

Report to the Congress: Medicare Payment Policy

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Statement of
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Committee on Ways and Means
U.S. House of Representatives

Chairman Stark, Ranking Member Camp, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss MedPAC's March Report to the Congress and our recommendations on Medicare payment policy.

The Commission has become increasingly concerned with the trend of higher Medicare spending without a commensurate increase in value to the program. (An increase in value would be, for example, beneficiaries receiving higher quality services with no increase in spending.) That trend, combined with the retirement of the baby boomers and Medicare's new prescription drug benefit, will, if unchecked, result in the Medicare program absorbing unprecedented shares of the GDP and of federal spending. Policymakers need to take steps now to slow growth in Medicare spending and encourage greater efficiency from health care providers, while assuring access and maintaining or improving quality.

In our March report to the Congress, we review Medicare fee-for-service payment systems for eight sectors: hospital inpatient, hospital outpatient, physician, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). The Commission recommends changes to payment and other policies designed to make payments more accurate and to improve the value received by beneficiaries and taxpayers for their expenditures on health care.

Our March report also reviews recent findings and past recommendations on the Medicare Advantage (MA) plans beneficiaries can join in lieu of traditional fee-for-service Medicare, and the private plans offering the new prescription drug benefit. We express our support for the MA program, but also our concern that payments for private plans are higher than the amount traditional Medicare would have spent on the same beneficiaries. We also provide information on the enrollment, benefits and premiums of the plans offering the new prescription drug benefit, both the stand-alone prescription drug plans and the prescription drug plans affiliated with MA plans.

Medicare should exert continued financial pressure on providers to control their costs, much as would happen in a competitive marketplace. We have found, for example, that hospitals under financial pressure tend to control cost growth better than those that have non-Medicare

revenues that greatly exceed their costs. In all sectors, Medicare should also adjust payments for quality, paying more for high quality and less for poor quality. The Commission is striving to pursue innovative means to increase value in Medicare while maintaining financial pressure in all of its payment systems to restrain costs.

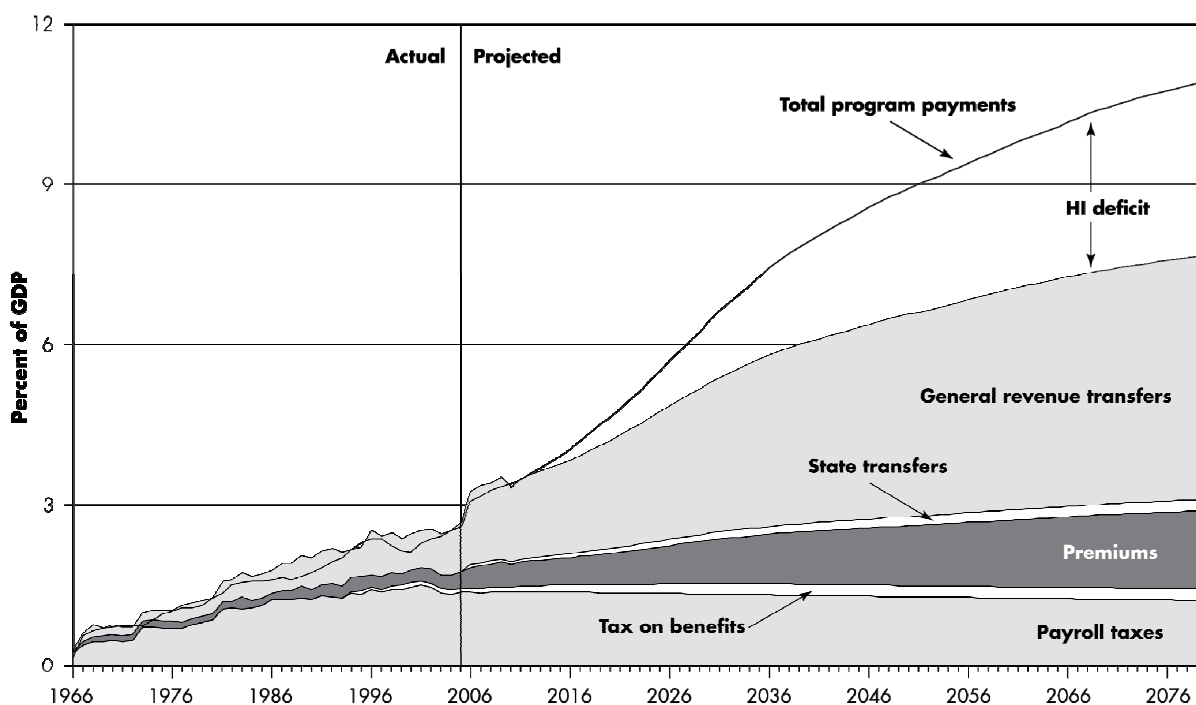
Context for Medicare payment policy

Medicare was designed to help ensure access to medically necessary care for the aged and disabled. Many analysts give Medicare credit for improving the economic position of its beneficiaries. Today, however, Medicare and other purchasers of health care in our nation face enormous challenges for the future. One challenge relates to the wide variation in the quality and use of services within our health care system, with quality often bearing no relationship or even a negative relationship to spending. Analysts point to geographic variation in spending as evidence of inefficiency and waste. Although spending is rising it is not clear that beneficiaries are seeing commensurate increases in the quality of their care or their health. A second challenge is that, as is true for other purchasers of health care, Medicare's spending has been growing much faster than the economy. In Medicare, forces such as the broad use of newer medical technologies and enrollment growth will likely push future spending higher. Because of these forces, the Commission warns of a serious mismatch between the benefits and payments the program currently provides and the financial resources available for the future.

Figure 1 shows the Medicare trustees view of the future of Medicare financing. Total expenditures for Medicare will take up an increasing share of the nation's GDP and quickly exceed dedicated financing. In their most recent report, the Medicare trustees project that, under intermediate assumptions, the hospital insurance (HI) trust fund (which finances Part A of Medicare) will be exhausted in 2018. Because Medicare cannot pay for Part A services once the HI trust fund is exhausted, either those expenditures will have to cease or some new source of financing will have to be found. For other parts of Medicare (Part B and Part D), general tax revenues and premiums automatically increase with expenditures. Those automatic increases will impose a significant financial liability on Medicare beneficiaries, who must pay premiums and cost sharing, and on taxpayers in general. For example, if income taxes remain at their historical average share of the economy, the Medicare trustees

estimate that the program's share of personal and corporate income tax revenue would rise from 10 percent today to 24 percent by 2030 and to 40 percent by 2080.

Figure 1. Medicare faces serious challenges with long-term financing



Note: GDP (gross domestic product), HI (Hospital Insurance). Tax on benefits refers to income taxes that higher income individuals pay on Social Security benefits that are designated for Medicare. State transfers (often called the Part D "clawback") refer to payments from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

Strategies to help ensure a more sustainable Medicare program include using payment policy to obtain greater value (that is, higher quality using fewer resources or restraining unnecessary spending), increasing the program's financing, and restructuring Medicare's benefits and supplemental coverage. Policymakers will need to use a combination of approaches to address Medicare's long-term sustainability. Since Medicare heavily influences many aspects of health care, policymakers should keep in mind that the program could play a leading role in initiating some types of change. At the same time, broad trends in the health care system affect the environment in which it operates, and Medicare needs to work in collaboration with private sector payers who face similar pressures from growth in health spending.

Assessing payment adequacy and updating payments in fee-for-service Medicare

The Commission recommends payment updates for 2008 and other policy changes for fee-for-service Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system is changed. To help determine the appropriate level of aggregate funding for a given payment system, the Commission considers whether current Medicare payments are adequate by examining information about beneficiaries' access to care; changes in provider supply and capacity; volume and quality of care; providers' access to capital; and, where available, the relationship of Medicare payments to providers' costs. Ideally, Medicare's payments should not exceed the costs of the efficient providers. Efficient providers use fewer inputs to produce quality services. We then account for expected cost changes in the next payment year, such as those resulting from changes in input prices.

Improvements in productivity reduce providers' costs in the coming year. Medicare's payment systems should encourage providers to reduce the quantity of inputs required to produce a unit of service by at least a modest amount each year while maintaining service quality. Thus, in most cases where payments are adequate, some amount representing productivity improvement should be subtracted from the initial update value, which is usually an estimate of the change in input prices. Consequently, we apply a policy goal for improvement in productivity (the ten year average of productivity gains in the general economy, 1.3 percent for 2008). This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare. Competitive markets demand continual improvements in productivity from these workers and firms; as a prudent purchaser, Medicare should expect the same of health care providers.

Hospital inpatient and outpatient services

Most indicators of payment adequacy for hospitals are positive. More Medicare-participating hospitals have opened than closed in recent years. Inpatient and outpatient service volume continues to increase but at reduced rates of growth in 2005 and into 2006. The quality of care hospitals provide to Medicare beneficiaries is generally improving. Spending on hospital construction increased substantially in recent years while the median values of several

financial indicators (such as measures of debt service coverage) reached their best value ever recorded in 2005.

Hospitals with consistently lower Medicare margins (the excess of payments over costs divided by payments) over the last three years tend to have higher private payer payments. Those higher payments allow those hospitals to continue to have higher costs, and thus they are under less pressure to control costs. Table 1 shows that hospitals with consistently low Medicare margins over the last three years had revenues from non-Medicare payers that were 1.16 times the hospitals' costs for providing the services. Conversely, hospitals with consistently high Medicare margins had non-Medicare revenues just under their costs. Those hospitals were under pressure to control their costs and did so more successfully, with costs increasing at a lower rate and length of stay decreasing at a faster rate than hospitals with consistently low margins. The result was that in 2005 hospitals with low Medicare margins were less competitive with nearby hospitals and those with high Medicare margins more competitive. Excluding hospitals with consistently high standardized costs (about 17 percent of hospitals) would raise the industry-wide Medicare margin by 3 percentage points.

Table 1. Hospitals with consistently low or high adjusted overall Medicare margins face different cost pressures

Indicators:	Hospitals' adjusted Medicare margins:	
	Consistently low	Consistently high
Non-Medicare ratio of revenues to costs (2005)	1.16	0.99
Average annual increase in inpatient cost per case (2002–2005)	6.3%	5.2%
Annual change in Medicare length of stay (1997–2005)	–2.3%	–3.1%
Standardized cost per case (2005):		
Subject hospital	\$6,203	\$4,527
Hospitals within 15 miles	5,742	5,103

Note: Hospitals with consistently low or high margins had adjusted overall Medicare margins (margins calculated excluding indirect medical education and disproportionate share payments over empirically justified amounts) from 2002 to 2005 that were in the top or bottom third each year. Per cases costs are standardized for wages, case-mix, severity, outlier cases, and teaching intensity. Median values shown.

Source: MedPAC analysis of data from the Centers for Medicare & Medicaid Services.

Lack of pressure to control costs because of high non-Medicare revenues may have also contributed to an increase in the growth in costs per unit of service in 2006, leading to the negative Medicare margin (-5.4 percent) we project in 2007.

Balancing positive indicators and negative margins, the Commission recommends that the Congress update both inpatient and outpatient services by the hospital market basket, with this increase implemented concurrently with a quality incentive payment program. A pay for quality performance program would pay those hospitals with higher quality more than the basic payment rate. Although such a program would operate separately from the update, a hospital's quality performance would likely determine whether its net increase in payments in 2008 would be above or below the market basket increase.

Part of the funding for a quality incentive payment policy for all hospitals should come from reducing indirect medical education (IME) payments. Our analysis finds that more than half of the IME add-on payment is unrelated to the additional cost of care that results from the intensity of a hospital's teaching program (measured by the ratio of residents per bed). The Commission recommends that the Congress reduce the IME adjustment by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio, concurrent with implementation of a system for adjusting payments for severity of illness. Teaching hospitals as a group already have better financial performance than non-teaching hospitals under Medicare. They will also benefit from the severity adjustments to hospital payments that CMS is considering for proposed regulation and which are necessary to help improve the accuracy of the payment system.

Our recommendations on the update and IME payments, along with the contemplated severity adjustments and a focused pay-for-performance initiative, should be viewed as a package that would improve the accuracy of Medicare's acute inpatient payments while creating an incentive for improving the quality of care.

For several years, policymakers have been considering options for the federal government to help hospitals with their uncompensated care. We found little evidence of a relationship between the disproportionate share payments hospitals receive and the cost of caring for Medicare patients or the amount of uncompensated care they provide. If policymakers desire

to provide a federal payment for uncompensated care, it should be distributed on the basis of each hospital's uncompensated care not as an add-on to a Medicare per case payment rate. To provide the necessary data, the Commission recommends that CMS improve its instrument for collecting information on uncompensated care. The Commission has previously suggested specific changes to help CMS revise its data collection instrument.

Physician services

Our analysis finds that most indicators of payment adequacy for physicians are stable. Beneficiary access to physicians is generally good with few statistically significant changes in recent years. We find that the number of physicians providing services to Medicare beneficiaries has more than kept pace with growth in the beneficiary population in recent years, and per beneficiary service volume grew at a rate of 5.5 percent in 2005. Our claims analysis shows small improvements in the quality of ambulatory care. The ratio of Medicare payment rates to private payment rates was essentially unchanged.

In consideration of expected input costs for physician services and our payment adequacy analysis, the Commission recommends that the Congress update payments in 2008 for physician services by the projected change in input prices less the Commission's expectation for productivity growth. Physicians, like other providers and the taxpayer and firms that fund Medicare, should be expected to increase their productivity each year.

Although the recently passed Tax Relief and Health Care Act directs additional funds to physicians in 2008, the sustainable growth rate (SGR) formula continues to call for substantial negative updates through 2015. Though currently we do not see overall access problems, the Commission is concerned that consecutive annual cuts would threaten beneficiary access to physician services over time, particularly those provided by primary care physicians. As a mechanism for volume control, the current national SGR has several problems, which the Commission examines in its mandated report to the Congress: *Assessing Alternatives to the Sustainable Growth Rate System*.

Fee-schedule mispricing may be one factor contributing to disparities in volume growth among services. The Secretary could play a lead role in identifying mispriced services by measuring volume growth for specific services, while taking into account changes in the

number of physicians performing the service and other factors. CMS or the Relative Value Update Committee (RUC) could use the results from these analyses to flag services for closer examination of relative work values. Alternatively, the Secretary could automatically correct such mispriced services and the RUC would review such changes during its regular five-year review process.

Outpatient dialysis services

Most of our indicators of payment adequacy for outpatient dialysis services are positive. Beneficiaries' access to dialysis care is generally good; the number of facilities increased, capacity increased, and there do not appear to be access problems. The growth in the number of dialysis treatments kept pace with patient growth. Quality of care is improving for some measures; more patients are receiving adequate dialysis and more have their anemia under control. Yet, one quality measure—patients' nutritional status—has not improved during the past five years. Recent evidence about trends in opening new dialysis facilities suggests that providers have sufficient access to capital. Between 2003 and 2005, the cost per treatment for composite rate services and dialysis drugs fell, largely driven by decreases in drug prices. We project that Medicare payments will cover the costs of providing outpatient dialysis services to beneficiaries in 2007 with a margin of 4.1 percent.

Considering expected input costs and our payment adequacy analysis, the Commission recommends that the Congress update the composite rate for outpatient dialysis services in 2008 by the projected change in input prices less the Commission's expectation for productivity growth.

The Commission remains concerned that Medicare continues to pay separately for drugs and laboratory tests that providers commonly furnish to dialysis patients. Medicare could better achieve its objectives of providing incentives for controlling costs and promoting access to quality services if all dialysis-related services, including drugs, were bundled under a single payment. In addition to broadening the payment bundle, the Secretary should continue efforts to improve dialysis quality. The Commission has recommended that Medicare base a portion of payments on the quality furnished by facilities and physicians who treat dialysis patients. The Secretary also needs to continue to develop quality measures and to monitor and

improve dialysis care. Together, these steps should improve the efficiency of the payment system, better align incentives for providing cost-effective care, and reward providers for furnishing high-quality care.

Post-acute care providers

The recuperation and rehabilitation services that post-acute care providers furnish are important to Medicare beneficiaries. In our March report the Commission analyzes payment adequacy for the four types of post-acute care (PAC) providers: skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs).

Prospective payment systems (PPSs) for each setting were developed and implemented separately. While the PPSs have changed the pattern of service use within each setting, we do not have adequate data to evaluate whether beneficiaries are being treated in the setting that provides the most value to them and the program. Three barriers undermine the program's ability to know if it is purchasing high-quality care in the least costly PAC setting consistent with the care needs of the beneficiary:

- Case-mix measures often do not accurately track differences in the costs of care.
- There is no common instrument for patient assessment across PAC settings, which makes it difficult to compare costs, quality of care, and patient outcomes.
- There is a lack of evidence-based standards of care.

Similar barriers limit our ability to compare differences in financial performance among the provider within each post-acute setting. We do not know if better financial performance results from higher efficiency or differences in the mix of patients chosen for treatment, but, as might be expected, we found that those facilities had consistently low unit costs, used fewer resources, and had higher occupancy.

Skilled nursing facility services

Our indicators of payment adequacy are generally positive for skilled nursing facilities (SNFs), but quality shows a decline. Beneficiaries have good access to SNF care, although those who

need certain expensive services may experience delays in finding SNF care and end up staying longer in the hospital. The number of facilities providing SNF care to Medicare beneficiaries has remained almost constant. Spending and volume of days and stays increased in 2005, with cases continuing to shift to rehabilitation case mix groups, which receive higher payments. Two outcome measures for Medicare SNF patients show declining quality in recent years: average facility rates of avoidable rehospitalizations increased and discharges to the community declined. SNFs appear to have good access to capital. We project that Medicare payments will more than cover the costs of providing SNF care to Medicare beneficiaries in 2007 with margins for freestanding SNFs of around 11 percent.

The data suggest that skilled nursing facilities should be able to accommodate cost increases in 2008. Therefore, the Commission recommends that the Congress should eliminate the update to payment rates for SNF services for fiscal year 2008.

Some have argued that, although Medicare payments may be more than adequate, Medicaid payments to nursing facilities are inadequate and, therefore, Medicare should increase its payments to SNFs. The Commission rejects this argument for three reasons. First, Medicare payments should be set to cover the costs of an efficient provider, not to cover the additional costs of caring for non-Medicare patients. Second, increasing Medicare payments would target the wrong facilities; SNFs with more Medicare patients and fewer Medicaid patients would receive larger increases, and those with fewer Medicare patients and more Medicaid patients, would receive smaller increases. Third, if Medicare took this perspective, States might scale back their spending in response.

Home health services

Our measures for home health are positive. Access to care continues to be satisfactory; more than 99 percent of beneficiaries live in an area served by a home health agency (HHA) in 2006. The number of beneficiaries using the benefit increased substantially, the number of HHAs participating in Medicare also continues to increase rapidly, but the growth in new HHAs varies among regions with two states accounting for two-thirds of the growth. For most measures quality has increased slightly, but the rate of hospital readmissions and of unplanned admissions to emergency rooms has not changed. Between 2004 and 2005

average cost per episode grew at a rate of under one percent yielding a margin for freestanding agencies of over 16 percent. We project that Medicare payments will more than cover the costs of providing home health care to Medicare beneficiaries in 2007 and project margins remaining over 16 percent.

The data on access, quality, volume, and financial performance suggest that agencies should be able to accommodate cost increases in 2008, hence, the Commission recommends that the Congress should eliminate the update to payment rates for home health care services for calendar year 2008.

Inpatient rehabilitation facility services

Judging payment adequacy for inpatient rehabilitation facilities, which has been robust in recent years, is now more difficult because of a major change in Medicare policy. The change was CMS's modification of the 75 percent rule, which requires IRFs to have 75 percent of admissions with one or more of a specified list of conditions, and 2005 was the first full year the new rule took effect. Medicare is the principal payer for IRF services, accounting for about 70 percent of discharges.

The number of IRF cases increased rapidly after the introduction of the PPS but decreased as the 75 percent rule started to be phased in. Medicare spending followed the same trends, increasing rapidly from 2002 to 2004 but decreasing from 2004 to 2005. Our other indicators show that the supply of IRFs was stable in 2005, the patients treated by IRFs in 2005 were more complex than those who shifted to alternative settings, and quality indicators for all IRF patients and for those who were discharged home improved slightly. Most IRFs are hospital-based units that access capital through their parent institutions, which have good access.

As expected, in response to the modified 75 percent rule growth in costs per case accelerated between 2004 and 2005. This is because the volume of cases declined, and the patient mix became more complex as patients with lesser needs were treated in other settings. Aggregate Medicare margins for 2005 were high, around 13 percent. We estimate that margins in 2007 will be lower, largely because of the effect of the 75 percent rule. We estimate that the margin will range between 0.5 and 5.5 percent, depending on the ability of the IRFs to control their costs to compensate for the drop in volume.

In this time of transition from historically high margins and growth to lower margins and volume declines, the Commission recommends that the Congress update payment rates for IRFs for 2008 by 1 percent.

Long-term care hospitals

Our indicators of payment adequacy for long-term care hospitals (LTCHs) are largely positive. Medicare is the predominant payer for LTCH services and accounts for more than 70 percent of LTCH discharges. The number of LTCH providers increased between 2004 and 2005, with the number of LTCH hospitals within hospitals (HWHs) growing twice as fast as the number of freestanding facilities. The number of cases increased 10 percent annually from 2003 to 2005 and Medicare spending grew at almost triple that pace during the same period. The rate of growth slowed in 2006. The evidence on quality is mixed. Risk-adjusted rates of death in the LTCH, death within 30 days of discharge, and one of four patient safety indicators (PSIs) showed improvement between 2004 and 2005. But more patients were readmitted to acute care and three PSIs worsened. Rapid expansion of both for-profit and nonprofit LTCHs demonstrates good access to capital for this sector.

LTCHs' Medicare margins for 2005 were high, almost 12 percent, but CMS has made a number of policy changes that will reduce payments. We estimate the margin in 2007 to be between 0.1 and 1.9 percent with the magnitude depending on how LTCH-HWHs respond to the 25 percent rule (this rule pays less for certain patients these facilities admit from their host hospitals).

The Commission is concerned about growth in long-term care hospitals because we are not certain that this high-cost service is being used only on patients who need it. LTCHs have shown themselves to be very responsive to changes in payments and should be able to accommodate cost changes in 2008. These findings, as well as the other factors the Commission considers, which are almost all positive, lead us to recommend that the Secretary should eliminate the update to payment rates for LTCH services for 2008. The Commission recommends limiting growth in payments per case until the industry and CMS agree on patient and facility criteria to better define these facilities and the patients appropriate for them, as we previously have recommended.

Update on Medicare private plans

In our March report the Commission presents recent findings on the Medicare Advantage (MA) plans beneficiaries can join in lieu of traditional fee-for-service Medicare, and the private plans offering the new prescription drug benefit.

All beneficiaries will be able to join an MA plan in 2007, and enrollment in MA plans grew substantially in 2006 with the percentage of beneficiaries enrolled in MA plans reaching 17 percent, a level close to its all-time high. Almost half the growth in 2006 was in private fee-for-service MA plans. In addition, our analysis of MA payments shows that the benchmarks (which are the reference level for plan bids and the maximum program payment) now average 116 percent of traditional Medicare fee-for-service (FFS) levels, and payments average 112 percent.

The ratio of benchmarks and payments varies by plan type, although it exceeds the expected Medicare FFS expenditures for those beneficiaries for all types of plans. Table 2 shows that payments to HMOs are 110 percent of expected FFS costs. Payments for PFFS plans are 119 percent of expected Medicare FFS costs as they are located in areas of the country where benchmarks are much greater than FFS. The amount returned to beneficiaries in the form of extra benefits and reduced premiums varies as well. For example, PFFS plans returned a much lower share of plan payments to beneficiaries in the form of extra benefits and reduced premiums than HMOs.

Table 2. Medicare Advantage benchmarks and payments in 2006 exceed expected Medicare fee-for-service expenditures for all types of plans

Type of plan	Enrollment as of July 2006 (in thousands)	Benchmark relative to FFS cost	Payments relative to FFS cost
HMO	5,195	115%	110%
Local PPO	285	120	117
Regional PPO	82	112	110
PFFS	774	122	119

Note: FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service). Payments relative to expected FFS costs for the beneficiaries enrolled in Medicare Advantage plans.

Source: MedPAC analysis of data from the Centers for Medicare & Medicaid Services on plan bids, enrollment, and benchmarks.

The Commission has always supported a private plan option in Medicare, and has recommended a policy of financial neutrality between private plans and traditional Medicare fee-for-service. Financial neutrality includes setting payment benchmarks at 100 percent of fee-for-service costs and removing duplicative payments for indirect medical education. In addition to financial neutrality between MA and FFS, the Commission has also recommended neutrality between types of MA plans, including eliminating the stabilization fund for PPO plans and making bidding rules consistent across plan types. Further, the Commission has recommended a pay for quality performance program for MA plans, and calculating clinical measures for the FFS program that would permit CMS to compare quality in the FFS program with that in MA plans.

The report also provides information on the enrollment, benefits, and premiums of the plans offering the new prescription drug benefit, both the stand-alone prescription drug plans and the prescription drug plans affiliated with Medicare Advantage plans. Our analysis of Part D plan offerings for 2007 shows that about 30 percent more plans entered the market for 2007 than in 2006 and that the typical beneficiary has a choice of over 50 stand-alone drug plans. More plans are including coverage in the gap for generic drugs. (The gap is that part of drug spending where the basic benefit provides no coverage.) Looking at average premiums unweighted by plan enrollment, those for basic plans are lower in 2007 than in 2006, and those for plans with enhanced coverage are higher

Plans bid to provide Part D coverage, and current law calls for weighting Part D plan bids for 2007 with plans' 2006 enrollment when calculating the national average bid (called enrollment weighting). Because enrollees tended to choose lower premium plans, enrollment weighting would have led to a lower government subsidy, which would mean lower Medicare payments to plans and higher enrollee premiums. Similarly, the law also calls for enrollment weighting in the formula for calculating each region's low-income premium subsidy amount for 2007. CMS chose not to fully enrollment weight bids in either case. This action means that enrollees will pay lower premiums and more low-income enrollees will be able to remain in their current plan. However, it also does not allow the full benefits of competition to be realized and thus, the cost to Medicare will increase.

CMS is using its general demonstration authority to transition to enrollment weighting over time. The Commission is concerned that CMS is using its demonstration authority to provide higher payments rather than demonstrate policy options. The Commission has previously recommended that the Secretary should use his demonstration authority to test innovations in the delivery and quality of healthcare, not as a mechanism to increase payments. The Commission has also previously recommended that the Secretary have a process for timely delivery of Part D data to Congressional support agencies. CMS has proposed a regulation that supports the intent of that recommendation. MedPAC supports that proposed regulation and urges CMS to make it final.