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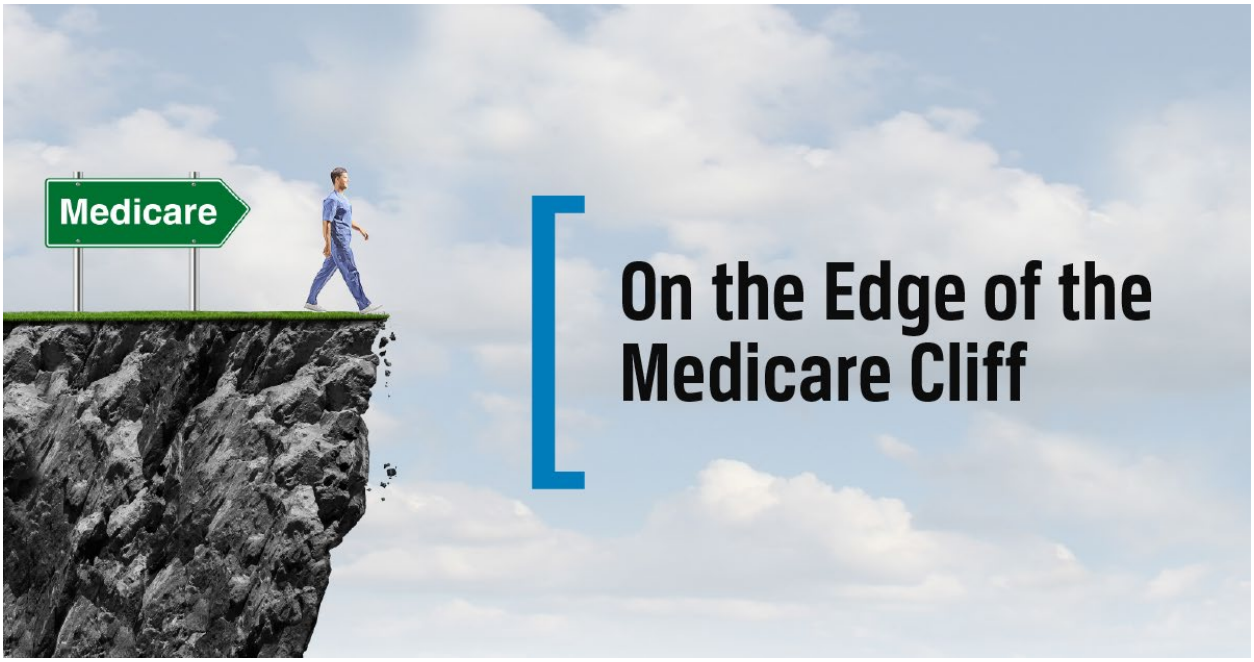


The annual Medicare Trustee report (Trustee Report) was recently released by the U.S. Department of Treasury, Department of Health and Human Services, and Department of Labor. The report paints a dire picture of the sustainability of the Medicare programs as currently structured. What does that mean for retirees and the healthcare providers who serve them? Is Medicare reimbursement at risk if this critical Federal program is running out of money in the near future? How would that impact access to care for this patient population?

Medicare

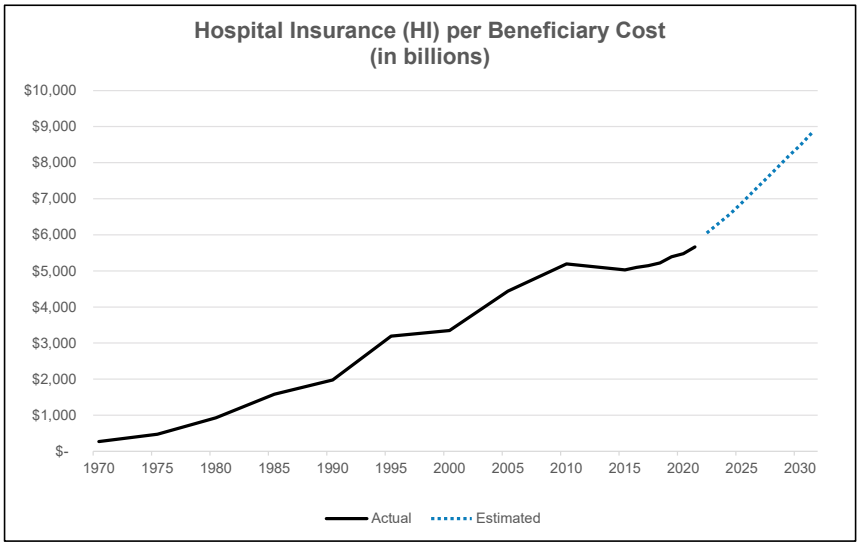
As background, Medicare is funded by two trust funds:

- **Hospital Insurance (HI) Trust Fund** – This fund, commonly known as Medicare Part A, provides payments related to inpatient hospital services as well as hospice, skilled nursing facility (SNF), and home health services that are provided to Medicare beneficiaries after they are discharged from hospitals.
- **Supplementary Medical Insurance (SMI) Trust Fund** – This fund, commonly known as Medicare Part B, provides payments related to services rendered by physicians, as well as outpatient hospital, home health, and other services provided to Medicare beneficiaries who have chosen to enroll in the program.

While there is always uncertainty in predicting annual revenue and expenditures for the Medicare trust funds, the COVID-19 pandemic has made it even more difficult to estimate future activity. For example, healthcare spending for services unrelated to COVID actually decreased during COVID case surges in 2020 and 2021, as patients curtailed preventive and elective services. At the same time, COVID-related costs, including testing, treatment, and vaccination, were significant. Additionally, the Medicare Accelerated and Advance Payments Program was expanded dramatically during the pandemic to aid healthcare providers as they dealt with a disrupted cash flow stream while still needing to maintain capacity to provide

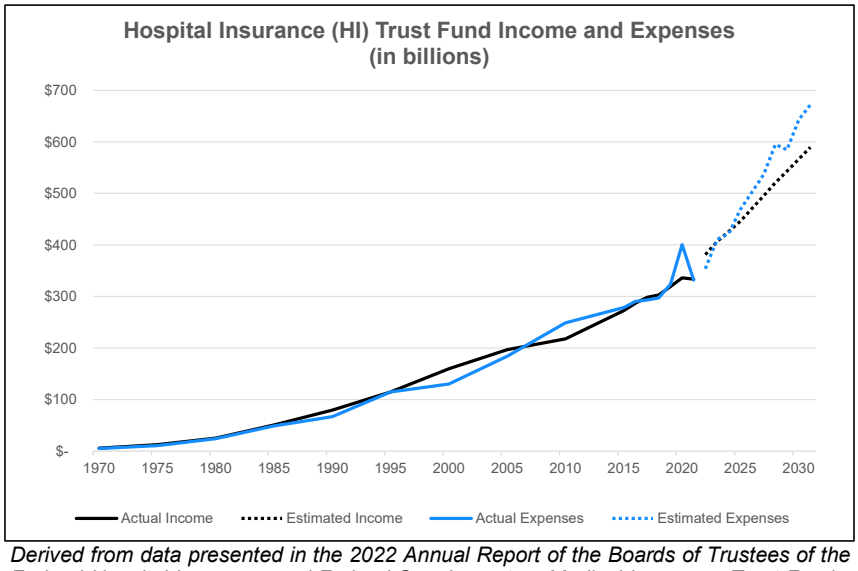
healthcare services to patients. These payments, which totaled over $107 billion[i], resulted in an unusually high cash outflow in 2020. However, the amounts are being recouped over time, reducing the cash outflow for subsequent Medicare claims. The analysis in the Trustee Report assumes that all accelerated and advance payments will be fully recouped by September 2022, meaning a more typical level of cash outflows will be present in 2023 and beyond. Of course, typical uncertainties such as how scientific and technological developments will impact healthcare costs in the future still remain.

One thing we know for certain is that the expenditures per beneficiary have been steadily increasing, as illustrated in the chart below:



Derived from data presented in the 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table V.D1. – HI and SMI Average Incurred per Beneficiary Cost.[ii]

The Trustee Report concludes that the HI trust fund will be depleted in 2028. While this is two years beyond the depletion date estimated in the prior year report, it's still only a few years away. Though the Trustees expect a surplus in 2022 as a result of continued recoupment of accelerated and advanced payments, the fund is expected to operate at a deficit in all future years until funds become fully depleted, as illustrated below:



Derived from data presented in the 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table V.H5. - Operations of the HI Trust Fund during Fiscal years 1970–2031.[iii]

Current law requires that when the HI fund is depleted, "payments would be reduced to levels that could be covered by incoming tax and premium revenues."[iv] Assets in the HI trust fund have fallen below the recommended level of 100% of expected annual expenditures every year since 2003.

The SMI trust fund, however, is expected to remain solvent "over the next 10 years and beyond because income from premiums and general revenue for Parts B and D are reset each year to cover expected costs and ensure a reserve for Part B contingencies."[v]

Interestingly, the Trustee Report notes challenges in sustainability even aside from any reductions in Medicare payments that might occur as a result of the trust fund becoming depleted, due to current laws relating to payments to physicians. Specifically, "physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases."[vi] Further, "if the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private insurance."[vii]

This concern is also highlighted in the Medicare Payment Advisory Committee's (MedPAC) June 2022 *Report to the Congress,* which noted that "while hospitals' total (all-payer) margins have reached record highs, their Medicare profit margins have decreased over the last two decades." [viii] In fact, "since 2008, hospitals' Medicare margins have varied somewhat but have remained substantially negative."[ix] This led MedPAC to conclude that "eventually this disparity could negatively affect access to high-quality care for certain Medicare beneficiaries. In the extreme, hospitals whose patients consist nearly entirely of those on Medicare or Medicaid or patients who are uninsured could have to reduce unprofitable service lines or even be forced to close."[x]

To summarize, "current-law projections indicate that Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation. Such legislation should be enacted sooner rather than later to minimize the impact on beneficiaries, providers, and taxpayers."[xi]

Potential Solutions

Given the dire forecast related to the HI trust fund, significant changes will be necessary to either increase income to the fund (i.e., increase taxes and/or premiums), or rein in expenditures. In fact, the nonpartisan Committee for a Responsible Federal Budget (CRFB) claims that "to immediately eliminate Medicare's projected deficit, it would take a roughly *24% increase in the payroll tax rate, or a 15% spending cut, to ensure solvency – or some combination of the two* [emphasis added]."[xii] Clearly, these would be significant adjustments, and either solution would have a profound impact on daily American life. A 24% increase in payroll tax would have a notable impact on every worker's take-home pay, while a 15% cut in Medicare spending would have a profound impact on hospitals and physicians and their ability to maintain operations in the midst of a significant decline in revenue – which would ultimately impact whether it remains financially viable for them to continue providing care to Medicare beneficiaries.

The CRFB has proposed several spending reduction options that could each play a role in extending the life of the HI trust fund.[xiii] Each of these proposals would impact segments of the healthcare continuum, but are intended to cut excess spending where possible by incentivizing behavior that encourages cost savings where appropriate while continuing to provide quality patient care.

Eliminating Site of Service Differential

Historically, the Center for Medicare and Medicaid Services (CMS) reimbursed services rendered at a hospital outpatient department (HOPD) at a higher rate than if the service were rendered in a freestanding setting such as a physician's office or ambulatory surgery center (ASC). As more and more HOPDs are

operated at off-site locations rather than on hospital campuses, the reason for the higher payments has become less evident. On the contrary, it is thought that part of the reason for health system acquisition of physician practices is to increase reimbursement for a similar set of services by billing as an HOPD rather than as a freestanding facility. The CRFB brief on this topic cites a MedPAC analysis that indicated Medicare spending for evaluation and management (E&M) visits in 2017 "was nearly $2 billion higher and beneficiary cost-sharing $480 million higher as a result of higher payments to HOPDs."[xiv]

CMS has been moving towards site-neutral payments for several years, starting with a MedPAC recommendation in 2014. A recent MedPAC presentation notes that while the Bipartisan Budget Act of 2015 aligned HOPD rates with Medicare Physician Fee Schedule (PFS) rates used to reimburse physicians for services rendered in a physician's office in certain circumstances, the effect of the policy has been limited.[xv] The CRFB proposal, which it notes was also proposed by both President Trump and President Obama, builds on MedPAC recommendations and focuses on services that "are commonly and safely performed in physicians' offices or ASCs and for which the patient mix is relatively equal."[xvi] For the specified services, Medicare reimbursement would be based on the "lower cost, site-neutral rate."[xvii] CRFB estimates that this could result in a savings of $153 billion to Medicare over a ten-year period, as well as a savings of $137 billion for Medicare beneficiaries (a combination of lower premiums and lower cost-sharing, including Medigap participants).[xviii]

In MedPAC's June 2022 *Report to the Congress*[xix], they reiterated their position that aligning payment rates across ambulatory settings is appropriate for many services. Their analysis identified 57 ambulatory payment classifications (APCs) for services that are most commonly provided in a physician's office and for which it would be reasonable to align payment rates across all sites (HOPD, ASC, and freestanding physician's office) with the PFS. An additional 11 APCs were identified as having the highest volume in ASCs, leading to the conclusion that the ASC payment rate would be appropriate if the service is rendered in an ASC or HOPD, while the lower PFS rate would continue to apply if the service is rendered in a freestanding physician's office. Finally, MedPAC identified 101 APCs that are most appropriately or most often provided in the HOPD setting (including emergency department visits). For these services, MedPAC proposes to continue using different payment rates for each ambulatory setting, with payment for services rendered in an HOPD generally higher. Assuming the changes in payments resulting from the proposed site-of-service alignment translated to Medicare savings (which ignores the current statutory requirement that all Medicare payment adjustments be budget-neutral), it is estimated that the savings based on 2019 claims activity would have been $6.6 billion. Additionally, savings in the form of reduced beneficiary cost-sharing would have been $1.7 billion.

Any mandated site-of-service reimbursement shifts would impact healthcare operations. This would likely be felt most acutely in locations that may not currently have an abundance of ASCs to be able to shift certain procedures from a hospital setting. Likewise, shifting more procedures – and their associated revenue – from hospitals could negatively impact the hospital's ability to maintain adequate funding to continue providing adequate emergency care. This is particularly true in lower-volume hospitals in rural areas. Health systems need to assess how much volume this type of change might implicate, and start planning for the operational changes that would be required.

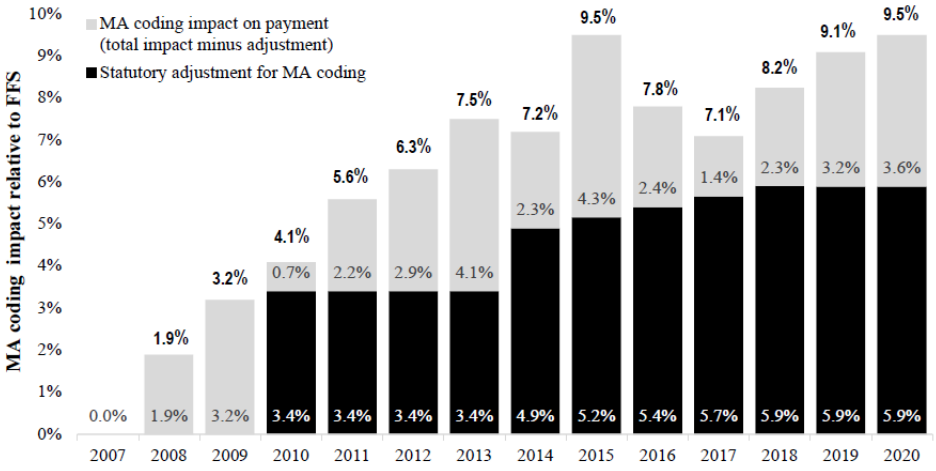
Reducing Medicare Advantage Overpayments

Differences in the reimbursement methodology for traditional fee-for-service Medicare and Medicare Advantage (MA) have resulted in significant differences in coding patterns between the two programs. For services rendered to traditional Medicare patients, reimbursement is generally based on procedure codes, so there is no financial benefit for coding multiple diagnoses unrelated to the purpose of the patient's visit. In contrast, MA reimbursement includes a risk adjustment factor to ensure that plans with higher acuity patients (older and/or sicker) are adequately compensated for the possibility that costs to provide care to such patient population will be higher than for a healthier patient population. Accordingly, MA plans have a significant financial incentive to code as many diagnoses as possible to receive a higher risk-adjusted payment.

The coding differences have drawn wide attention, and have been the subject of multiple studies. To address concerns of MA overpayments due to coding differences, the Deficit Reduction Act of 2005

required CMS to study the impact of the coding differences and make corresponding adjustments to MA risk scores to recalibrate reimbursement to be consistent with the original intent of the MA program. This resulted in a reduction of 3.41% to MA risk scores from 2010 to 2013, which was increased to a statutory minimum reduction of about 4.9% starting in 2014 and gradually increased to 5.9% where it has remained since 2018.[xx] However, a MedPAC analysis concluded that the coding differential continues to grow, as illustrated by the chart below[xxi]:

Figure 1. Impact of coding intensity on MA risk scores was larger than the adjustment for coding pattern differences, 2007–2020



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age and sex between MA and FFS populations. Annual adjustment for MA coding began in 2010. MA coding intensity increased MA risk scores by about 1 percentage point annually, but was offset by new risk adjustment model versions in 2014, 2016, and 2017 and by increased FFS coding in 2016 and 2017.

Source: MedPAC analysis of CMS enrollment and risk score files.

The growth in MA enrollment has only exacerbated the magnitude of this issue. MedPAC determined that "the combination of enrollment growth and coding intensity will result in excess Medicare spending of almost $15 billion in 2022 alone… By the end of 2022, Medicare will have cumulatively paid MA plans more than $91 billion just due to coding intensity" since 2007, with an additional $16.2 billion projected for 2023.[xxii] Regardless, CMS finalized its proposal to continue to apply the statutory minimum 5.9% coding pattern adjustment for calendar year 2023.[xxiii]

Incorporating Price Competition into Medicare Part B Drugs

Currently, providers who administer drugs are reimbursed based on the average cost for the specific drug, plus a 6% add-on to cover storage, handling, and associated costs, as well as a separate amount for administration of the drug. However, this approach actually provides financial benefit to physicians who administer more expensive drugs since it yields a higher add-on. (For example, the add-on for a $10,000 medication would be $600 compared to $60 for a $1,000 drug.)

To combat this, the CRFB has proposed implementing "clinically comparable drug pricing." Under this approach, a single Medicare payment would be determined for each "clinically comparable" group of drugs, based on the average sales price for the grouping weighted by average annual usage.[xxiv] The proposal would allow CMS to "both define which therapeutic classes are eligible for grouping and to select the drugs with comparable clinical outcomes to include in those groups." Additionally, the cost-sharing for Medicare beneficiaries would be based on the lower of the weighted average sales price for the drug grouping or the average sales price for the actual drug administered. With this methodology, providers would receive no financial benefit for administering high-cost drugs within a clinical group, and beneficiaries would have lower out-of-pocket cost for using a lower cost alternative.

CRFB analyzed the potential cost savings for three high-utilization classes of drugs: macular degeneration, rheumatoid arthritis, and prostate cancer. Their analysis concluded that for just those three classes, this approach could save Medicare $49 billion over a 10-year period, plus additional savings of $29 billion to Medicare Advantage and $32 billion in cost savings to beneficiaries through reduced cost-sharing and lower premiums.[xxv] Savings across the full spectrum of drug classes would be even higher.

Final Thoughts

The demographic reality is that we have an aging population in this country. As the number of Medicare beneficiaries grows, the number of workers whose payroll taxes feed the Medicare trust funds continues to decline. According to the Trustee Report, from 1980 through 2008 there were approximately 4 workers per Medicare beneficiary, but that ratio began dropping as the Baby Boomer generation hit retirement age.[xxvi] The ratio was down to less than 3 by 2021, and is expected to hit about 2.5 by 2030 and 2.2 in 2096.[xxvii] At the same time, the cost of healthcare continues to rise, partly driven by advances in technology and the development of new drugs which can be effective but costly.

While policy-makers try to determine effective ways to reduce Medicare spending in order to prolong the lifespan of the trust fund, providers continue to face their own challenges. Rising costs have led to lower margins, and providers are concerned that any reductions in Medicare reimbursement will inhibit their ability to provide high-quality care. Even absent any Medicare policy changes, providers are facing the return of a 2% cut to Medicare reimbursement as sequestration resumes fully beginning July 1, 2022, as well as an additional 4% PAYGO cut starting January 1, 2023. This is all happening as the country battles inflation at a 40-year high and challenges attracting and retaining staff who are dealing with burnout and fatigue after more than two years of battling the COVID-19 pandemic. With all these challenges, providers will need to place even greater emphasis on historical trend analysis and financial forecasting so that they can be proactive about making necessary changes to ensure their operations are sustainable. This could include monitoring payer mix, identifying unprofitable service lines that may need to be discontinued, renegotiating contracts with commercial payers to ensure optimal reimbursement, or identifying cost-cutting opportunities.

These challenges will not be easy to solve, and have dramatic implications for both Medicare beneficiaries (today and in the future) and the healthcare providers who serve them. If effective solutions to bolster the Medicare trust funds while ensuring adequate reimbursement levels to providers can't be identified and implemented, providers over time will begin opting out of Medicare participation. This would leave a population of Americans who have spent a lifetime supporting the Medicare program through payroll taxes without access to care during the time when they need it most.

JTaylor's healthcare consulting team is comprised of professionals with a wide variety of backgrounds who are equipped to provide insight to guide you through this challenging time. We offer a variety of advisory services including strategic planning, service line profitability analysis, managed care contracting, and rate benchmarking. To find out more or to contact a member of our team, please visit our website.

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[iii] Boards of Trustees (2022), 224.
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[xxvii] CRFB (2021), *Injecting Price Competition*.