Partner Insight Series:

Highlights of MedPAC's Report to Congress

May 31, 2024

www.JTaylor.com

What are the Biggest Takeaways from MedPAC's 2024 Report to Congress?

In March, the Medicare Payment Advisory Commission ("MedPAC") released its annual report to Congress outlining recommendations for Medicare payment systems to hospitals, physicians, and other healthcare providers. MedPAC is a nonpartisan, independent agency that provides the U.S. Congress with analysis and advice on payment policy and other issues relating to the Medicare program. Funded by U.S. taxpayers, the Commission conducts research into Medicare payment trends and possible issues that may arise in the future, including access to care and quality of care. MedPAC is tasked with making recommendations "aimed at obtaining good value for expenditures – which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources."

MedPAC issues two reports each year. The March report focuses on Medicare payment rates for various types of healthcare providers, while the June report focuses more broadly on Medicare payment structures. However, Congress has no obligation to adopt MedPAC's recommendations.

In this edition of JTaylor's Partner Insights Series, we highlight some of the trends MedPAC has uncovered along with their recommendations and the potential implications if Congress implements MedPAC's recommendations.

Medicare Trends

The MedPAC report notes that Medicare spending is projected to double in the next ten years, growing by 7% to 8% annually. The two most significant factors driving this growth are (1) an increasing number of Medicare beneficiaries as the population ages, and (2) an increase in the volume and intensity of services provided per beneficiary. As the "baby boom" generation becomes eligible for Medicare, the number of beneficiaries is expected to increase by 10 million between 2022 and 2029.

Additionally, increased participation in Medicare Advantage (MA) plans has resulted in increased spending. In 2023, 52% of Medicare beneficiaries with both Part A (for inpatient hospital care, skilled nursing facilities, hospice care, and home health) and Part B (for physician services, outpatient care, medical supplies, and preventive services) were enrolled in MA plans. MedPAC found that Medicare spent "substantially more per beneficiary for MA enrollees compared with what spending would have been for these enrollees in traditional FFS [fee-for-service] Medicare in 2023." In fact, MedPAC estimates that Medicare spends 22% more for MA beneficiaries than for similar services provided to Medicare FFS beneficiaries, which would result in a difference of $83 billion in 2024. The difference primarily results from higher coding intensity, favorable selection of beneficiaries by MA plans, and setting payment benchmarks above FFS spending levels.

MedPAC's Payment Recommendations

When making payment recommendations, MedPAC considers both the financial challenges facing the Medicare program and the need for efficient use of resources, as well as the expected

impact on the beneficiaries' access to high-quality care. The report notes that "payment rates should be sufficient to provide high-quality care for beneficiaries but not exceed the level necessary to do so." With these goals in mind, below are MedPAC's key recommendations for 2025 payment rates.

- **Hospital Inpatient and Outpatient Services** – MedPAC expects hospital margins to improve in 2024, but largely due to the one-time remedy payment of $9 billion in aggregate to hospitals participating in the 340B drug program. However, there is concern that payment rates will be insufficient in 2025. Accordingly, MedPAC recommends the following:
  - Update the base payment rates for general acute care hospitals by the amount specified in current law plus 1.5%.
  - Add $4 billion to disproportionate share and uncompensated care payments and distribute these funds to hospitals using the Medicare Safety Net Index (MSNI).

  These two recommendations combined would effectively increase inpatient and outpatient hospital payments by 2.8% from what current law would achieve, although it would not impact all hospitals equally. Since rural hospitals tend to have high shares of Medicare patients (including low-income Medicare beneficiaries), MedPAC estimates they would receive around 5% more in FFS payments than under current law, while facilities with a lower number of Medicare patients could see a much lower revenue increase.

- **Physician and Other Professional Services** – The report notes a concern that lower compensation for primary care physicians as compared to specialists is driving physicians away from a career in primary care. Still, MedPAC believes that "current payments to clinicians appear to be adequate," but acknowledged that "cost increases could be difficult for clinicians to continue to absorb." MedPAC recommends the following updates for 2025:
  - Update the base payment rate by the amount specified in current law, plus 50% of the projected increase in the Medicare Economic Index (MEI). It is expected that this would yield a payment increase of about 1.3% above current law.
    - MedPAC recommends that this revision to the base payment rate formula be a permanent update that would be built into subsequent payment rates, rather than using the temporary updates reflected in current law.
  - Establish safety net add-on payments of 15% for primary care and 5% to other clinicians for providing services to low-income Medicare beneficiaries, which is the same recommendation made by MedPAC in 2023. This is expected to increase FFS revenue by 4.4%, on average, for primary care providers and by 1.2% for others.

  Overall, these recommendations would yield an increase in fee schedule revenue of around 3%, though the impact would vary by specialty. Primary care providers are estimated to see an average increase of 5.7% from both recommendations combined, while other specialties would experience a much lower boost of around 2.5%.

- **Outpatient Dialysis** –MedPAC recommends no change from current law, which is expected to result in a 1.8% base payment rate increase in 2025.

- **Skilled Nursing Facilities (SNFs)** – Margin on FFS Medicare was high for freestanding SNFs at 18.4% in 2022 and is projected to be 16% in 2024, although margins do fluctuate significantly across facilities due to differences in cost, economies of scale, and other factors. Because of this, MedPAC recommends reducing the base payment rate by 3% in fiscal year 2025 to more closely align payments with aggregate costs.

- **Home Health** – MedPAC argues that payments for home health services have substantially exceeded costs in recent years, resulting in an average margin for freestanding home health agencies of 22.2% in 2022 and an expected margin of 18% in 2024. Accordingly, the commission recommends a 7% reduction in the base payment rate for 2025.

- **Inpatient Rehab** – To combat FFS recent Medicare margins of around 14% for inpatient rehabilitation facilities, MedPAC proposes a reduction in the base payment rate by 5% for fiscal year 2025.

- **Hospice** – MedPAC maintains that current payment rates are sufficient for hospice services, noting a projected FFS Medicare margin of 9% in 2024. Since no payment increase is necessary, MedPAC recommends that Congress eliminate the update to base payment rates for fiscal year 2025 (which would otherwise increase hospice payment rates by 2.8%).

Status of Ambulatory Surgery Centers

Ambulatory Surgery Centers (ASCs) are facilities that provide outpatient surgical procedures to patients who do not require an overnight stay. The popularity of ASCs has grown immensely as these facilities offer greater convenience and lower out-of-pocket costs compared to traditional hospitals. In recent years, ASCs have expanded their service offerings due to advancements in clinical practices and technology, and corresponding changes to Medicare payment provisions that allow more procedures to be performed in an ASC setting. Accordingly, many procedures traditionally offered only in hospitals have transitioned to ASCs.

MedPAC's report highlights the rapid increase in ASC FFS Medicare payments in the past five years as seen in the table below.

				Average annual change	
	2017	2021	2022	2017–2021	2021–2022
Medicare payments (billions of dollars)	$4.6	$5.7	$6.1	5.9%	5.8%
Medicare payments per FFS beneficiary	$136	$186	$205	8.2	10.0

Note: FFS (fee-for-service), ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments include spending for new-technology intraocular lenses. We calculated the percentage change columns using unrounded numbers.

Source: MedPAC analysis of data from the Office of the Actuary at CMS and data from physician/supplier standard analytic files.

MedPAC's Recommendation to Congress: Require ASCs to report cost data, a practice that is already required for other types of facilities such as hospitals, skilled nursing facilities, rural health clinics, and others.

For over ten years, MedPAC has recommended that ASCs be required to submit cost data, emphasizing the request yet again in this year's report. This request stems from the fact that current ASC reimbursement rates are not based on actual ASC costs but instead are based on hospital outpatient department (HOPD) charges adjusted to cost. This raises concerns for several reasons, including the following:

1. ASC payment rates could be higher than costs for some services and lower than cost for other services. This would create incentives for providers to only offer high margin services and reduce the service offerings for lower margin cases that are still in demand by Medicare beneficiaries.
2. ASCs and HOPDs are structured differently and do not always share similar cost structures. Additionally, ASCs are commonly for-profit entities providing single-specialty services in urban areas, which leads to differing payer and services mixes than their HOPD counterparts.

MedPAC is cognizant that cost reporting would place additional administrative burden on ASCs, which are often smaller businesses. However, the Commission believes the reporting is necessary to accurately assess the adequacy of Medicare payments to ASCs. MedPAC asserts that cost reporting for ASCs could be more streamlined than what is required for hospitals to minimize the added burden.

Despite MedPAC's continuing recommendation, Congress has historically taken little action on this issue. While that may ultimately be the case yet again in 2024, we believe Congressional action could have meaningful impacts for ASC owners and operators. In fact, we have seen numerous ASCs optimize their service offerings around the high margin cases that MedPAC is suggesting could be squeezed once cost data is available and analyzed. Additionally, many ASCs operate with small back-office support teams. The requirement to provide cost data could increase the workload of these small teams and require the onboarding of additional personnel.

Rural Emergency Hospitals

In recent years, many rural hospitals across the U.S. have faced financial difficulties due largely to declining inpatient volume, which has resulted in a significant number of closures. In fact, the report notes that an average of 10.5 rural hospitals closed each year from 2013 to 2020. The closure of rural hospitals can have severe consequences for the surrounding communities, leaving residents with limited access to medical care. To combat this issue, Congress created the Rural Emergency Hospital (REH) designation in 2021. These facilities must meet specific criteria to obtain the designation, including emergency staffing requirements and transfer agreements with trauma centers. Facilities with the REH designation receive monthly payments from Medicare ($270,000 per month in 2023, for annual funding of about $3.2 million) in addition to 105% of the Outpatient Prospective Payment System (OPPS) rates for outpatient and emergency services, and standard OPPS rates for other services.

The REH designation was created as a pathway for rural hospitals with lower inpatient volume to remain financially viable and reduce the number of hospital closures. In 2023, 21 hospitals converted to REHs, but eight rural hospitals still closed. MedPAC outlines several reasons these hospitals did not utilize the REH option, including state regulations that did not allow for an REH designation, proximity to other critical access hospitals, and ineligibility due to too many beds. For the group of hospitals that did convert, average inpatient admissions had declined by 55% from 2011 to 2021, averaging only about one admission per day in 2021. The profit margin for most of

the hospitals that converted to REHs was negative in 2022, with the median profit margin for the group at -11%.

Because it is still too soon to assess the success or failure of the program, MedPAC did not make any formal recommendations to Congress regarding REHs but are continuing to monitor data from facilities who have obtained the designation. The report did note, however, that the REH pathway appears to be a more efficient and effective avenue to maintain emergency services in rural communities without subsidizing inpatient departments that are rarely used.

Final Thoughts

MedPAC's recommendations regarding changes to Medicare payment policy provide insight to the potential future direction of the Medicare program and reimbursement for services provided to Medicare beneficiaries. As the growth and consolidation of ASCs continues and Medicare spending for services provided in these centers increases, we can expect a continued push from MedPAC for ASCs to report cost information. Should this occur, reimbursement for services provided in an ASC setting could change as Medicare seeks to correct any pricing imbalances. While changes in reimbursement would likely be revenue-neutral in aggregate, they could vary dramatically at the case type level, which would in turn impact certain ASCs disproportionately depending on their case mix. Valuators, facility operators, and transaction advisory professionals will need to stay on top of MedPAC's recommendations and their potential impact should Congress take responsive actions.

Herd A. Midkiff, CVA
Partner – Consulting Services
817.546.7036 | hmidkiff@jtaylor.com

Herd has over 20 years of experience serving clients in the healthcare, non-profit, and investor-owned sectors. He has extensive experience in strategic planning, including joint ventures, business acquisition, due diligence services, and managed care contracting support. He also draws upon his healthcare and finance background to provide business enterprise and compensation valuation services. His clients include large multi-hospital health systems, physician-owned hospitals, entrepreneurs, and attorneys.

Note: All historical trends, statistics, graphs and recommendations contained herein were obtained from the MedPAC *Report to the Congress: Medicare Payment Policy* (March 2024).