MEDPAC | Medicare Payment Advisory Commission

TESTIMONY MATERIALS

Responses to questions for the record for the hearing entitled: Examining how improper payments cost taxpayers billions and weaken Medicare and Medicaid

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Submitted to the:
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives

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On April 16, 2024, the Subcommittee on Oversight and Investigations of the Energy and Commerce Committee convened a hearing at which Michael E. Chernew, Ph.D., Chair of the Medicare Payment Advisory Commission (MedPAC), testified about improving payment accuracy in the Medicare program. Following the hearing, Representative Dan Crenshaw and Representative Kat Cammack submitted questions for the record to MedPAC. This document provides MedPAC's responses.

MedPAC is dedicated to providing independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. We hope the Committee Members find the information provided in our responses helpful, and we welcome the opportunity to provide any additional resources that can be used by the Committee to ensure Medicare patients have good access to care and to reduce provider burden.

The Honorable Dan Crenshaw

Question: Dr. Chernew, you say that MA plans will be paid $88 billion more than FFS spending would be in 2024. How do you know how much FFS will spend in 2024? Or MA for that matter?

Answer: To project FFS spending in 2024, we started with the projection of FFS spending by county included in the 2024 MA rate book published by CMS. We then adjusted that projection to remove spending related to double payments for indirect medical education made to teaching hospitals. That projection of FFS spending is subject to uncertainty, and actual spending could be higher or lower if health care utilization or Medicare payment rates are higher or lower than projected.

To project MA spending in 2024, we used information from the benchmarks that CMS published with the rate announcement on July 31, 2023; the bids that MA plans submitted to CMS; data on expected enrollment in MA plans; and expected risk scores. With that information, we estimated Medicare's payments to MA plans in 2024. Because MA spending is based on those published benchmarks and the bids that plans submitted, there is less uncertainty in projecting MA spending than in projecting FFS spending. However, actual MA spending could still be higher or lower if risk scores are higher or lower than expected (among other reasons).

Each year, MedPAC includes an estimate of the effects on Medicare spending when a beneficiary enrolls in MA or FFS. In our March 2024 report to the Congress, we estimated that Medicare spending would be about $83 billion higher in 2024 because of higher Medicare spending when beneficiaries enroll in MA relative to FFS. That estimate of higher spending stems largely from two issues related to risk adjustment: (1) differences in how diagnoses are coded in MA relative to FFS and (2) favorable selection experienced by MA plans, where beneficiaries with lower spending relative to their risk scores disproportionately enroll in MA relative to FFS. The Commission included a chapter detailing its methods for estimating coding intensity

and favorable selection in its March 2024 report to the Congress. Those analyses are subject to uncertainty, and the Commission will continue to refine its estimates in the future.

Question: Dr. Chernew, do you agree that dual-eligible beneficiaries cost Medicare more, on average, than non-duals? Do you agree that dual-eligible beneficiaries are more likely to enroll in MA?

Answer: In 2022, a higher share of beneficiaries qualifying for dual eligibility are enrolled in MA relative to Medicare FFS. On average, dual-eligible beneficiaries have higher per person spending than other beneficiaries. In 2021, we found that per person Medicare FFS spending for certain Medicare-covered services, including inpatient hospital, skilled nursing facility, and home health, was higher for dual-eligible beneficiaries than for non-dual Medicare beneficiaries. Because dual-eligible beneficiaries tend to have relatively higher risk scores, MA plans receive a higher payment, on average, for dual-eligible enrollees than for non-dual-eligible enrollees. The extent to which this higher payment for dual-eligible beneficiaries offsets their higher cost depends on the selection effect within the dual-eligible population (some would spend more than the average dual-eligible beneficiary and others less than the average dual-eligible beneficiary). If dual-eligible beneficiaries with lower expected spending than the average dual-eligible beneficiary systematically enroll in MA, there will be a positive selection effect among the dual-eligible population, even though these beneficiaries have higher spending than the average Medicare beneficiary.

Question: Dr. Chernew, it appears there is significant imbalance in the expertise represented on MedPAC. This could potentially skew the commission's perspective on issues directly impacting health care costs and quality. What steps do you recommend being taken to address this imbalance and ensure MedPAC's recommendations are well-rounded and representative of differing views?

Answer: Under Section 1805 of the Social Security Act, MedPAC Commissioners are appointed by the Comptroller General of the United States for their expertise across the health care spectrum. MedPAC does not have any authority in the appointment process.

The Commission appreciates the importance of diverse experience and views in its work and takes several steps to promote such diversity. The Commission routinely meets with and receives data and information from stakeholder groups, and publishes a list of stakeholders with whom MedPAC staff meet each year . The Commission also receives public comments as part of its public meetings and publishes official comment letters on our website. The Commission also promotes transparency in its work, including webcasting its public meetings so that members of the public can easily view them, posting transcripts of public meetings, publishing its reports and other products on its website, and publishing its anticipated analytic agenda for the coming year . The Commission leadership periodically meets with the

Chairs and Ranking Members of the Committees with jurisdiction over Medicare to receive feedback on the Commission's agenda.

The Honorable Kat Cammack

Question: Dr. Chernew, thank you for joining us. Given our committee's focus on curbing wasteful spending within Medicare, I want to discuss MedPAC's recommendations on "site neutral payments." This policy aims to standardize payments for services, regardless of the setting, which could potentially eliminate unnecessary spending. Do you agree that this would reduce wasteful spending in the Medicare program? Can you detail MedPAC's specific recommendations on site neutral payments and their projected impact on Medicare spending?

Answer: Adjusting rates paid for certain services delivered in higher-cost settings to more closely align with the rates paid in lower-cost settings in which it is safe to provide the service would reduce incentives to shift the billing of Medicare services from lower-cost settings to higher-cost settings. The result would be lower Medicare program spending, lower beneficiary cost sharing, and an incentive for providers to improve efficiency by caring for patients in the lowest-cost site appropriate for their condition. In our June 2023 report to the Congress, MedPAC recommended that "The Congress should more closely align payment rates across ambulatory settings for selected services that are safe and appropriate to provide in all settings and when doing do does not pose a risk to access." The recommendation would have no direct effect on Medicare program spending because CMS would apply budget-neutral increases to the OPPS payment rates of the nonaligned services to offset the effects of the lower aligned payment rates. However, this recommendation likely would have an indirect effect on program spending, as it would reduce incentives for hospitals to acquire physician practices, which would lower the extent to which the billing of the services with aligned payment rates shifts from the physician fee schedule to the OPPS. We cannot be certain of the magnitude of the program savings because we are not certain of the extent to which this policy would mitigate hospital acquisition of physician practices. However, we would expect that the magnitude of the program savings would rise over time if provider consolidation slowed.