MedPAC Meeting Notes

April 11, 2024

Telehealth in Medicare: Status Report
Slides (pdf)
On April 11, the Medicare Payment Advisory Commission (MedPAC) considered an analysis of telehealth services covered by Medicare. Staff presented a briefing (slides attached) that included an overview of Medicare's current telehealth policies, some of which are set to expire at the end of 2024. They also presented data depicting trends in telehealth use, the clinicians providing telehealth services, and policies that appear to have been designed to limit waste, fraud, and abuse associated with telehealth.

In general, commissioners noted the benefits of telehealth, particularly as they help to address patient access issues and improve geographic and racial/ethnic care disparities. There was considerable discussion about how the proliferation of telehealth services has impacted care in RHC and FQHCs. Staff noted that the results indicated a larger uptake in rural communities but also cautioned that utilization could be limited in RHCs and rural FQHCs because those providers are the only ones in the community. The discussion tended to separate telehealth and behavioral telehealth and many commissioners noted that the shortage of providers, particularly behavioral health providers, is a reason not to limit access to telehealth and not to create disparate payments for telehealth and in-person visits.

Most commissioners also agreed that, unless there is a clinical reason, it does not make sense to continue to require patients to receive in-person care in order to be eligible for telehealth benefits. They suggested that it seemed like an arbitrary requirement that may have been used by Congress as a crude tool to protect program integrity and that other policies might be more effective in achieving that goal. Commissioners expressed an interest in learning more about how Medicare Advantage plans are administering telehealth benefits. There was also passing mention of blocking "incident-to" telehealth billing so that utilization could continue to be monitored accurately.

Considering Approaches for Updating the Medicare Physician Fee Schedule
Slides (pdf)
MedPAC staff provided background information on the Medicare Physician Fee Schedule (PFS) (slides 1-5 in the attached document) and reviewed the commission's historical priorities in determining the adequacy of Medicare Part B payment. They noted three main concerns driving the commission's decision to consider modifying provider payments in the future:

1. Medicare Economic Index (MEI) growth is projected to exceed fee schedule updates by more than it did in the past
2. Site of service payment differentials
3. Weak incentive to participate in A-APMs in the late 2020s

MedPAC staff proposed three approaches to updating the fee schedule to address these concerns.

Approach 1: Update practice expenses by the hospital market basket minus productivity

- Update the practice expense (PE) portion of fee schedule payment rates by the hospital market basket index, minus productivity.
    - Would require two conversion factors:
        - PE conversion factor would be automatically updated each year
        - Work & PLI conversion factor would not be automatically updated
- Rationale
    - Disparities in updates for PE costs between the physician fee schedule and hospital OPPS may incentivize vertical consolidation
    - Measures of clinician supply and beneficiary access could be interpreted to mean that payments for work are currently sufficient
- Potential additional policies:
    - Ensuring accuracy of RVUs is important for any PFS reform approach, but especially if PE and work RVUs were updated at different rates
    - Reform 10- and 90-day global surgical codes
        - Evidence that work RVUs for these codes are overvalued
        - Reducing spending on these codes could be redirected to increasing payments for other codes
    - Commission could pursue other policies for improving the accuracy and timeliness of data used to determine RVUs

Approach 2: Update payment rates by Medicare Economic Index minus 1 percentage point

- Update single conversion factor by the Medicare Economic Index (MEI) minus 1 percentage point
    - Put a floor on annual updates equal to half of MEI
- Rationale
    - Presumes both PE and work costs increase over time
    - MEI is designed to track weighted cost trends of clinician practices, including both work and PE
    - In two decades prior to pandemic, PFS updates have averaged about MEI minus 1 percentage point
        - Clinician participation has generally been stable and beneficiary access similar to privately insured
    - Likely to be more predictable and stable than past update approaches
- Potential additional policies
    - Could be paired with policies to address issues with practice expense RVUs that contribute to vertical consolidation
    - Rescale RVUs to reflect updated MEI data
        - Aggregate RVUs normally reflect MEI's distribution of PE and work costs associated with furnishing clinician services
        - CMS has not rescaled RVUs to reflect updated MEI cost data
        - Rescaling would increase PE RVUs and could help address vertical consolidation
    - Commission could pursue other policies to improve accurate and timely valuation of PE RVUs

Approach 3: Extend the Advanced Alternative Payment Model (A-APM) participation bonus for a few years

- Approaches 1 and 2 would replace current law's differential updates
- To incentivize participation in A-APMs over MIPS, could:
  - Repeal MIPS (per our 2018 recommendation)
  - Extend the A-APM participation bonus for 2 or 3 years (through 2028 or 2029)
- If MIPS is continued, an extended A-APM participation bonus could help maintain clinician participation in A-APMs in the late 2020s, given uncertainty about whether MIPS will become a more generous program
- Once MIPS's future direction becomes clearer, could reassess the need for the A-APM participation bonus
- If bonus is temporarily extended: What size to make it? Freeze payment & patient participation thresholds? Restructure bonus?

Before opening the discussion, MedPAC Chair, Michel Chernow noted that these are very early conversations. The commission would not be voting on an approach today. Commissioners were encouraged not to get caught up in intricate details that could be incorporated into different proposals or removed as the commissioners wish.

There appeared to be broad support for reforming Medicare reimbursement in some way. The Chair even noted that he was sympathetic to the notion that physician payment should keep up with inflation. However, he also cautioned that doesn't mean he necessarily believes that existing or historical payments were accurate. Many commissioners noted the relationship between adequate payment and the physician shortage. One commissioner renewed commentary regarding how MedPAC evaluates the adequacy of the physician workforce. He noted that qualitative surveys of beneficiaries' experiences likely result in under-reporting of beneficiary access issues and suggested that MedPAC generate a quantitative metric and/or considers duration of a patient's delay before seeing a specialist and how that scheduling was impacted by other facets of their lives, like their ability to get time off work.

Commissioners were generally supportive of preserving incentives to improve participation in alternative payment models, with the exception of Brian Miller who pointed to evidence that the Center for Medicare and Medicaid Innovation has spent millions of dollars and they have generated minimal savings from only some of the payment models they created. Commissioner Jonathan Jaffery suggested that APM bonus payments should be based on the patients who are in the A-APMs, not the provider's entire book of Medicare patients. His suggestion received significant support.

Approaches 1 and 2 seemed less well understood. While some commissioners demonstrated a preference for one over the other, neither choice was emphatically endorsed or rejected.

Notable Comments on Approach 1

- It has the potential to exacerbate some of the existing underlying distortions in the Fee Schedule
- How we create RVUs needs to be restructured to be more consistent with how the rest of the Medicare program works (i.e., market-basket adjustments).
- Volume and intensity will always go up.
- This approach should be modified to create differential (higher) payment adjustments for safety net providers and primary care providers.
- Support eliminating the globals.

Notable Comments on Approach 2

- Is a little on the rich side,
- If Congress were to enact MedPAC's recommendation for site neutral payments, many physician-owned hospitals would be switching to the fee schedule. This means that, if we know that current fee schedule payments are inadequate, they will have to catch up.

Assessing consistency between plan-submitted data sources for Medicare Advantage enrollees

Slides (pdf)

In its June, 2019 report, MedPAC observed that Medicare Advantage (MA) plans have a strong incentive to submit data that contribute to enrollee risk scores but a weaker incentive to report on other encounter data. They recommended expanding the performance metric framework for assessing encounter data completeness, applying a payment withhold to increase compliance, and collecting MA data through Medicare Administrative Contractors if necessary.

MedPAC staff provided an overview of the types and sources of data that are submitted to CMS and summarized their analysis of MA data completed in March 2024. MedPAC staff also evaluated MA plan-reported encounter data against MA plan bid data and HEDIS data. All of this information can be found in the attached slides.As the discussion would further demonstrate, all of these data sets have some commonality but, because they are designed for different purposes, they do not tell the whole story. MedPAC staff concluded that

- Sources of data on MA enrollee' use of services are incomplete but are incrementally improving.
- Data validation is limited for physician and outpatient encounters
- MedPAC's 2019 recommendations would address many of these issues.

Although the commissioners were not yet considering options for policy recommendations, they did note that, like 2019 recommendation suggests, when the Medicare program starts to use the data for fundamental programmatic purposes, plans will have an incentive to report. In response Chair Chernow asked if it was better to build the policy and assume the data will come or require the data and then build the policy around it. Commissioners emphasized that we need better data on a program that spends so much and impacts so many. One commissioner also noted that creating more common approaches to data collection across all sectors (MA, FFS, and ACOs) is the only way to have accurate and complete information.