National Rural Health Association

MedPAC June Report to Congress

MedPAC's annual June Report to Congress includes recommendations around updating clinician payments, a discussion of prior authorization in Medicare Advantage, an assessment of utilization in Medicare Advantage, and considerations around inpatient rehabilitation facilities and the Medicare Hospital at Home program. Please find the full report here. If you have any questions, please contact Alexa McKinley Abel (amckinley@ruralhealth.us).

Key highlights:

Physician Fee schedule (PFS).

Absent congressional action, the PFS payment rate is set to remain flat in 2025 and in 2026, increase by 0.75% for clinicians participating in advanced APMs (A-APMs) and 0.25% for clinicians in MIPS. A-APM bonuses are currently 5% of all Medicare PFS payments in 2024, 3.5% in 2025 and 1.88% in 2026. They are set to end in 2026.

Suggestions for updating the PFS payment rate:

- Update the practice expense factor in the PFS rates by the hospital market basket, adjusted for productivity to address current differences between services billed in a hospital outpatient department and in a clinician's office.
    - MedPAC notes that this would lead to larger updates for certain specialists compared to primary care and behavioral health providers so PFS services should be revalued as well.
- Update the PFS payment rates by the Medicare Economic Index (MEI) minus 1% paired with an update floor of half of MEI. This would update rates for all codes by the same factor so the percentage updates would be the same across services and specialties.

MedPAC also considers extending A-APM bonuses for a few more years to help maintain participation or restructuring A-APM bonuses to be based on a clinician's PFS payments for fee-for-service (FFS) beneficiaries in A-APMs instead of for all FFS beneficiaries.

Medicare Advantage (MA).

MedPAC studied prior authorization trends across plans. From 2009 to 2019, MA plans increased their use of prior authorization for most service categories and in 2023 99% of MA beneficiaries were enrolled in plans that required prior authorization for some services. MedPAC reports that 95% of prior authorization requests were approved in 2021 for both coverage and payment, 1% only had partial coverage or payment approved, and 4% denied both. In the same year, about 229,000 determinations were reconsidered and 80% were approved after an appeal. MedPAC notes concerns prior authorization, including provider burden, and OIG findings that many prior authorization denials should have been approved.

MedPAC also evaluated CMS' current network adequacy requirements. Network adequacy is measured in a number of ways – minimum number of providers to meet the population needs, maximum time and distance standards, and maximum wait times to receive services. Network adequacy is assessed by CMS at the contract, or county, level rather than the more granular plan level. CMS audits network adequacy every 3 years. Audits can also be performed if an MA organization (MAO) offers a new contract or expands its service area, a significant contract is terminated, CMS

receives a network adequacy complaint, or an organization discloses to CMS that it is out of compliance.

MedPAC presents data that shows only 18% of requests for network adequacy exceptions were in rural areas and 5% were in counties with extreme access considerations. Meanwhile MAOs requested most exceptions for contracts in metropolitan (35%) and micropolitan areas (22%). The top five specialties that MAOs requested exceptions for were ophthalmology, cardiac surgery, gastroenterology, cardiothoracic surgery, and allergy and immunology.

Inpatient rehabilitation faciltiies (IRFs).

MedPAC considers alternatives to lower payments to IRFs for certain beneficiaries citing a high relative cost of care and adverse incentives to admit patients inappropriately. IRFs differ from acute care hospitals because 60% of admissions must be patients with 1 of 13 specific conditions (called the "compliance threshold") and the remainder can be patients with other conditions. MedPAC compared patients admitted to skilled nursing facilities and IRFs to determine if some patients in IRFs could instead be treated in the SNF setting.

Alternative payment approaches outlined:

- Lowering IRF rates for patients that are not part of the compliance threshold. MedPAC acknowledges that this could lead to IRFs scaling back admissions for non-compliant threshold patients.
- Lower IRF rates in aggregate so that they would equal the cost of care.
- Blend current rates and rates that equal the cost of care.

Medicare Acute Hospital at Home (HAH) program.

The HAH program was created during the COVID-19 pandemic amidst concerns about hospital capacity. HAH would have ended with the public health emergency but Congress extended it to December 31, 2024. In this program, hospitals apply to CMS to provide inpatient acute care to beneficiaries at home. Payment is equal to what Medicare would have paid under the Inpatient Prospective Payment System had the beneficiary been in the hospital.

As of April 2024, CMS approved 328 hospitals to participate and there have been 23,000 HAH discharges. The majority of hospitals operating a program in 2022 were urban. Data suggests that not all approved hospitals have launched a HAH program – in 2022, 284 hospitals were approved but only 105 reported at least one discharge. Hospitals interviewed by MedPAC cited starting up the program as being an issue due to financial viability concerns and the capacity to deal with any operational challenges. Also, hospitals may have been dissuaded from investing in a program that is set to expire.

MedPAC suggests that policymakers consider the following for the future of HAH:

- Ensure HAH care does not overlap with or draw patients from other less costly home-based services.
- Measure outcomes for the program to safeguard quality of care.
- Reconsider the IPPS payment rate for HAH services as it may be too high compared to the cost of providing care in a brick-and-mortar setting.

- Continue requiring that a beneficiary be evaluated in a hospital before admission to the program to avoid misuse.

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