# 2021 Physician Fee Schedule Changes Do Not Account for Impact on Medicare Advantage

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BETTER MEDICARE ALLIANCE

*Analysis conducted by Avalere Health*

## Executive Summary

The Consolidated Appropriations Act of 2021 included a 3.75% increase in provider payments under the Medicare Physician Fee Schedule for 2021. However, these increased payments are not accounted for in 2021 payments to Medicare Advantage plans, because 2021 payment rates to health plans were set prior to this change, as they were required by statute to be finalized by April of 2020. This unanticipated change in payment policy may result in CMS underpaying Medicare Advantage plans by an average of 0.83%, or $202.4M, in 2021 and could be a significant problem if such changes are made year over year.

## Overview

On December 21, 2020, Congress passed the Consolidated Appropriations Act (CAA) of 2021. In addition to funding federal agencies through fiscal year (FY) 2021, the bill also included a 3.75% increase in provider payments under the Medicare Physician Fee Schedule (MPFS). Congress made this change to offset scheduled decreases to the MPFS that would otherwise have been in place for 2021. However, because 2021 Medicare Advantage payment was finalized in April of 2020, CMS payment to Medicare Advantage plans in 2021 does not account for the additional costs that plans could face from this payment change. To the extent that plans pay providers based on the MPFS, the increase in the MPFS could lead to increased costs, and potential underpayment, for Medicare Advantage plans.

## Background on Medicare Advantage Plan Payment and the MPFS

The statutory required timing of finalizing Medicare Advantage benchmarks can create challenges because CMS sets county-level benchmarks based on estimated Medicare fee-for-service (FFS) spending per beneficiary in that county in April prior to the benefit year. Any changes made after April, such as those put forward by the CAA of 2021, are not reflected in the Medicare Advantage payment. In calculating the benchmark, CMS anticipates Part A and Part B spending for Medicare providers. These benchmarks include CMS' assumptions for provider payments based on historical trends; CMS detailed these assumptions in the Final Rate Notice for 2021.

The MPFS sets Medicare FFS payment rates for physician services (e.g., patient visits, ordering of laboratory tests, administration of products, etc.) for the following calendar year. CMS does not require Medicare Advantage plans to pay providers the rates established by the MPFS. However, plans in many cases have provider contracts tied to the MPFS. This sets up a situation in which providers would expect Medicare Advantage plans to include equivalent increases to the MPFS in their payments even though plans are being paid by CMS based on a lower anticipated fee schedule. In this scenario, plans would experience underpayments because these higher provider costs were not accounted for in the payment rates, due to the timing of when CMS calculates the county benchmarks.

## Potential Impact of 3.75% Increase in Provider Payments

To assess the impact of the unanticipated changes in provider reimbursement, Better Medicare Alliance commissioned Avalere to model the potential impact in Medicare Advantage plan payments by assessing the percent increase in the 2021 benchmarks had CMS anticipated the increase in provider payments included in the CAA of 2021.

Avalere found that, if the increase to the MPFS had been incorporated into the 2021 Medicare Advantage benchmarks, Medicare Advantage plan payments would have increased nearly 1%, which equates to $202.4M for the 2021 contract year. The actual 2021 payments will be lower because the MPFS adjustment was not incorporated. The impact will vary by geography. Among the 5 states with the largest Medicare Advantage enrollment, payment could range from 1.04% lower in Florida to 0.76% lower in Pennsylvania (Table 1). Among the metropolitan statistical areas with the most Medicare Advantage enrollees, payments to plans could be close to 1% lower in the greater New York City, Miami, and Los Angeles areas (Table 2).

### Table 1: Potential Impact to Medicare Advantage Plan Payments, Top 5 States by 2021 Medicare Advantage Enrollment

| Top 5 States | 2021 February Medicare Advantage Enrollment | Anticipated FFS Costs Under FFS Rates Published by CMS in April 2020 | Anticipated FFS Costs Under FFS Rates After 3.75% MPFS Increase | Percent Difference |
|---|---|---|---|---|
| **California** | 2,900,666 | $2.96B | $2.98B | 0.86% |
| **Florida** | 2,389,134 | $2.42B | $2.43B | 1.04% |
| **Texas** | 1,945,774 | $2.07B | $2.08B | 0.84% |
| **New York** | 1,665,280 | $1.55B | $1.56B | 0.89% |
| **Pennsylvania** | 1,279,013 | $1.16B | $1.17B | 0.76% |

### Table 2: Potential Impact to Medicare Advantage Plan Payments, Top 5 Metropolitan Statistical Areas by 2021 Medicare Advantage Enrollment

| Top 5 Metropolitan Statistical Areas | 2021 February Medicare Advantage Enrollment | Anticipated FFS Costs Under FFS Rates Published by CMS in April 2020 | Anticipated FFS Costs Under FFS Rates After 3.75% MPFS Increase | Percent Difference |
|---|---|---|---|---|
| **New York-Newark-Jersey City, NY-NJ-PA** | 1,325,877 | $1.38B | $1.39B | 0.98% |
| **Los Angeles-Long Beach-Anaheim, CA** | 1,038,701 | $1.12B | $1.13B | 0.92% |
| **Miami-Fort Lauderdale-West Palm Beach, FL** | 695,940 | $753.6M | $760M | 0.99% |
| **Chicago-Naperville-Elgin, IL-IN-WI** | 469,251 | $485.2M | $489.1M | 0.81% |
| **Houston-The Woodlands-Sugar Land, TX** | 462,541 | $537.4M | $541.7M | 0.80% |

Source for Metropolitan Statistical Areas: United States Office of Management and Budget (OMB). Core based statistical metropolitan divisions, and combined statistical areas (CSAs) Delineation Files. Accessed here.

## Implications for Medicare Advantage Plans and Beneficiaries

**Any modifications to factors that increase costs included in Medicare Advantage payment that occur after the month of April when payment rates are set could cause inaccurate CMS payment to Medicare Advantage plans.** While the increase in provider payments under the MPFS may help alleviate the financial burden on providers resulting from COVID-19, the timing of these changes has a negative impact on Medicare Advantage.

Specifically, as the changes to provider reimbursement included in the CAA occurred in December, after the publication of the Rate Notice in April, these costs were not reflected in Medicare Advantage plan benchmark calculations. **Avalere's analysis finds that Medicare Advantage plan payments could be up to 1% lower than what they would have been had CMS anticipated and included these costs in the original benchmark calculations.**

**To avoid underpaying Medicare Advantage plans, CMS should consider anticipating changes made after publication of the Final Rate Notice to provider payments when setting the Medicare Advantage benchmarks, or be allowed by Congress to make subsequent adjustments prior to the final bid submissions in June, or be allowed by Congress to make additional payments to health plans to account for the increased costs.** That is, CMS should avoid repeating a situation that occurred in earlier years when Congress would pass end of year legislation to offset potential reductions under the Sustainable Growth Rate (SGR). For a number of years, CMS assumed that reductions under the SGR would take place when it estimated annual Medicare Advantage benchmarks. However, each year from 2003 through 2012, Congress suspended the SGR reductions after CMS set Medicare Advantage payment rates. As a result, actual physician payments were higher than plans had anticipated, and to the extent that plan payments to providers were linked to the MPFS, plans were underpaid. In April 2013, CMS acknowledged this problem and changed its approach by no longer assuming SGR reductions would occur when setting the FFS payment rates for 2014. CMS maintained this policy until Congress permanently repealed the SGR payment formula.

**Year over year underpayment to Medicare Advantage plans due to late year increases in reimbursements in the MPFS could impact enrollee affordability and patient access to care.** Medicare Advantage plans rely on accurate payments from CMS that reflect Medicare costs associated with providing care to their enrollees. CMS should consider incorporating likely changes to provider reimbursement in the benchmarks to avoid Medicare Advantage plans from limiting benefit offerings or increasing premiums in response to payment rates that do not reflect Medicare costs.

## Methodology

Avalere first identified the share of Medicare spending at the county level that is associated with physician spending (e.g., E&M, Procedure, Testing, and Imaging Costs) using data from CMS. Avalere used data from the five-year lookback period of 2014 to 2018 that CMS uses to calculate the 2021 county rates. For each county, Avalere estimated the average portion of FFS spending associated with physician spending over the 2014 to 2018 period. Then, Avalere applied this portion of the spending, at the county level, to determine the impact on the estimated 2021 FFS costs for the county. For example, if 40% of the county's costs were physician payments, the corresponding increase in that county due to the 3.75% MPFS increase would be 1.5% (3.75% * 40%). Avalere then estimated the overall cost difference between the new costs and the published FFS costs by taking the difference between these two values. Avalere multiplied the number of Medicare Advantage enrollees as of February 2021 from CMS to determine the total FFS costs to Medicare Advantage plans before and after application of the 3.75% MPFS increase.