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## **Executive summary**

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As part of its mandate from the Congress, each June the Commission reports on refinements to Medicare payment systems and issues affecting the Medicare program, including changes to health care delivery and the market for health care services. The seven chapters of the June 2022 report cover the following topics:

- **An approach to streamline and harmonize Medicare’s portfolio of alternative payment models.** The Commission provides specific suggestions to operationalize our June 2021 recommendation that CMS reduce the number of Medicare alternative payment models (APMs) and design models to work better together.
- **Vulnerable Medicare beneficiaries’ access to care.** In response to a congressional request, the Commission presents an analysis of the service utilization of beneficiaries who reside in a medically underserved area (MUA), are dually eligible for Medicare and Medicaid, or have multiple chronic conditions.
- **Supporting safety-net providers.** The Commission provides a general framework to identify safety-net providers and evaluate whether new Medicare safety-net funding might be warranted in a health care sector. We apply our framework to identify safety-net hospitals, evaluate the financial performance of safety-net hospitals, and model the redistribution of current disproportionate share hospital (DSH) and uncompensated care payments using our safety-net hospital metric.
- **Addressing high prices of drugs covered under Medicare Part B.** The Commission discusses approaches for Medicare Part B to address high launch prices for new “first-in-class” drugs with limited clinical evidence, high and growing prices among products with therapeutic alternatives, and financial incentives associated with the percentage add-on to Medicare Part B’s payment rate.
- **Improving the accuracy of Medicare Advantage payments by limiting the influence of outliers in CMS’s risk-adjustment model.** The Commission presents an option to address the influence of outliers in the CMS hierarchical condition category

(HCC) risk-adjustment model used to adjust payments to Medicare Advantage (MA) plans.

- **Aligning fee-for-service payment rates across ambulatory settings.** The Commission presents an analysis of an approach to align the payment rates across ambulatory settings—hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding physician offices—that currently have different Medicare payment rates for the same services.
- **Segmentation in the stand-alone Part D plan market.** The Commission discusses segmentation in the market for stand-alone prescription drug plans (PDPs) based on beneficiaries’ eligibility for Part D’s low-income subsidy (LIS) and drug spending, its effects on Medicare spending, and potential policies to address segmentation and its effects.

This report focuses on Medicare’s payment policies and ways to improve those policies where appropriate. The Commission is fully aware that the health care system, Medicare beneficiaries, and policymakers have faced extraordinary challenges during the coronavirus public health emergency, and we continue to consider the effects of the COVID-19 pandemic in our work. We remain ready to assist the Congress and CMS as part of our mission to preserve beneficiaries’ access to high-quality care, control Medicare spending growth, and provide sufficient payment for efficient providers.

### **An approach to streamline and harmonize Medicare’s portfolio of alternative payment models**

In Chapter 1, we present specific suggestions to operationalize our June 2021 recommendation that CMS reduce the number of Medicare APMs and design models to work better together:

- Implement a foundational population-based payment approach that reduces the number of accountable care organization (ACO) model tracks from seven down to a smaller number of tracks that could each be geared toward provider organizations of different sizes and involve different degrees of financial risk.

- Move away from “rebasings” ACOs’ spending benchmarks every few years based on actual spending, and instead rely on periodic administrative updates to benchmarks using a growth factor that is unrelated to ACOs’ own spending performance and is known to ACOs in advance.
- Implement a national episode-based payment model for certain types of proven clinical episodes (e.g., hip and knee replacements) that will enhance savings and/or improve outcomes.
- Require certain providers to participate in the national episode-based payment model for all their fee-for-service (FFS) Medicare patients, including beneficiaries already attributed to an ACO.
- For beneficiaries concurrently attributed to the episode-based payment model and an ACO, allocate episode bonus payments so that (1) episode-based providers have an incentive to furnish efficient, high-quality care; (2) providers in ACOs have an incentive to refer their attributed patients to low-cost, high-quality episode-based providers; and (3) when combined, these incentives are not so large that they increase total Medicare spending.

The Commission believes implementing these suggestions would reduce the complexity and uncertainty that providers face when deciding to participate in an APM, increase provider participation in these models, and improve incentives for providers to furnish care more efficiently and improve quality.

### **Congressional request: Vulnerable Medicare beneficiaries’ access to care (final report)**

In Chapter 2, we present our final report in response to a July 2020 bipartisan request from the House Committee on Ways and Means for an update of our June 2012 report on rural beneficiaries’ access to care and for information on access to care for beneficiaries who reside in an MUA, are dually eligible for Medicare and Medicaid, or have multiple chronic conditions.

In our June 2021 interim report to the Congress, we found that rural and urban beneficiaries had similar utilization of care, although some minor differences existed. In this final report, we present descriptive statistics using data from before the COVID-19

pandemic on the service utilization of beneficiaries who reside in an MUA, are dually eligible for Medicare and Medicaid, or have multiple chronic conditions. We found:

- Beneficiaries who reside in MUAs generally received the same volume of services as those who did not across the services we examined—evaluation and management (E&M) encounters with clinicians, hospital inpatient and outpatient visits, skilled nursing facility days, and home health episodes.
- Medicare beneficiaries who were eligible for full Medicaid benefits had substantially higher service use, including about twice the number of hospital inpatient admissions and about five times the number of skilled nursing facility days per beneficiary, compared with other Medicare beneficiaries. However, we cannot rule out the possibility that dual-eligible beneficiaries needed more care than they received or faced difficulties in accessing the care they did receive.
- Beneficiaries with more reported chronic conditions had substantially higher service use compared with those with fewer reported chronic conditions. As with the service use patterns of dual-eligible beneficiaries, we are unable to make any judgment regarding whether the higher levels of service use we observe for beneficiaries with multiple chronic conditions are sufficient to meet their clinical needs.

Because further research is needed to better understand the sufficiency of dual-eligible and other vulnerable beneficiaries’ access to care, the Commission is examining how to better identify vulnerable Medicare populations and to evaluate Medicare’s policies to support safety-net providers.

### **Supporting safety-net providers**

In Chapter 3, we present a framework, applicable across provider sectors, to identify safety-net providers and evaluate whether new Medicare safety-net funding might be warranted in a health care sector. We apply our framework to identify safety-net hospitals using alternative metrics to those used in Medicare’s current DSH program. We then model a redistribution of current DSH and uncompensated care payments using our alternative safety-net metrics. This chapter is the

first in an ongoing body of work on supporting safety-net providers.

**A framework for identifying safety-net providers.**

Our framework first identifies safety-net providers as those that disproportionately serve (1) low-income Medicare beneficiaries who are less profitable to care for than the average beneficiary or (2) uninsured patients or patients with public insurance that is not materially profitable. In our analysis, low-income Medicare beneficiaries are defined as those who receive the Part D LIS. This group includes beneficiaries with limited assets and an income below 150 percent of the federal poverty level, as well as those who receive full or partial Medicaid benefits who automatically qualify for the LIS. Compared to the full Medicare population, LIS beneficiaries are three times as likely to be disabled and are twice as likely to be Black or Hispanic. These beneficiaries often have the greatest health care needs but the fewest personal resources to address those needs, making it critical to ensure that they have access to a safety net of health care providers.

**A framework for determining the need for new Medicare safety-net funding.** Once safety-net providers are identified, the second part of our framework defines criteria to determine whether the Medicare program should allocate new funding to support safety-net providers. Medicare should spend additional funds to support safety-net providers only if:

- low-income beneficiaries are at risk of negative outcomes (e.g., access problems due to provider closures) without additional funding;
- Medicare is not a materially profitable payer in the sector; and
- current payment adjustments cannot be redesigned to adequately support safety-net providers.

**Applying our framework to safety-net hospitals.**

In acute care hospitals, Medicare patients, and in particular, low-income Medicare patients, would generate lower levels of profitability than commercial patients without additional safety-net payments. Therefore, hospitals with high shares of Medicare patients, low-income Medicare patients, and uninsured patients may have insufficient resources to compete

for labor and technology with hospitals that treat a higher share of commercial patients.

The Commission's analyses have shown that, on average, Medicare beneficiaries have good access to hospital care. However, in this analysis of safety-net hospitals, we found that hospitals with high shares of LIS Medicare beneficiaries tend to have lower levels of profitability. The quarter of hospitals with the lowest shares of total Medicare volume associated with LIS beneficiaries had a median non-Medicare margin of 15 percent, compared with 2 percent among the quarter of hospitals with the highest shares of such beneficiaries. Hospitals with high shares of LIS beneficiaries also had a higher risk of closure.

We compared the existing DSH policies with a measure based on LIS beneficiary share and a measure we developed called the Safety-Net Index (SNI), which is the sum of (1) the share of the hospital's Medicare volume associated with LIS beneficiaries, (2) the share of its revenue spent on uncompensated care, and (3) an indicator of how dependent the hospital is on Medicare. Our results suggest that the measures based on LIS beneficiaries and the SNI are better predictors of financial strain than the current DSH measure. In addition, the current DSH measure leads to Medicare subsidizing Medicaid and is negatively correlated with the share of hospitals' patients who are enrolled in Medicare. The results of our analysis suggest that the new SNI metric could do a better job of targeting Medicare funds to safety-net hospitals than simply expanding the funds allocated to the existing DSH program would.

In addition to analyzing how well the three safety-net metrics predicted non-Medicare margins and risk of closure, we also modeled a redistribution of current DSH and uncompensated care payments using the SNI metric. By shifting from the current DSH system of payments to an SNI system of payments, a slightly larger share of safety-net payments would go to hospitals with high Medicare shares and a greater risk of closure. While these results should be considered illustrative, they provide a sense of how distributing safety-net dollars using a metric that considers hospitals' Medicare shares would alter the distribution of Medicare funds.

## Addressing high prices of drugs covered under Medicare Part B

In Chapter 4, the Commission examines alternative approaches for Medicare Part B to address high launch prices for new “first-in-class” drugs that have limited clinical evidence, high and growing prices among products with therapeutic alternatives, and financial incentives associated with the percentage add-on to Medicare Part B’s payment rate.

Medicare spending on prescription drugs covered under Part B is substantial (about \$40.7 billion in 2020) and growing rapidly (increasing nearly 10 percent per year, on average, between 2009 and 2019). The prices Medicare pays for drugs are an important driver of this growth. Manufacturers have historically set high prices for many new treatments whether or not evidence exists that the product is more effective than existing standards of care. As a result, drug launch prices have been increasing, and are not necessarily commensurate with new products’ efficacy relative to existing therapies. Prices for existing products are also a concern because of high launch prices and/or postlaunch price growth among some products, even for those with therapeutic alternatives. Cost sharing for high-priced products can deter appropriate uptake, and Medicare program spending on high-priced products can crowd out valuable alternative uses of taxpayer resources.

Medicare has had only an indirect influence on how new Part B-covered drugs are priced. Medicare pays for most Part B drugs and biologics at a rate of 106 percent of the average sales price (ASP + 6 percent). Medicare lacks the authority to use tools to pay for Part B drugs in a way that balances a drug’s net clinical benefit with an appropriate reward for innovation and affordability for beneficiaries and taxpayers. Medicare also lacks tools to promote price competition among Part B drugs with therapeutic alternatives.

We discuss three approaches to improve price competition and payment for Part B drugs by the Medicare program. Some of the strategies could also apply to Part D drugs as well as other categories of services, including medical devices.

**Addressing uncertain clinical benefit and high launch prices of first-in-class drugs.** To address high launch prices of select “first-in-class” Part B drugs that

the Food and Drug Administration (FDA) approves with uncertain clinical evidence (i.e., based only on surrogate or intermediate clinical endpoints under its accelerated approval pathway), the Congress could give the Secretary discretion to:

- First, use coverage with evidence development (CED) to collect clinical evidence relevant to Medicare beneficiaries about the new drug while providing patients access to the product. Ensuring that the CED process is clear, transparent, and predictable with a process for public input would be key and might include criteria for evaluating whether the product is a candidate for CED.
- Second, set a cap on the drug’s payment rate based on information about the new product’s estimated net clinical benefit (based on evidence from, for example, FDA clinical trials) and cost compared with the standard of care, to prevent manufacturers from setting a high price for a new product with little or no evidence that it is more effective than existing standards of care. Medicare would need to develop a clear and predictable decision-making framework that ensures transparency and opportunities for public input, including how comparator treatments would be selected, how costs would be defined, and what time horizon would be used.

This dual approach would likely lead to development of better evidence after FDA approval and better alignment of payment to the known clinical benefit of the drug. We envision that the Secretary would apply such a dual approach when needed for selected drugs approved under the FDA’s accelerated pathway, based on factors such as a drug’s clinical benefit compared with its alternatives at the time of FDA approval and fiscal impact. We also envision that, over time, Medicare would reevaluate the application of CED and the drug’s payment rate based on, for example, information from postapproval clinical trials. Since 2006, under existing statutory authority, the Secretary has applied CED to roughly 25 services, and the dual approach is not intended to affect the Secretary’s current use of CED. The Congress would need to provide the Secretary statutory authority to use methods other than ASP to set the payment for select first-in-class Part B drugs.

**Promoting price competition among drugs with therapeutic alternatives.** To spur manufacturer competition among drugs with similar health effects, the Congress could give CMS the authority to use internal reference pricing, under which Part B drugs would remain in their own billing code but Medicare would establish a single reference price for those with similar health effects. Under reference pricing, manufacturers would have incentive to lower their prices relative to competitors to make their products more attractive to providers and garner market share, which would result in savings for beneficiaries and taxpayers. CMS would need a method for determining groups of products that are clinically similar, the payment rate for a reference group, medical exceptions to reference pricing policies, and payment for products that have multiple indications. CMS would also need to determine how frequently reference prices would be updated.

**Improving provider incentives under the ASP payment system.** To address concerns about possible financial incentives associated with Medicare Part B's current 6 percent drug add-on to ASP, the add-on could be modified by placing a fixed dollar limit on the add-on payment, converting a portion of the percentage add-on to a fixed fee, or a combination of these approaches. The impact on payments for Part B drugs would vary, with a fixed dollar limit on the add-on payment reducing payment for very expensive drugs, and the application of a fixed fee raising payments for relatively inexpensive drugs while decreasing payments for more expensive ones.

### **Improving the accuracy of Medicare Advantage payments by limiting the influence of outliers in CMS's risk-adjustment model**

In Chapter 5, the Commission presents an option to address the influence of outliers in the CMS-HCC risk-adjustment model used to adjust payments to MA plans.

The Medicare program pays managed care plans that participate in the MA program a risk-adjusted monthly capitated amount to provide Medicare-covered services to their enrollees. The purpose of risk adjusting payments is to accurately predict average costs for beneficiaries with the same attributes that affect health care costs, so that plans' incentives to avoid beneficiaries with high-cost conditions are

reduced, while plans also have an incentive to manage their enrollees' conditions to keep their costs down. The CMS-HCC model has largely been successful in serving its general purpose, but inaccuracy introduced into the model by outlier beneficiaries who have the largest differences between actual medical costs and the costs predicted by the model is a concern. To address inaccuracy introduced in the model by outliers, we evaluated a modification to the CMS-HCC risk-adjustment model that incorporates the principles of reinsurance and repayment by redistributing a share of annual beneficiary costs in the FFS data used to estimate the risk-adjustment model coefficients.

We found that the modification to reduce the effect of outliers in the standard CMS-HCC model improves the predictive power of the model. In addition, we also found improvements in model performance for groups of beneficiaries for which the standard CMS-HCC model performs less well (those with very low and very high actual costs and those with very large underpredictions (cost predicted by the model is less than actual cost) and overpredictions (cost predicted by the model is greater than actual cost)).

A benefit of this approach to addressing large prediction errors is that it improves the performance of the CMS-HCC model without added burden on plans or beneficiaries to provide additional data. CMS would continue to use the existing risk-adjustment model that is familiar, straightforward, and easy to understand. In addition, this approach would not require any change to the flow of funds from CMS to MA plans (that is, no actual reinsurance or repayment transfers).

Although this approach would improve model performance, substantial issues remain for MA risk adjustment, such as the financial benefit to plans for coding conditions more intensively compared to FFS clinicians' coding and payment inaccuracies among beneficiaries who are not among the largest overpredictions and underpredictions addressed in this analysis. The Commission intends to address these issues in future work.

### **Aligning fee-for-service payment rates across ambulatory settings**

In Chapter 6, the Commission discusses aligning the payment rates across ambulatory settings. Medicare payment differences for the same service across

ambulatory settings—HOPDs, ASCs, and freestanding physician offices—encourage arrangements among providers that result in care being provided in the settings with the highest payment rates, thereby increasing total Medicare spending and beneficiary cost sharing without significant improvements in patient outcomes.

To evaluate whether an ambulatory service should continue to have different payment rates in the three settings or whether it would be appropriate to align the payment rates more closely across the three settings, we analyzed the ambulatory payment classifications (APCs) used in the outpatient prospective payment system (OPPS) to pay for services provided in HOPDs. Each APC includes a set of services that are similar in terms of clinical attributes and cost; all services in the same APC have the same OPPS payment rate. Of the OPPS's 169 APCs for services, we identified 57 APCs for which it would be reasonable and appropriate to align the OPPS and ASC payment rates with those set in the physician fee schedule (PFS). We also identified 11 APCs for which it would be appropriate to align the OPPS payment rates with the ASC payment rates and continue to use the PFS payment rate when the service is provided in a freestanding office. In the 68 APCs for which it is reasonable to align payment rates across ambulatory settings, we found that patient severity has little effect on the costs incurred by HOPDs when furnishing the services, so adjustments to payments for patient severity do not appear to be necessary. For 101 APCs, such as emergency department (ED) visits, the HOPD is the most frequent setting, or the services cannot be provided in settings other than HOPDs. For these APCs, each setting should continue to have a different payment rate, with generally higher payments for HOPDs.

As policymakers consider how to align payment rates across ambulatory settings, we suggest that the APCs for ED visits, critical care visits, and trauma care visits be reclassified from standard APCs to comprehensive APCs, which package all services—with a few exceptions—into a single payment unit. As a result, higher payment rates for the provision of services during these visits would be maintained, appropriately reflecting the hospital-level costs of items and services provided.

In aggregate, if changes in payments resulting from aligning payment rates were taken as program savings, Medicare program spending in 2019 would have declined by \$6.6 billion and beneficiary cost-sharing obligations by \$1.7 billion. Across all hospitals, a site-neutral policy would have reduced overall Medicare revenue by 4.1 percent and beneficiary OPPS cost sharing by 13.2 percent.

Under current law, CMS would be required to fully offset the lower Medicare spending and beneficiary cost sharing from aligning ambulatory payment rates by increasing the OPPS payment rates for all other (nonaligned) APCs to produce a budget-neutral result. Combining alignment of payment rates with a budget-neutrality adjustment within the OPPS would lower incentives to shift services to higher-cost settings but would reduce savings for Medicare and beneficiaries. However, if the budget-neutrality adjustment were not applied, some hospitals that are the primary source of access to physicians' services for these low-income patients would experience reductions in Medicare revenue under the payment alignment policy, which could adversely affect access for these beneficiaries. Policymakers could consider an alternative to the budget-neutrality policy that would explicitly target hospitals that serve a high share of low-income beneficiaries to limit the loss of Medicare revenue for these hospitals. Over time, the payment rate alignment policy would produce savings for the Medicare program and lower cost sharing for beneficiaries under either the budget-neutrality or the stop-loss policy because incentives to shift services from the lower-cost physician office and ASC settings to the higher-cost HOPD setting would be mitigated.

### **Segmentation in the stand-alone Part D plan market**

In Chapter 7, the Commission discusses segmentation in the market for stand-alone Part D PDPs, including insurers' rationale and strategies for segmenting the market, the effects of segmentation on program spending, and potential reforms to reduce segmentation or limit its negative consequences.

The Part D program uses stand-alone PDPs to provide drug coverage to beneficiaries in the FFS Medicare program. Insurers that participate in the PDP market can offer up to three plans, and they tailor those plans



to appeal to different types of beneficiaries. Most major insurers generally offer one plan to target LIS beneficiaries and two plans to target beneficiaries without the LIS—one for those with low drug costs and one for those with high drug costs. Insurers differentiate their plans through a mix of program rules and changes in plan features such as premiums, beneficiary cost sharing, the specific drugs covered by the plan, and pharmacy networks. Two distinctive features of this strategy are keeping the premium for the plan that targets LIS beneficiaries just below the LIS subsidy amount and offering plans with “enhanced” coverage (which combines standard Part D coverage with supplemental benefits) that turn out to have lower premiums than plans with “basic” coverage (which is limited to standard coverage only).

Segmenting the market makes PDPs more profitable for insurers. For LIS beneficiaries, insurers want to maximize the revenue they receive for each enrollee, which is easier to do when LIS enrollees are segmented into separate plans. For other beneficiaries, insurers want to capitalize on the fact that beneficiaries are sensitive to premiums when they first select a PDP but rarely switch plans after that, which insurers can do more easily by pairing a newer, low-premium plan that attracts new Part D enrollees with an older, more established plan with premiums they can increase more easily.

But for beneficiaries, the implications of a segmented market are more complicated. Segmentation benefits many enrollees who do not receive the LIS by giving them greater access to low-premium plans. At the same time, segmentation may make it harder for beneficiaries to understand their plan options, despite requirements that insurers offer plans with meaningful differences. The common-sense distinction between “basic” and “enhanced” plans has been lost, and it can be difficult to determine what extra benefits are provided by enhanced PDPs with low premiums. In addition, beneficiaries in enhanced PDPs with high premiums likely pay more for their coverage than they otherwise would. For the Medicare program, segmentation likely increases Part D spending because it allows sponsors to charge higher premiums for plans that serve LIS beneficiaries and older plans that serve beneficiaries who do not receive the LIS.

Policymakers could consider reforms that would either reduce the level of segmentation in the market or address undesirable consequences of segmentation. These reforms include:

- Modifying the auto-enrollment process for LIS beneficiaries. Policymakers could give insurers a stronger incentive to bid more competitively by auto-enrolling a larger share of new LIS beneficiaries in plans with lower premiums and reassigning LIS beneficiaries to new plans when premiums rise above the benchmark.
- Changing how the requirement for plans to have “meaningful differences” is administered. For example, policymakers could require enhanced PDPs to cover a minimum percentage of the out-of-pocket costs that their enrollees would otherwise pay for basic coverage. This approach would prevent insurers from offering enhanced PDPs with very little additional coverage.
- Requiring PDP insurers to treat their enrollees as a single risk pool for the purpose of providing basic coverage. Under this reform, every enrollee in an insurer’s PDPs would pay the same premium for basic coverage and have the same formulary, cost-sharing rules, and pharmacy network. Insurers would still be allowed to offer enhanced coverage, but only by providing extra benefits on top of the uniform basic coverage, somewhat akin to an insurance rider. As under the current system, enrollees would pay for the full cost of any extra benefits through a supplemental premium.

Overall, segmenting the market based on beneficiaries’ LIS eligibility is a greater concern because it reduces the incentives for plans that serve the LIS population to bid competitively. The consequences of segmenting other beneficiaries based on their drug spending are more mixed because segmentation reduces premiums for some beneficiaries while increasing premiums for other beneficiaries. Policymakers could therefore focus any reforms on measures that address the consequences of segmentation based on beneficiaries’ LIS eligibility. ■

