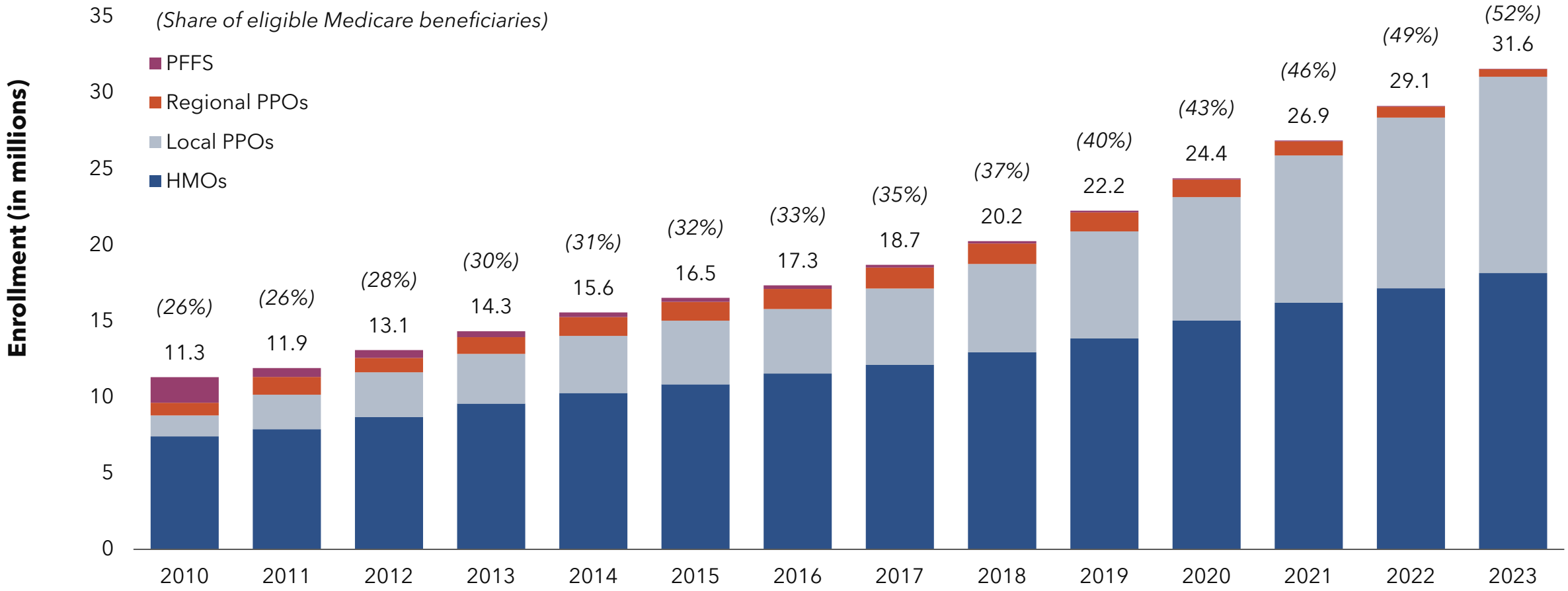


Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), ACH (acute care hospital). Psychiatric lifetime days remaining were calculated as of June 2022. Psychiatric stays in a general ACH hospital (scatter-bed stay) were defined as a hospital stay paid under the IPPS or a critical access hospital with a diagnostic-related group (DRG) falling in major diagnostic category (MDC) 19 (mental diseases & disorders). Stays in freestanding and hospital-based IPFs also included only stays with a DRG in MDC 19. All differences were statistically significantly different from each other at the 1% level.

Source: MedPAC analysis of enrollment and Medicare Provider Analysis and Review data from CMS for 2017 to 2022.

The Medicare Advantage program

Since 2010, MA enrollment has grown substantially



Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

Source: MedPAC analysis of CMS enrollment files, July 2010–2023.

MA plans typically have flexibility to use tools like provider networks and prior authorization

- Tools such as provider networks and prior authorization can be used to coordinate and manage care and control service use
- MA plans must:
  - Abide by network adequacy standards
  - Maintain directories of in-network providers
- Networks and prior authorization
  - Have potential to promote more efficient care, including quality
  - However, the misapplication of these tools could lead to delay or denial of needed care
  - Increase burden on providers
- Commissioners discussed provider networks and prior authorization during MedPAC's November 2023 public meeting
  - Expected publication in forthcoming June 2024 report to the Congress

Note: MA (Medicare Advantage), FFS (fee-for-service).

MA network adequacy requirements

- CMS assesses MA network adequacy for 29 provider types and 13 facility types
  - Networks are assessed at the county level, and standards vary by population
  - MA plans must ensure a minimum number of in-network providers are within specified time and distance from beneficiaries
- CMS recently changed network adequacy standards
  - Relaxed standards to encourage entry of MA plans in rural areas
  - Modified standards for certain specialties
  - Strengthened requirements for timeliness and range of services
  - Two additional provider types (2024) and a new facility type (2025)

Note: MA (Medicare Advantage).

MA plans are permitted to use prior authorization (PA) for certain services

- PA has been identified as a major source of administrative burden for many providers
- MA plans most often require PA for highest-cost services such as Part B drugs, skilled nursing facility stays, acute inpatient hospital stays
- Use of PA by MA plans increased from 2009 to 2019 for most service categories
- Nearly all MA enrollees are in plans that require PA for some services
- In 2021, MA plans approved the majority of PA requests (95%) and reconsideration requests (80%)

Note: MA (Medicare Advantage).
Source: Neprash, H.T., J.F., Mulcahy, and E. Golberstein. 2024. The extent and growth of prior authorization in Medicare Advantage. American Journal of Managed Care 30, no.3 (March 1): e85-e92. Ochieng, N., J. Fuglesten Biniek, M. Freed, et al. 2023. Medicare Advantage in 2023: *Premiums, out-of-pocket limits, cost sharing, supplemental benefits, prior authorization, and Star ratings*. Washington, DC: Kaiser Family Foundation. MedPAC analysis of determinations and reconsiderations: Part C data from the CMS Part C and Part D reporting requirements public use file for contract year 2021.

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Discussion

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