Medicare Payment Advisory Commission, March 2025 Public Meeting
March 6-7, 2025, Meeting Summary
[Meeting materials available at https://www.medpac.gov/meeting/march-6-7-2025/]

On March 6-7, 2025, the Medicare Payment Advisory Commission (MedPAC, or "the Commission") held its March public meeting. HFMA has prepared the following summary of that meeting. Unless specifically attributed to MedPAC commissioners or staff, all forward-looking statements in this summary reflect prognostication of the Commission's likely actions; such statements are not informed by any proprietary / inside information about MedPAC's future plans.

Thursday, March 8, 2025

1. REFORMING PHYSICIAN FEE SCHEDULE UPDATES AND IMPROVING THE ACCURACY OF RELATIVE PAYMENT RATES (Geoff Gerhardt, Brian O'Donnell, Rachel Burton; 10:00 AM - 11:30 AM)

ISSUE: For many years, MedPAC has found that payments under fee-for-service Medicare's physician fee schedule (PFS) have been adequate to ensure that beneficiaries' access to clinician care is as good as, or better than, that of privately insured individuals. However, commissioners have voiced concerns about whether current-law updates to Medicare's PFS will continue to be adequate, given inflation trends.

MEETING DISCUSSION: Statutory updates to payment rates under Medicare's physician fee schedule have been low in recent years, and the updates beginning in 2026 pursuant to MACRA will continue to be lower than projected inflation. In each of the last several years, MedPAC has recommended higher-than-current law payment updates to the PFS. In November of 2024, MedPAC discussed options for replacing the future MACRA updates with a standing statutory update that would more closely track inflation (using the Medicare Economic Index (MEI) as a proxy). At this meeting, the Commission discussed a draft recommendation from the Chair that would update PFS rates "based on a portion of the growth in the Medicare Economic Index (MEI)" [using MEI minus 1 percentage point as an example]. This recommendation would increase payments to physicians (resulting in a program cost) relative to current law. However, it is worth noting that the recommendation did not specify the update percentage (unusual for MedPAC in the context of payment updates), and staff did not present an estimate of the magnitude of the spending impacts implied by the recommendation. Implementing this recommendation would require a statutory change.

In general, commissioners supported the draft recommendation as proactive – despite payment adequacy indicators being positive, commissioners believe that the MACRA updates are unsustainable in ensuring beneficiary access to physician care given anticipated future inflation. Several commissioners suggested bounding the resulting updates ("ceilings and floors").

The Commission also discussed its November 2024 concerns about the accuracy of relative value units under the PFS, one of which focused on the potential for duplicative payments for practice expense (PE) when physician services are provided in hospital outpatient departments or other facility settings. MedPAC staff asserted that given the growing share of practices owned by hospitals or physicians employed by them, CMS could exclude indirect PE (*i.e.*, the portion of PE intended to cover the overhead of operating a physician office such as rent and utilities) from PFS payment if the clinician is not financially independent from the hospital. The impact of this policy would depend on how the policy was implemented but could decrease PE facility payments by $1 billion and $4.5 billion – these reductions would be redistributed to non-facility PE payments for physician services.

At this meeting, the Chair presented a draft recommendation which recommends that the Congress direct the HHS Secretary to regularly update the cost data used to update relative value units (RVUs) under the PFS, and to ensure that the methodology for updating RVUs reflects the cost differentials when physician services are provided in different settings. This recommendation would not change Medicare program spending in the aggregate. While executing this recommendation would not require a change in statute (CMS could do this within the agency's administrative authority), the language "Congress should direct the Secretary" suggests MedPAC thinks CMS would not take this action on its own volition, and would need statutory directive to do so.

Based on the commissioners' discussion, it is anticipated that MedPAC will bring both draft recommendations up for a vote at its April 2025 public meeting, and we would anticipate strong support for both recommendations among the commissioners. We believe that stakeholders could expect minor wording changes to the recommendations, and a potential modification of the first recommendation (payment updates) to include explicit mention of a floor on any MEI formula-derived update. Other commissioner comments will likely be addressed in the language of the corresponding June report chapter in which these recommendations would appear.

2. REDUCING BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES AT CRITICAL ACCESS HOSPITALS (Jeff Stensland, Brian O'Donnell; 11:40 AM - 12:25 PM)

ISSUE: The critical access hospital (CAH) program was enacted into law in 1997 to help ensure rural Medicare beneficiaries' access to hospital care. The program provides cost-based Medicare payments to rural hospitals with 25 or fewer beds. The cost-based payments for outpatient services are far higher than payment rates to hospitals under the outpatient prospective payment system and help CAHs remain financially viable. However, this results in higher beneficiary cost-sharing liability for most fee-for-service Medicare outpatient CAH services because CAH cost-sharing is set at 20 percent of charges, rather than 20 percent of the Medicare payment amount. Beneficiary coinsurance liability represented more than 50 percent of CAHs' total Medicare outpatient revenues in 2022. However, 84 percent of beneficiaries had supplemental coverage that would shield them from this liability.

MEETING DISCUSSION: MedPAC discussed this issue in September 2024, and included a draft recommendation in January 2025 that would set beneficiaries' cost-sharing liability for CAH outpatient services at 20 percent of the otherwise applicable OPPS payment amount, and cap beneficiaries CAH coinsurance liability at an amount equal to the Part A deductible (consistent with coinsurance under the OPPS. The recommendation would leave total outpatient revenues to CAHs unchanged, but would shift these revenues from beneficiaries to the Medicare program, and result in higher program FFS spending, higher Medicare Advantage spending, and higher Part B premiums for all beneficiaries. MedPAC brought the January recommendation up for a vote at this meeting.

[The recommendation only specifies "the payment amount" rather than "the payment amount otherwise applicable under Medicare's OPPS" or words to that effect. More specificity would be required should Congress consider this recommendation in specific legislative language.]

Commissioners voted unanimously in favor of the recommendation. It will appear in a chapter in MedPAC's forthcoming June 2025 Report to the Congress.

Implementing this recommendation would require a change in law.

3. MEDICARE INSURANCE AGENTS (Ledia Tabor, Jennifer Druckman, Pamina Mejia; 1:30 PM - 2:45 PM)

ISSUE: Increasingly, beneficiaries have reported working with insurance agents (also referred to as brokers) to select their Medicare coverage. MedPAC's interest is driven by concerns that commissions or other broker financial incentives may result in beneficiaries being steered to plans (Medigap, Part D, or Medicare Advantage (MA)) that are not optimal for them. This is MedPAC's first foray into this topic, and the information is being provided in response to commissioner requests in order to lay the analytic foundation for potential future Commission work.

MEETING DISCUSSION: The staff presentation covered basic information on agent/broker qualifications and roles, Federal and state regulatory requirements governing their work, and how they are compensated (again, including regulatory constraints).

MedPAC staff reported that brokers typically receive higher commissions for initial enrollments than for renewals, and that they receive higher commissions for Medicare Advantage – Prescription Drug Plans (MA-PD) than they do for Medigap or standalone Part D Prescription Drug Plans (PDPs). Staff also report that brokers receive higher commissions for enrolling beneficiaries in higher-cost plans within a given plan type compared to lower-cost plans. MedPAC staff also indicate that CMS in recent years has received greater numbers of beneficiary complaints with respect to broker/agent activities.

Staff also indicated potential future work that MedPAC may conduct: Beneficiary focus groups, interviews with State Health Insurance Assistance Program (SHIP) counselors, ongoing tracking of basic relevant information, and investigations of other topics related to beneficiary decision

making (*e.g.*, Medicare Plan Finder). As this is an initial set of information, MedPAC is not planning to include it in its forthcoming June 2025 Report to the Congress.

Commissioners appeared to react highly favorably to the material the staff presented. Some commissioners were interested in whether Medicare requires brokers to discuss with enrollees in MA plans the difficulties they may experience if they later decide to disenroll from MA and return to traditional Medicare. The majority of commissioners emphasized the profound complexity of the decisions facing beneficiaries with respect to their coverage options. Some commissioners suggested the need for an alternative to the current broker/agent system, with one saying that the current structure "will never be a good situation for beneficiaries… can't be fixed… blow it all up." Another commissioner stated that "the incentives are wrong" at multiple levels, and suggested the need for a public sector approach, rather than leaving enrollment assistance to the plans. Other comments included phrases like "fundamentally broken," "lack of transparency," "misaligned incentives," *et cetera*.

It is worth noting that one commissioner expressed the opposite view, arguing that a central bureaucratic approach is unnecessary, given that beneficiaries make other major financial decisions on their own. However, these comments were not consistent with the majority of commissioners' reactions, and we believe it is unlikely these comments will alter the trajectory of future MedPAC work in this area.

Given the commissioners' discussion, we would anticipate that MedPAC will devote resources to continuing this body of work. A likely trajectory would involve a chapter in the MedPAC June 2026 Report to the Congress, which could lay the groundwork for a subsequent report with recommendations on this topic (MedPAC usually takes two analytic cycles before getting to recommendations on a new topic). *Stakeholders with equity in the broker/agent/plan space would be well-advised to engage with MedPAC **this spring** in order to start to meaningfully inform and shape the Commission's work.*

4. PRELIMINARY WORK ON MEDIGAP (Ledia Tabor, Jennifer Druckman; 2:55 PM - 4:10 PM)

ISSUE: Beneficiaries selecting fee-for-service Medicare can obtain supplemental (Medigap) insurance to protect themselves against certain cost sharing and coinsurance. As with the preceding session on brokers, this is MedPAC's first discussion of this topic in recent memory, and the information is being provided in response to commissioner requests in order to lay the analytic foundation for potential future Commission work. Commission staff are not anticipating that this material will compose a June 2025 report chapter.

MEETING DISCUSSION: The staff presentation covered basic information on Medigap, including enrollment, coverage, plan options, financial considerations (*e.g.*, premiums and financial protections), and how Medigap is regulated. Staff identified three areas for potential future work: Medigap questions in MedPAC's annual focus groups, examining trends in the Medigap market over time, and examining the role of state guaranteed-issue policies on the Medigap market. Based on the staff presentation, it is not believed that MedPAC has

identified a clear and present problem with respect to Medigap, nor is the Commission teeing up specific policy options for future development at this time.

Commissioners were engaged in the topic, and asked a large number of clarifying questions on points of fact. Some commissioners noted the value of Medicare collecting information on beneficiaries' supplemental coverage (ESI, Medigap, *et cetera*), which is not currently available.

Substantively, commissioners suggested certain sub-populations of interest, such as the over-age 65 population still working, or beneficiaries who lose employer-sponsored health insurance at retirement. One commissioner suggested that the staff conduct additional work on the effects of induced demand for health care services (as a function of Medigap coverage) on Medicare Advantage benchmarks.

5. MANDATED REPORT: PAYMENT FOR GROUND AMBULANCE SERVICES (Dan Zabinski, Jeff Stensland; 4:15 PM - 5:15 PM)

ISSUE: The Bipartisan Budget Act (BBA) of 2018 required CMS to implement a ground ambulance data collection effort. In response, CMS has developed the Ground Ambulance Data Collection System (GADCS), which includes data collected from ground ambulance organizations, including information on the organizations' characteristics, service areas, total time for ambulance responses, number of responses and transports (volume), service mix (emergency, non-emergency, basic life support, advanced life support), labor costs, facility costs, vehicle costs, equipment and supply costs, and revenues. BBA 2018 also requires MedPAC to evaluate the adequacy of Medicare payments for ambulance services, evaluate the data CMS collects pursuant to the BBA 2018 mandate (including the burden on providers in reporting this data) and make recommendations on any future changes to this data collection. The MedPAC report is due June 15, 2026.

MEETING DISCUSSION: The staff presentation provided the commissioners with background on Medicare's ambulance fee schedule, findings from MedPAC's preliminary assessment of the GADCS data, and a workplan for completing the work required by the BBA 2018 mandate.

Commissioners raised technical questions on several aspects of the material (reasons for ambulance calls that did not result in a transport, reasons for cost differences based on ownership, *et cetera*), and made suggestions for specific analyses that could be conducted in the course of this work, and how results could be displayed in the final report (*e.g.*, display cost-per-response by type of response (basic life support *vs*. advanced life support, emergency / non-emergency)). In general, however, commissioners seemed to understand the objectives of the mandate, and concurred with the staff workplan.

It is very early in the course of this work for commissioners to identify specific policy direction, but it is likely that this kind of specific guidance will be forthcoming as the work evolves over MedPAC's 2025-2026 analytic cycle. *Stakeholders with equity in the ambulance space would be well-advised to engage with MedPAC* ***this spring, and in the fall of 2025,*** *in*

order to start to meaningfully inform and shape the Commission's work in responding to the BBA 2018 mandate.

Friday, March 7, 2025

6. EXAMINING HOME HEALTH CARE USE AMONG MEDICARE ADVANTAGE ENROLLEES (Betty Fout, Evan Christman, Andy Johnson, Stuart Hammond; 9:00 AM - 10:10 AM)

ISSUE: Commissioners have previously expressed interest in understanding home health (HH) care use among Medicare Advantage (MA) enrollees. Multiple studies have used Medicare's home health Outcomes and Assessment Information Set (OASIS) data to examine home health use among MA enrollees, but it is difficult to draw conclusions from these studies because OASIS data contain no information on the number, length, or type of home health visits that beneficiaries receive.

MEETING DISCUSSION: Staff have updated and refined the preliminary analysis presented in October 2024 in light of commissioner guidance. Staff used 2021 MA home health encounter data and OASIS data to conduct these analyses.

MA home health users were more likely to be older, poorer, and to have had an acute care hospitalization during the year compared to beneficiaries who did not use home health care. In contrast to FFS Medicare, which does not impose cost sharing for home health care, 24 percent of MA home health users were enrolled in plans that imposed some level of cost sharing. Staff presented information on differences in HH use among different types of MA plans, and differences between MA and FFS home health users (*e.g.*, in general, HH use was roughly 10 percent lower among MA enrollees compared to FFS in terms of HH visits per user; other metrics of utilization showed smaller differences).

Staff reported results of interviews with home health agencies, which indicated that MA payment rates were substantially lower than FFS rates, often below the cost of providing this care. Far fewer home health agencies provided care to MA enrollees compared to FFS beneficiaries.

MedPAC staff did not tee up any particular policy direction for future iterations of this work; it will appear as an informational chapter (no recommendations or policy options) in MedPAC's forthcoming June 2025 Report to the Congress.

During the discussion segment of the meeting, certain commissioners made comments at odds with information presented at previous meetings regarding HHAs' and MA plans' financial performance under Medicare. (Staff corrected one commissioner with respect to HH financial performance.) Commissioners asked a number of technical questions about the analysis, and suggested that additional information (*e.g.*, specific estimates of MA cost sharing for HH, outcomes (such as hospital readmissions or emergency department use), patient satisfaction, MA plans' coverage of other types of post-acute care, *et cetera*) would help build out future analyses. Several commissioners expressed a certain amount of relief that MA plans do not appear to be

impeding access to HH care for their enrollees. In general, commissioners supported the current work, and it is anticipated that MedPAC staff will continue to refine these analyses using more current data as part of its maintenance of effort with respect to both home health care and Medicare Advantage.

7. INSTITUTIONAL SPECIAL NEEDS PLANS (Eric Rollins, Carol Carter; 10:15 AM - 11:45 AM)

ISSUE: In 2022, about 1.2 million beneficiaries lived in nursing homes (NH), which provide services such as 24-hour medical and skilled nursing care, rehabilitation services, meals, and assistance with activities of daily living. As a group, the long-stay NH population has significant care needs and high medical costs, and there have been long-standing concerns about the quality of care they receive in nursing homes. Institutional special needs plans (I–SNPs) are specialized MA plans for beneficiaries who live in nursing homes. These plans aim to improve quality and manage costs by providing more care in the NH setting and modifying how NHs are reimbursed.

MEETING DISCUSSION: MedPAC staff presented a range of information on I-SNPs, their sponsors, and the characteristics of the populations they serve. Staff also described other types of plans that serve the Medicare institutionalized population (Medicare-Medicaid Plans, Dual-eligible Special Needs Plans, and PACE plans).

Nursing homes that are larger, for-profit, and urban were more likely to participate in I-SNPs than other types of nursing homes. Residents of NHs that participated in I-SNPs had longer lengths of stay and lower mortality than other NH residents, but MedPAC is not yet able to determine whether these differences are related to quality of care, or patient selection. NHs with I-SNPs performed better on quality measures, and had lower use of hospital inpatient care, but MedPAC staff cautioned that these results should be interpreted cautiously given data and risk-adjustment limitations.

As with several other sessions at the March meeting, this was informational, and staff did not raise specific policy directions, but rather solicited guidance from commissioners on future work. It does not appear that this material is slotted for publication in the forthcoming June report to the Congress. (Commissioners often refer to the staff's written meeting materials as a "chapter," but this does not necessarily imply that it will appear in this year's report.)

Commissioners reacted positively to the staff work. At least one commissioner signaled that I-SNPs ideally, given the right incentives, are entities that could be held accountable for a frail population that has traditionally been challenging to care for. Several commissioners suggested ideas for additional analyses, such as examining the relationship between staffing ratios and outcomes, and how that relationship varies among nursing homes affiliated with I-SNPs versus those that are not so affiliated. Commissioners were also interested in exploring supplemental benefits that I-SNPs may be providing for their enrollees. It is anticipated that MedPAC will continue to research issues related to the I-SNP, institutionalized, and institution-eligible Medicare populations as part of its policy research maintenance of effort through its 2025-2026 analytic cycle.

Beyond the substantive content of this presentation, interestingly, one commissioner argued for the restoration of the opportunity for live public comments following the end of each segment of MedPAC's public meetings.