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## MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT TO CONGRESS ON MEDICARE PAYMENT POLICY

**Washington, DC, June 15, 2022**—Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2022 *Report to the Congress: Medicare and the Health Care Delivery System*. Each June, as part of its mandate from the Congress, MedPAC reports on issues affecting the Medicare program as well as broader changes in health care delivery and the market for health care services. This year's report includes seven chapters:

**| An approach to streamline and harmonize Medicare's portfolio of alternative payment models.** In our June 2021 report to the Congress, the Commission recommended that CMS reduce the number of Medicare alternative payment models and design models that work together when combined. In this chapter, the Commission provides suggestions to CMS to operationalize that recommendation. Specifically, CMS should consider: implementing a population-based payment approach that reduces the number of accountable care organization (ACO) model tracks; transitioning to periodic administrative updates to benchmarks using a growth factor; and implementing a mandatory national episode-based payment model for certain types of proven clinical episodes. For beneficiaries concurrently attributed to the episode-based payment model and an ACO, the Commission suggests that CMS 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.

**| Congressional request: Vulnerable Medicare beneficiaries' access to care (final report).** A bipartisan request by the House Committee on Ways and Means in July of 2020 asked the Commission to update its 2012 analysis of rural beneficiaries' access to care, and also asked us to examine access issues for additional vulnerable populations (beneficiaries who reside in a medically underserved area (MUA), are dually eligible for Medicare and Medicaid, or have multiple chronic conditions). We reported on rural beneficiaries' access to care in our June 2021 report to the Congress. In this final report, we found that beneficiaries who reside in MUAs generally received the same volume of services as those who do not across the services we examined, suggesting that residing in an MUA may not be a good indicator of a vulnerable Medicare population. By contrast, we found that 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. Beneficiaries with more reported chronic conditions also had substantially higher service use compared with those with fewer reported chronic conditions. However, we are unable to determine whether the higher levels of service use we observed for dual-eligible beneficiaries and for those with multiple chronic conditions was sufficient to meet their clinical needs.

**| Supporting safety-net providers.** Medicare beneficiaries with low incomes 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. However, treating low-income beneficiaries might entail extra costs that are not sufficiently accounted for in Medicare’s standard payment systems and can generate lower revenues for providers, which could result in diminished access to or quality of care for beneficiaries. This chapter discusses a two-part framework, potentially applicable across provider sectors, to identify providers who serve a disproportionate share of these beneficiaries and evaluate whether new Medicare safety-net funding might be warranted. We initially apply this framework to identify safety-net hospitals using a Safety-Net Index (SNI). Our results suggest that the SNI is a better predictor of financial strain on hospitals at which Medicare beneficiaries make up large shares of their patient population than the current disproportionate share (DSH) measure, and thus could better target Medicare funds to safety-net hospitals.

**| Addressing high prices of drugs covered under Medicare Part B.** Medicare spending on Part B-covered prescription drugs is substantial and growing rapidly, due primarily to the high prices Medicare pays both for new treatments and for existing drugs. By statute, Medicare pays for most Part B drugs and biologics at a rate of 106 percent of the average sales price (ASP + 6 percent) and does not have the flexibility to pay for Part B drugs in a way that balances a drug’s net clinical benefit with appropriate incentives for innovation, and affordability for beneficiaries and taxpayers. In this chapter, we discuss three approaches to improve price competition and payment of Part B drugs by the Medicare program. To address high launch prices of select “first-in-class” Part B drugs that the FDA approves with uncertain clinical evidence, the Congress could give the Secretary discretion to use coverage with evidence development (CED) to collect clinical evidence and set a cap on the drug’s payment rate based on the new product’s estimated incremental clinical benefit and cost compared to the standard of care. To spur manufacturer competition among drugs with similar health effects, the Congress could give the Secretary the authority to use internal reference pricing, which would give manufacturers an incentive to lower their prices relative to competitors. To address concerns about possible financial incentives associated with Medicare Part B’s current 6 percent drug add-on payment, 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.

**| Improving the accuracy of Medicare Advantage payments by limiting the influence of outliers in CMS’s risk-adjustment model.** The Medicare program pays managed care plans that participate in the Medicare Advantage (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 clinical and demographic attributes that affect health care costs, reducing incentives for plans to select patients, while giving them an incentive to manage their enrollees’ conditions to keep their costs down. The CMS-HCC risk-adjustment 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 evaluate a modification to the CMS-HCC risk-adjustment model that redistributes a share of annual beneficiary costs in the fee-for-service data used to estimate the risk-adjustment model coefficients. This modification substantially improves the predictive power of the CMS-HCC model.

**| Aligning fee-for-service payment rates across ambulatory settings.** Medicare payment differences for the same service across ambulatory settings—hospital outpatient departments

(HOPDs), ambulatory surgical centers (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. In this chapter, we build on prior Commission work to align payment rates across these settings, generally reducing payments to hospitals under the outpatient prospective payment system for services that are appropriate for site-neutral payments. In aggregate, if changes in payment resulting from aligning payment rates were taken as program savings, Medicare program spending in 2019 would have been \$6.6 billion lower and beneficiary cost-sharing obligations \$1.7 billion lower compared to current law. Given the size of the reduction in Medicare revenue for certain hospitals, for illustrative purposes, we modeled a budget-neutral scenario, under which reduced payments for site-neutral services would be offset by increased payments for other services, and a temporary stop-loss policy that would limit reductions in payments for safety-net hospitals. Under either the budget-neutral or the stop-loss policies, we expect the payment rate alignment policy would produce savings for the Medicare program and lower cost sharing for beneficiaries 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.** The Part D program uses stand-alone prescription drug plans (PDPs) to provide drug coverage to beneficiaries in the fee-for-service Medicare program. Most major insurers generally offer one plan focused on LIS beneficiaries, and two plans designed for beneficiaries without the LIS—one for those with low drug costs and one for those with high drug costs. Insurers differentiate their plans through features such as premiums, beneficiary cost sharing, the specific drugs covered by the plan, and pharmacy networks. 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, and it can be difficult to determine what extra benefits are provided by enhanced PDPs with low premiums. Segmentation also likely increases Part D spending for the Medicare program. This chapter discusses three reforms that policymakers could consider to reduce the level of segmentation in the market or address undesirable consequences of segmentation. First, policymakers could give plan sponsors 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. Next, policymakers could change 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. Third, policymakers could require PDP sponsors to treat their enrollees as a single risk pool for the purpose of providing basic coverage.

The full report is available at MedPAC’s website (<http://www.medpac.gov>).

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*The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission’s goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.*