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# MedPAC Issues Several Notable Medicare Reimbursement Recommendations

On January 16-17, 2020, the *Medicare Payment Advisory Commission* (MedPAC) met to discuss Medicare issues and policy questions to develop and approve a report for recommendations to Congress. MedPAC is an independent congressional agency established to advise the U.S. Congress on issues affecting the Medicare program.[1] MedPAC is tasked with analyzing the quality of care, access to care, and other matters relevant to the Medicare program.[2] The commissioners bring diverse expertise in the financing and delivery of healthcare services.[3] The recent meeting will impact the formation of MedPAC's reports to Congress for 2020,[4] which reports play a significant role for lawmakers and the healthcare industry overall. This *Health Capital Topics* article will discuss MedPAC's discussions and decisions in this recent meeting as relates to the payment and quality of hospitals, physicians, and ambulatory surgical centers (ASCs).

### *Hospital Quality the Main Concern*

MedPAC voted unanimously during its meeting to reduce the payment differences between physician offices and hospital outpatient departments (HOPDs).[5] MedPAC's recommendation, if adopted, may reduce hospitals' incentive to acquire physician groups on the premise of reimbursement differences rather than the type of care provided.[6] The recommendation could also reduce healthcare costs to patients.[7] The proposal follows the *Centers for Medicare & Medicaid Services* (CMS) endorsement of the idea of "*site-neutrality*," where services are paid the same reimbursement rate regardless of the facility, which was included in the 2020 *Hospital Outpatient Prospective Payment System* (OPPS) final rule.[8]

Additionally, MedPAC recommended a "*net payment*" increase of 3.3% (which includes a base rate increase of 2%) to acute care hospitals, part of which payment is tied to increasing the quality of care provided.[9] The MedPAC recommendation is higher than CMS's scheduled 2.8% payment increase for hospitals.[10] Significantly, the increase is largely due to shifting a portion of it to additional quality incentive payments through the *hospital value incentive program*.[11] MedPAC expressed its desire to "*minimize the difference in payment rates across sites of care consistent with our site-neutral work*."[12] According to MedPAC, the payment increase expresses the committee's motivation to maintain access to care but also maintain pressure on providers to constrain costs.[13] MedPAC hopes that the cost pressures on hospitals are still real enough to encourage hospitals to become more efficient.[14] Tying payment increases to quality may make hospitals more accountable for the total cost of care provided. The commission also recommended the elimination of quality penalties, equating to a de facto 0.5% increase in hospital payments.[15] Overall, MedPAC's recommended base payment rate to acute care hospitals would be 2%, which is 0.8% lower than CMS's rate increase.[16] However, that low percentage is offset by the elimination of quality penalties and the possibility of financial rewards through the achievement of quality objectives, raising the "*net payment rate*" to 3.3%.[17] MedPAC claims that the new lower base rate and rate increases tied to quality will not affect access to care or provider willingness to deliver care to Medicare beneficiaries.[18] The recommendation's goal is to reward high-performing hospitals and move payment toward being conditioned on the provision of high-quality care.[19]

MedPAC reported during its meeting that the quality of hospital care remains stable, with small improvements in mortality and readmission rates,[20] and that access to capital is robust, due to the healthy all-payor margins, which were 6.8% in 2018, nearly an all-time high.[21] MedPAC did not mention the recent CMS requirement that hospitals disclose "*payer-specific negotiated charges*."[22] The latest *price transparency* requirement, which is discussed in more detail in the November 2019 *Health Capital Topics* article entitled "*Trump Administration Brings Transparency to Healthcare*,"[23] could significantly affect all-payor margins. MedPAC also reported that Medicare margins for hospitals were -9.3%, and -2% for efficient hospitals.[24] Interestingly, the commission did not indicate if these negative Medicare margins, coupled with the possible effects of the *price transparency* requirement, will affect access to capital or overall viability for U.S. acute care hospitals.[25]

### *No Payment Increases for Physicians*

MedPAC did not recommend any changes to the CMS proposed rates for physicians and other healthcare professional services.[26] Pursuant to the 2015 *Medicare Access CHIP Reauthorization Act* (MACRA), the base physician fee rate will not be updated for years 2020 through 2025.[27] It also allows for an up to 7% payment adjustment (positive or negative) based on the achievement of various quality metrics implemented

through the *Merit-based Incentive Payment System* (MIPS).[28] Existing law also provides enhanced reimbursement for exceptional performance.[29]

Moreover, MedPAC asserted that existing CMS policies have not decreased access to care, and the number of clinicians billing Medicare has grown faster than the number of beneficiaries.[30] These factors combined may take wage pressure off of hospitals and other employers of clinicians because the reimbursement levels of clinicians will not change, and the number of clinicians available to bill Medicare is increasing.[31] MedPAC reported that quality findings are mixed because of wide geographic variations.[32] However, the commission found that the median MIPS score is currently 99.6 points out of 100 in 2020, up from 89 in 2019.[33] MIPS incentive payments would allow the maximum reimbursement increase of 1.7% under the physician fee schedule.[34] Currently, commercial payment rates to physicians are approximately 135% of Medicare.[35] There will be no payment increases for physicians, except under MIPS, for at least five years,[36] in order to encourage physicians to move to an advanced payment model, which may allow for up to a 5% bonus each year if quality measures are achieved.[37] Commissioner Lawrence Casalino[38] admitted that the overall payment policies are not being similarly implemented on hospitals, which raises fairness questions.[39] The observation may speak to the power of large hospitals in comparison to individual providers.

*Another Push for ASC Cost Data*

Once again, MedPAC recommended that ASCs report cost data to CMS.[40] CMS has been resistant to require ASCs to report cost data despite MedPAC's continued insistence on cost data reporting to provide a more comprehensive analysis of quality and cost.[41] MedPAC contended that cost data would "*improve the accuracy of the ASC payment system*." Further, to motivate ASCs to report cost data, MedPAC proposed eliminating the 2020 conversion factor for all ASCs.[42] MedPAC estimates that Medicare would decrease spending by approximately $1 billion over five years if Congress implements the recommendation.[43] According to the commission, the decrease (essentially a one-year rate freeze) would not affect access to ASC services or ASCs' willingness to furnish the services.[44]

*Reliance on Medicare*

As of 2018, Medicare spending comprised 21% of U.S. health expenditures.[45] As a result of the higher projected enrollment growth expected from aging *Baby Boomers*, Medicare spending is expected to exceed Medicaid and private insurance spending by 2027.[46] Total government spending is expected to reach 47% of national health expenditures by 2027.[47] Moreover, per capita personal healthcare spending for people age 65 and older is three times higher than spending per working-age person.[48] Consequently, healthcare providers will be faced with a future wherein Medicare is the primary source of income for many providers. This reality prompts a number of questions, especially considering the comments of Commissioner Marjorie Ginsburg, a health policy researcher and founding director of the *Center for Healthcare Decisions*[49]:

> "*[W]e know hospitals are running a deficit if they're relying only on Medicare patients, and they stay alive because they have commercial patients.*"[50]

What does a future for hospitals look like when they no longer have the life support of commercial patients? Moreover, does Medicare also decide the salaries of physicians in the future when Medicare spending is so significant? Chairman Francis Crosson, MD, founder of *Permanente Foundation* (the physician half of *Kaiser Permanente*),[51] rebuffed ideas of calculating physician reimbursement based on compensation levels, stating:

> "*50 percent or more of practice costs for the physician is the personal income for the physician. And so just as you said what's a reasonable income, that's an issue -- an absolute reasonable income is an issue that we've not engaged in, and we don't exactly --I don't know how we could do that.*"[52]

However, there is a potential that Medicare may be forced (sooner rather than later) to calculate reasonable physician compensation levels. While this may be unthinkable currently, projected Medicare spending levels would require Medicare to assess the very nature of reasonable physician income. For now, Medicare's outsized role in healthcare is recognized, but counterbalanced by commercial payors. The government extent of control in setting reasonable physician income, and the future of hospitals relying on Medicare reimbursement, will be hotly contested issues in the (near) future.


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2 *Ibid.*
3 *Ibid.*
4 *Ibid.*
5 "Medicare Payment Advisory Commission, Meeting Transcripts, January 16, 2020" Medicare Payment Advisory Commission, January 16, 2020, http://www.medpac.gov/docs/default-source/default-document-library/jan20_medpac_meeting_transcript_sec.pdf?sfvrsn=0 (Accessed 2/19/20), p. 185-186, 211-212.
6 Explaining the primary motivation behind hospital acquisition of physician practices is to take advantage of reimbursement differences based on location of care. "Patients feel the pain of hospital-physician consolidation" By Michael Brady, November 7, 2019, https://www.modernhealthcare.com/patients/patients-feel-pain-hospital-physician-consolidation (Accessed 2/19/20).
7 Finding higher patient cost-sharing costs are associated with hospital acquisition of physician practices. "Patients feel the pain of hospital-physician consolidation" By Michael Brady, November 7, 2019, https://www.modernhealthcare.com/patients/patients-feel-pain-hospital-physician-consolidation (Accessed 2/19/20).
8 "Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule" Federal Register Vol. 84, No. 221 (November 15, 2019), p. 61386. The OPPS final rule is discussed more fully in a November 2019 Health Capital Topics article. "CMS Finalizes 2020 Physician & Outpatient Fee Schedules" Health Capital Topics, Vol. 12, Issue 11 (November 2019), https://www.healthcapital.com/hcc/newsletter/11_19/HTML/FEE/convert_finalized-fee-schedules_hc_topics_draft-11.20.19.php (Accessed 2/19/20).
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10 *Ibid*, p. 183-184.
11 *Ibid*, p. 186.
12 *Ibid.*
13 *Ibid*, p. 184.
14 *Ibid.*
15 *Ibid*, p. 183-186.
16 *Ibid.*
17 *Ibid.*
18 *Ibid.*
19 *Ibid.*
20 *Ibid*, p. 183.
21 *Ibid.*
22 "CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Requirements (CMS-1717-F2)" Centers for Medicare & Medicaid Services, November 15, 2019, https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price (Accessed 2/19/20).
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24 Medicare Payment Advisory Commission, January 16, 2020, p. 183.
25 *Ibid.*
26 *Ibid*, p. 212-214.
27 *Ibid*, p. 213.
28 *Ibid.*
29 *Ibid.*
30 *Ibid*, p. 213-214.
31 *Ibid.*
32 *Ibid*, p. 214-215.
33 *Ibid*, p. 216.
34 *Ibid*, p. 220-221.
35 *Ibid*, p. 224.
36 *Ibid*, p. 230.
37 *Ibid.*
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39 Medicare Payment Advisory Commission, January 16, 2020, p. 230.
40 *Ibid*, p. 318-319.
41 *Ibid.*
42 *Ibid*, p. 319-320.
43 *Ibid*, p. 320.
44 *Ibid.*
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47 *Ibid.*
48 *Ibid.*
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50 Medicare Payment Advisory Commission, January 16, 2020, p. 221-222.
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