Justification of Appropriation Request for the Committees on Appropriations

Fiscal Year 2024

MEDPAC | Medicare Payment Advisory Commission

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Justification of Appropriation Request

Summary

For fiscal year (FY) 2024, the Medicare Payment Advisory Commission (MedPAC) requests $13,824,000, the same amount as our FY 2023 appropriation. Our 2024 request reflects the costs of our usual human capital, policy research, and data management and security needs. Historically, and for our FY 2024 request, MedPAC has adopted a fiscally constrained approach to spending, where it is in the control of the agency. This year's request reflects a combination of expected increases in spending (largely due to factors outside of MedPAC's direct control including an increase to MedPAC's statutory salary cap; an increase in the number of public meetings held during FY 2024; replacement of computer and other IT equipment; and the general increase in the cost of travel, goods, and services), partially offset by a decrease in funding for external research contracts.

Our requested level of funding will ensure we can meet the legislated requirements of the Commission and respond to the frequent and complex requests for assistance from the Congress. The Commission has work underway to complete three mandated reports and one Congressional request that are due in 2023. These mandated reports are in addition to the two standing reports that the Commission produces each year pursuant to our authorizing legislation, as well as several other informational products that we provide upon request to support the Congress.

In addition to formal reports, the Commission routinely provides assistance to the Congress in the form of testimony, technical assistance, and briefings, particularly to staff members of the committees with jurisdiction over Medicare. During 2022, the Commission briefed committee staff both formally and informally on telehealth policy, hospital payment policy, the physician fee schedule, drug payment policy, site-neutral payment policy, and the Medicare Advantage program. MedPAC also held a Member-level briefing on the Medicare program, its funding sources, and recent MedPAC recommendations.

MedPAC received a heavy volume of requests for assistance from Congress in 2022, fielding approximately 200 requests for technical assistance. Throughout the year, the Commission continued its regular order business and submitted 14 comment letters to the Administration in response to proposed regulations and requests for information. These comment letters help to inform congressional staff of potential effects of different proposals affecting Medicare. We anticipate a similar or greater level of effort in 2024 regarding the provision of technical assistance, staff briefings, and comment letters.

This budget will provide MedPAC the resources necessary to support the Congress in its mission to oversee the Medicare program and ensure its long-term sustainability. In its analyses, recommendations, and technical assistance, MedPAC provides significant value to

the Congress. MedPAC continues to identify opportunities for savings to the Medicare program. Our current set of unimplemented recommendations would produce 10-year budget savings of more than $150 billion. Our objective in the coming year is to continue providing timely, accurate, and relevant assistance to the Congress in a budget-conscious manner.

Role of MedPAC

MedPAC is a nonpartisan congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. The Commission's work in all instances is guided by three principles:

1. Ensuring beneficiaries have access to high-quality care in an appropriate setting;

2. Giving providers an incentive to supply efficient, appropriate care and pay equitably; and

3. Ensuring the best use of taxpayer and beneficiary dollars.

In its role as an advisor to the Congress, MedPAC provides independent, analytically driven policy advice and day-to-day technical support. This support is comprised of a range of deliverables, including two standing mandated annual reports, comments on Medicare's proposed regulations, compilations of data and statistics on the Medicare program, and summaries of Medicare payment systems. We also produce additional reports as required by legislation and other congressional direction.

In addition to these deliverables, the Commission plays a vital role supporting the Congress in its policy deliberations related to the Medicare program. MedPAC strives to inform the Congress' discussions with reports on emerging issues or trends in Medicare. Commission staff members regularly provide briefings and analysis for Members and congressional staff.

Commission deliberations and formal recommendations help inform legislative frameworks and help congressional staff explain and present policy options to Members of Congress and stakeholders. When legislation is enacted, MedPAC monitors the implementation and impact of Medicare policies and programs and reports back to the Congress with findings.

Value of MedPAC

The greatest challenges for the Medicare program are ensuring that beneficiaries have access to high quality, medically necessary services; returning good value for taxpayers and beneficiaries; and safeguarding the long-term sustainability of the program. Medicare spending has grown substantially over the last decade, placing an increasing financial burden

on the taxpayers and beneficiaries who finance it. In 2021, Medicare spent $875 billion to provide care for 63 million beneficiaries.

Identifying policies to constrain growth in Medicare spending and opportunities for savings has been a trademark of MedPAC's work. MedPAC's unimplemented recommendations would produce over $150 billion in budget savings over the next decade.

The Commission's recommendations and analyses have informed much of the major Medicare legislation in the last several years, including the Inflation Reduction Act of 2022; Consolidated Appropriations Act, 2021; the Bipartisan Budget Act of 2018; the 21st Century Cures Act; the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); the Patient Protection and Affordable Care Act (ACA); and the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). MedPAC also continued work on issues of high interest to the Congress in 2022, including supporting Medicare's safety-net providers, addressing high prices of drugs covered under Medicare Part B, assessing vulnerable Medicare beneficiaries' access to care, aligning payment rates across ambulatory settings, reforming Medicare's hospital wage index, and improving the Medicare Advantage risk-adjustment model.

MedPAC provides timely assistance and value by virtue of being a highly efficient organization. With about 35 staff members and more than a third of our budget devoted to extramural research and analytic contracts, Commission staff are able to carry out the core functions of the organization while responding in a timely manner to congressional requests and mandates.

MedPAC's Dual Responsibilities

To fulfill its charge of informing and advising the Congress on the Medicare program, the MedPAC staff engages in two distinct but intertwined operations.

Working on a rigorous schedule of public meetings, Commission staff are responsible for supporting the Commission and producing its two annual Reports to the Congress, which are required by statute and submitted every March and June. These standing reports also provide a vehicle by which we respond to other mandates from the Congress. Developing and producing these reports involves an extensive, multi-step process. Throughout the course of a year, staff members generate original analyses, present iterations of these analyses to Commissioners at public meetings, incorporate Commissioner feedback, solicit and incorporate feedback from stakeholders and congressional staff, and submit work for external

review, all culminating in MedPAC's annual mandated reports. This work is paced throughout the year, with regular deadlines nearly every month.

Since 2018, legislation has tasked the Commission with twelve mandated reports due through 2026, including reports mandated by the Bipartisan Budget Act (BBA) of 2018; the Further Consolidated Appropriations Act, 2020; the Consolidated Appropriations Act, 2021; the Consolidated Appropriations Act, 2022; and House Report language accompanying the Consolidated Appropriations Act 2023. Of these twelve mandated reports, two are due in FY 2023 and two are due in 2024. The Commission has three reports due in 2026 as mandated by the BBA of 2018. The Commission has also received a formal Congressional request that we anticipate completing in June 2023.

The Commission submitted four mandated reports on schedule in 2022: One on the effects of home health payment reform (interim report), another on the extension of the increased inpatient hospital payment adjustment for low-volume hospitals, a third on the performance of Medicare Advantage (MA) special needs plans (SNPs), and a fourth on a unified post-acute care prospective payment system value-based purchasing prototype. The Commission also responded to a formal Congressional request for information on access to care for beneficiaries who reside in medically underserved areas, are dually eligible for Medicare and Medicaid, or have multiple chronic conditions.

At the same time, Commission staff provide advice and technical support to congressional staff, working with the committees with jurisdiction over Medicare and others to support the policymaking process. This technical support takes many forms, including reviewing drafts of legislation and providing technical feedback, representing and explaining the views of the Commission on particular topics, briefing congressional staff on Medicare payment systems, and generating original analytic work upon request. This work typically occurs over a much shorter and less predictable timeframe than the mandated reports. Congressional staff frequently submit requests with short turn-around times on a wide variety of Medicare topics that require, at different points, the expertise of all Commission staff members.

Demand for this latter type of Commission work has increased substantially over the past several years, in terms of the breadth and depth of issues we are asked to explore, the data we are asked to produce and analyze, and the number of staff and stakeholders with whom we consult. In 2022, MedPAC fulfilled approximately 200 requests from congressional staff for briefings, technical assistance, data analysis, and consultations on a wide variety of topics

including telehealth policy, hospital payment policy, the physician fee schedule, drug payment policy, site-neutral payment policy, and the Medicare Advantage program.

Cost Centers

MedPAC's budget has relatively few major cost centers: personnel, research contracts, and data management and security. The concentration of costs in these areas makes it difficult to continuously find additional efficiencies; however, we continue to constrain spending within our control.

Personnel

The Commission's greatest strength, as well as its largest cost center, is human capital. The Commission staff consists of a small management staff, an analytic staff, and a few administrative and operational staff. In addition, we fund Commissioners' travel and per diems when on MedPAC business. The management and analytical staff are highly-trained health policy analysts and economists, nearly all of whom are experts in their respective fields, with extensive experience working in research, the private sector, and government. Staff conduct a broad range of analytic work on topics identified as priorities by the Congress and the Commission.

As a labor-intensive organization known for its expert analysts, MedPAC must offer salaries within the congressional salary cap that are competitive with the Executive Branch, private research organizations, and private-sector companies that all recruit economists and analysts with expertise in health care policy and financing research.

With our current complement of staff, we divide our time between preparation for Commission meetings, report production, and responding to congressional inquiries. This type of resource allocation is a normal part of our operation, but in recent years the Congress has increasingly turned to the Commission for technical assistance and input to help inform its deliberations over Medicare policy. Since 2018, various legislation and committee requests have tasked the Commission with twelve new mandated reports and five formal letter requests, in addition to the two reports that the Commission produces each year. Maintaining our staff capacity is particularly important as we have incurred retirements of several key analysts over the last year and expect several more in the coming years. Staff recruitment has become increasingly difficult over the past several years given the highly competitive market for health care analysts. The Consolidated Appropriation Act, 2022, increased MedPAC's prior salary cap, which has helped with retention and recruitment of analytic staff but has increased our

personnel costs. Our FY 2024 budget request reflects a human capital strategy that will enable us to continue to support the Congress as effectively as possible.

For FY 2024, our budget request includes several cost increases beyond our control. The Commission contracts with the Ronald Reagan Building and International Trade Center (RRB) in Washington, DC, as the venue for its public meetings. Since April of 2022, MedPAC commissioners have met in the RRB while the public can attend the meetings virtually through our broadcasted online livestream. We have continued to livestream our public meetings given our statutory mandate to hold deliberations in public and the broad interest from staff on our committees of jurisdiction, stakeholders across the county, and members of the press. Livestreaming incurs a substantial additional cost to our public meetings.

Due to meeting space availability at the RRB, we shifted our October 2022 (FY 2023) meeting to late September 2022 (i.e., FY 2022), resulting in one fewer public meeting (with related expenses including commissioner travel and per diems). This shift meant that in FY 2023, our budget request included six meetings, instead of seven. The increase expected in 2024 reflects resuming MedPAC's typical schedule of seven public meeting within the fiscal year as well as an increase in costs associated with holding such meetings.

Research Contracts

MedPAC devotes a significant portion of our budget to contract support for select research projects. The Commission achieves efficiencies by contracting for additional expertise to supplement the work of Commission staff. Because of MedPAC's workload, the complexity of our analysis, and our ongoing technical assistance to congressional staff, access to external research contractors has been critical to providing timely advice to Congress on key Medicare policy issues. Contracted research allows us to be flexible and responsive to congressional requests for information and analysis and frees staff time to devote to more immediately pressing activities (e.g., policy analysis, technical assistance, et cetera). The budget request supports the development of new analyses to help MedPAC execute reports mandated by Congress. It also funds MedPAC's national beneficiary survey and beneficiary focus groups, one of our key indicators of the adequacy of Medicare's payments for physicians, and a data set of considerable interest to Medicare policymakers. Language included in House Report 117-403 that accompanied the Consolidated Appropriations Act, 2023, required MedPAC to compare per enrollee spending for beneficiaries enrolled in Medicare Advantage and traditional fee-for-service Medicare and provided MedPAC with additional funding to support the completion of that report. Because we will publish this report as part of our forthcoming

March 2023 report to the Congress, our FY 2024 request for research contracts is consistent with our FY 2023 request (i.e., a decrease from MedPAC's FY 2023 appropriation).

Data Management and Security

In addition to its research contracts, the Commission contracts with a data management firm to supplement its data programming capacity. The Congress relies on the Commission as a source of data-driven and empirically rigorous information and expertise. That requires MedPAC staff to analyze very large data sets, including large Medicare fee-for-service claims files; provider cost reports; Part D claims files; Medicare Advantage plan bids, quality, and encounter data; and commercial insurer claims data. Contracting with an outside data management firm enhances our ability to process large data sets in a timely manner. Working with this outside firm has also helped ensure that we fully comply with increased government security regulations regarding the security of personally identifiable health information on tens of millions of current and past Medicare beneficiaries. Ensuring the security of these data is absolutely essential, and the related costs under this contract represent a mission-critical expenditure for the Commission.

Activities and Accomplishments

The Commission is involved in the Medicare policymaking process in several capacities, including fulfilling reports mandated by the Congress on a wide range of areas of interest, identifying and calling attention to emerging issues and trends, supporting the legislative process through recommendations and technical assistance to the Congress, and monitoring the implementation and impact of new policies.

The Commission's impact can be gauged qualitatively, examining the degree to which the Commission's deliberations have shaped the policy conversation about Medicare in the Congress—and in the health policy environment more broadly. For example, recent Medicare legislation—both introduced and enacted—has been informed by MedPAC's recommendations (see *Adoption of MedPAC Recommendations* below for specifics).

The Commission's accomplishments can also be expressed in terms of outputs. These outputs include both congressionally mandated work products and additional requests made to the Commission. For example, in FY 2022, MedPAC:

- Submitted our two annually mandated reports to the Congress;
- Produced a data book on health care spending and the Medicare program;
- Produced a data book in collaboration with the Medicaid and Children's Health Insurance Program Payment Advisory Commission (MACPAC) on beneficiaries dually eligible for Medicare and Medicaid;
- Submitted four mandated reports: One on the effects of home health payment reform (interim report), another on the extension of the increased inpatient hospital payment adjustment for low-volume hospitals, a third on the performance of Medicare Advantage (MA) special needs plans (SNPs), and a fourth on a unified post-acute care prospective payment system value-based purchasing prototype;
- Responded to a formal Congressional letter request for information on access to care for beneficiaries who reside in medically underserved areas, are dually eligible for Medicare and Medicaid, or have multiple chronic conditions;
- Published 21 payment basics briefs, an annually updated series widely used by congressional staff;
- Responded to approximately 200 requests for technical assistance from Congress;
- Submitted written comments on 14 proposed rules and other policy solicitations from the Centers for Medicare and Medicaid Services (CMS);
- Held eight public meetings;
- Made presentations at four stakeholder meetings and conferences;

- Conducted 21 in-person focus groups with nearly 110 beneficiaries and about 30 physicians in three states, and conducted two site visits to better understand the experience of Medicare beneficiaries and their health care providers;
- Interviewed discharge planners at 10 hospitals that serve a high share of vulnerable beneficiaries to better understand access to skilled nursing facility services; and
- Held over 70 meetings with a wide range of stakeholders and policy analysts in order to gather input for policy consideration.

The following subsections, as well as Appendices C, D, and E, are lengthier summaries of the Commission's recent activities and accomplishments.

Adoption of MedPAC Recommendations

MedPAC recommendations have informed Medicare policy set by the Congress and CMS on a range of issues. It is difficult to quantify the degree to which our recommendations are adopted, because many are adopted with modifications. However, recent legislation has included key provisions that reflect the Commission's recommendations and advice. Selected policies adopted into law include:

- Inflation Reduction Act (IRA) of 2022 included two provisions consistent with policy ideas that the Commission discussed and recommended, including:
    - Restructuring the Medicare Part D benefit above the out-of-pocket threshold. In its June 2020 report, the Commission made recommendations on restructuring the Part D benefit to cap enrollees' out-of-pocket spending so that plans appropriately take on greater insurance risk to bring the benefit back to its original approach of using more risk-based payments with stronger incentives for plans to manage benefit spending. The IRA lowered enrollee cost sharing to 0 percent, raised plan liability for both brands and generics to 60 percent, and lowered Medicare reinsurance for brands to 20 percent and 40 percent for generics. These policies are directionally consistent with the Commission's June 2020 recommendations.
    - Modifying the average sales price (ASP) system. In its June 2017 report, the Commission made recommendations on modifying the Part B drugs ASP system. The IRA requires manufacturers to pay Medicare a rebate when the ASP for their product exceeds an inflation benchmark and ties beneficiary cost sharing to the inflation-adjusted ASP starting in 2023. This policy is consistent with the Commission's June 2017 recommendation.
- The Consolidated Appropriations Act, 2022 (CAA) extended Medicare telehealth flexibilities for five months following the end of the public health emergency

(PHE), directionally consistent with the Commission's March 2021 policy option to extend Medicare's telehealth flexibilities for a limited duration following the end of the PHE.

- The Consolidated Appropriations Act, 2021 (CAA) created a new hospital designation, the rural emergency hospital, consistent with the Commission's June 2018 recommendation.
- The Bipartisan Budget Act (BBA) of 2018 contained several provisions consistent with policy ideas that the Commission has discussed and recommended, including:
    - Sunsetting the exclusion of biosimilars from the Medicare Part D coverage gap discount program. In its March 2018 report, the Commission made recommendations to improve financial incentives that disadvantage biosimilars and promote greater competition that may reduce Part D prices over time. Sunsetting the biosimilar exclusion is consistent with the Commission's March 2018 recommendations.
    - Establishing an enrollment-weighted method of determining star ratings when Medicare Advantage (MA) contract consolidations occur. In its March 2018 report, the Commission made recommendations to prevent certain MA contract consolidations from affecting plan quality ratings and bonus payments. The BBA policy is consistent with the Commission's recommendations.
    - Eliminating the number of therapy visits as a payment factor in the home health prospective payment system (PPS) beginning in 2020. The Commission has long recommended that the number of therapy visits be eliminated as a factor in payment determinations (most recently in its March 2018 report).
    - Basing a modified Medicare low-volume hospital payment adjustment on total discharges, rather than Medicare discharges only. The Patient Protection and Affordable Care Act of 2010 (ACA) mandated the Commission report on serving rural Medicare beneficiaries. The Commission's report (included in its June 2012 report to the Congress) discussed the importance of targeting payments to providers in order to improve access while using Medicare spending efficiently. Using total discharges to measure patient volume is consistent with these goals.
    - Permanently reauthorizing institutional special needs plans (I-SNPs), narrowing the conditions eligible for chronic condition SNPs (C-SNPs), expanding the existing Center for Medicare & Medicaid Innovation (CMMI) Value-Based Insurance Design Model (allowing for MA benefit design flexibility), requiring the Secretary to develop a unified grievances and

appeals process for dual-eligible beneficiaries, and imposing more stringent standards to demonstrate dual-eligible SNP integration. These policies are consistent with a set of recommendations the Commission made in its March 2013 report.

  - Reforming the home health rural add-on payment to better target extra Medicare payments. In its March 2017 report, the Commission concluded that the home health rural add-on payment was poorly targeted. The BBA 2018 provision aims to better target the add-on payments, which is consistent with the Commission's concerns.
  - Establishing an Accountable Care Organization (ACO) Beneficiary Incentive Program to allow certain two-sided risk ACOs to make incentive payments to assigned beneficiaries. The Commission has supported giving ACOs more options for incentivizing beneficiaries to use providers within their ACO.
  - Expanding access to telehealth services in MA and ACOs, for end-stage renal disease (ESRD) beneficiaries and for stroke patients. In its March 2018 report on telehealth (mandated by the 21st Century Cures Act), the Commission articulated a set of principles (cost, access, and quality) to evaluate individual telehealth services before adoption into Medicare coverage, and discussed telestroke, MA plans, and ACOs as examples where greater flexibility may be desirable.
  - Requiring ground ambulance providers to submit cost reports. The Middle Class Tax Relief and Job Creation Act of 2012 directed the Commission to report to Congress on the Medicare ambulance fee schedule. In its report, the Commission supported requiring ground ambulance providers to submit cost reports.

- The Comprehensive Addiction and Recovery Act (CARA) adopted several policy ideas that the Commission has discussed and recommended to deal with the opioid crisis, including limiting the number of prescribers that a beneficiary can use when filling prescriptions for opioids. This approach was discussed in our June 2015 report to the Congress.
- The 21st Century Cures Act contained provisions reflecting many MedPAC recommendations including: expanding MA risk adjustment to include two years of diagnostic data and a count of the number of a beneficiary's chronic conditions, which MedPAC discussed in March 2016; adding an adjustment that accounts for socioeconomic status for hospital readmission penalties, which MedPAC discussed in its June 2013 report; and removing the statutory bar on beneficiaries with end-stage renal disease from enrolling in MA plans, which the Commission recommended in March 2004.

- In the Bipartisan Budget Act of 2015, Congress enacted a site-neutral payment policy for certain hospital outpatient department (HOPD) services. This policy is similar to MedPAC's March 2012 and 2014 recommendations to narrow or eliminate the difference between rates in HOPDs and physician offices for certain services.
- The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), enacted in 2015, requires hospitals to notify beneficiaries when they are placed in observation status, and to explain the financial implications of this status decision. The Commission recommended this policy in its June 2015 report on hospital short-stay policy issues.
- In the Medicare Access and CHIP Reauthorization Act of 2015, Congress repealed the sustainable growth rate (SGR) formula. MedPAC first recommended repealing the SGR in October 2011.
- The IMPACT Act of 2014 enacted a uniform patient assessment tool to collect standardized post-acute care assessment data across the post-acute care (PAC) provider settings. The Commission recommended the collection of common PAC assessment data in March 2014 and has been publicly discussing the need for such data since 2005.
- The IMPACT Act of 2014 implemented technical fixes to the statutory language authorizing focused medical reviews for hospices, consistent with the discussion of this issue in MedPAC's March 2014 report. Technical issues with the original language had prevented CMS from implementing focused medical reviews, which MedPAC originally recommended in March 2009.
- The Protecting Access to Medicare Act of 2014 directed the Secretary of the U.S. Department of Health and Human Services (HHS) to identify overpriced procedures in the physician fee schedule and reduce their relative value units (RVUs) accordingly and set a target for total annual RVU reductions. The Commission recommended such a policy in its 2011 letter to Congress on repealing the SGR. The bill also directed additional funds to CMS to collect data for the purpose of identifying overpriced procedures, consistent with another recommendation in our 2011 SGR letter.
- The Protecting Access to Medicare Act of 2014 enacted a readmissions penalty for skilled nursing facilities. MedPAC recommended such a policy in March 2012.
- The Protecting Access to Medicare Act of 2014 required the Secretary of HHS to conduct audits of ESRD providers' cost reports, with the legislation specifying that this policy was "as recommended by MedPAC."

In addition, CMS has adopted several of MedPAC's recommendations through its rulemaking process. Selected policies adopted through rulemaking since 2018 include:

- The hospital inpatient prospective payment system (IPPS) final rule for FY 2023 changed the calculation of the IPPS outlier fixed loss amount consistent with the Commission's comment to modify the approach to account for the number of costly COVID-19 cases in FY 2021.
- The physician fee schedule (PFS) final rule for CY 2023 required clinicians to use a claims modifier to identify all audio-only telehealth services consistent with the Commission's March 2022 recommendation.
- The PFS proposed rule for CY 2023 requested comment on incorporating an administrative benchmark approach to the Medicare Shared Savings Program (MSSP) consistent with discussions in MedPAC's June 2022 report to the Congress.
- Beginning on January 1, 2021, CMS expanded the durable medical equipment, prosthetic/orthotics, and supplies (DMEPOS) competitive bidding program (CBP) to include off-the-shelf knee and back braces. The Commission supported shifting such DEMPOS products from the DME fee schedule the CBP in its June 2018 report to the Congress.
- The Medicare Advantage and Part D final rule for CY 2021 implemented restrictions on dual-eligible special needs plan (D–SNP) "look-alike" plans. The Commission raised concerns over the growing use of "look-alike" plans to circumvent D–SNP requirements in its June 2019 report to the Congress.
- In the final rule updating the Medicare payment rates and the value-based purchasing program for skilled nursing facilities (SNFs) for FY 2020, CMS implemented a new case-mix system. The Commission began discussing needed reforms to the SNF PPS in its June 2007 report and the following year recommended a design to base payments on patient characteristics and to better target payments for nontherapy ancillary services.
- The hospital outpatient prospective payment system (OPPS) final rule for CY 2019 implemented site-neutral payment for evaluation and management clinic visits provided in off-campus hospital outpatient departments and freestanding physician offices. In 2012 and 2014, the Commission recommended the Congress reduce or eliminate differences in payment rates between hospital outpatient departments and physician offices.

- In the 2019 Medicare Advantage and Part D rate announcement and call letter, CMS adjusted the payment rate for Medicare Advantage employer group waiver plans so that the payments are more consistent with how comparable non-employer plans are paid. The Commission recommended this adjustment in its March 2014 report to the Congress.
- The physician fee schedule final rule for CY 2019 reduced the add-on percentage for certain Part B drugs paid based on wholesale acquisition cost (WAC) from 6 percent to 3 percent. The Commission recommended this policy in its June 2017 report to the Congress.
- The hospital inpatient prospective payment system (IPPS) final rule for FY 2018 included a policy change to begin using the S-10 worksheet in Medicare's cost reports to distribute uncompensated care payments. The Commission recommended this policy in its March 2016 report on hospital inpatient and outpatient services. That rule also included a revision to the methodology used for paying long-term care hospitals for short stays and improved incentives for providers to base discharge decisions on clinical needs and not payment. The Commission discussed this policy approach in multiple reports to the Congress, and in comment letters to CMS on the FY 2015 and FY 2016 proposed IPPS rules.

Commission Meetings

From October 2021 through September 2022, the Commission held eight public meetings to develop and approve reports and recommendations to the Congress. The Commission briefs staff from each committee with jurisdiction over Medicare before each meeting to ensure the staff are informed of the items that compose each meeting's agenda. Throughout FY 2022, the Commission's public meetings were available online through a livestream, each session was attended virtually by approximately 300 to 400 attendees, representing stakeholders, congressional staff, other government personnel, and members of the public. Members of the press who regularly cover health policy issues and write for publications that are frequently read by congressional staff also attend these meetings virtually. The agenda for each meeting over the past year is described in Appendix C.

Research Reports

In 2022, the Commission completed all requested/mandated reports and presented them to Congress in accordance with statutory deadlines. In the process of preparing these reports, Commission staff made about 50 public presentations to Commissioners, requiring staff to conduct relevant analyses as well as develop draft decision memoranda, background

documents, and other materials. Further, staff gather additional information for these reports through meetings with a wide range of external groups, described below.

March 2022 Report to the Congress

On March 15, 2022, the Commission submitted its annual mandated report to the Congress on Medicare Payment Policy, complying with a statutory requirement to each year provide Congress with recommendations on whether and how to update Medicare's payments to different providers, and the rationale for our recommendations. The report addressed the following areas:

- Assessing payment adequacy and updating payments for hospital inpatient and outpatient services, physician services, ambulatory surgical centers, outpatient dialysis services, hospice services, skilled nursing facility services, home health services, inpatient rehabilitation facility services, and long-term care hospital services;
- The status of the Medicare Advantage (MA) program, including plan availability, enrollment, payments to plans, and quality among MA plans;
- The status of Medicare's Part D prescription drug benefit, including an analysis of plan availability, enrollment, costs of the program, and consideration of cost sharing for beneficiaries receiving the low-income subsidy;
- Changes to the low-volume hospital payment adjustment (mandated report, described below);
- The impact of changes to the home health payment system (mandated report, described below);
- The performance of specialized MA plans that serve beneficiaries who are dually eligible for Medicare and Medicaid (mandated report, as described below); and
- Designing a value incentive program for post-acute care (mandated report, described below).

To fulfill a statutory requirement, this report also included our annual chapter on the budgetary context for Medicare payment policy.

June 2022 Report to the Congress

On June 15, 2022, the Commission submitted its annual mandated report to the Congress on Medicare and the Health Care Delivery System. This report focused on broad questions confronting the Medicare program, as well as more sector-specific issues, and fulfills a

statutory requirement to each year provide Congress with a report examining the issues facing the Medicare program. Topics included:

- An approach to streamline and harmonize Medicare's portfolio of alternative payment models;
- Vulnerable Medicare beneficiaries' access to care (Congressional request, detailed below);
- Supporting safety-net providers;
- Addressing high prices of drugs covered under Medicare Part B;
- Improving the accuracy of Medicare Advantage payments by limiting the influence of outliers in CMS's risk-adjustment model;
- Aligning fee-for-service payment rates across ambulatory settings; and
- Segmentation in the stand-alone Part D plan market.

Other Mandated Reports

In addition to our annual standing reports to Congress, the Commission publishes specific reports that directly respond to congressional mandates in legislation or formal requests. In 2022, the Commission published four reports in compliance with mandates in the Bipartisan Budget Act (BBA) of 2018 and the Consolidated Appropriations Act, 2021. The Commission also published one report in response to a formal request from the House Committee on Ways and Means.

- *Assessing the impact of the change to a 30-day unit of payment on home health agencies, interim report:* The Bipartisan Budget Act of 2018 replaced the 60-day unit of payment used for home health agencies (HHAs) with a 30-day unit of payment and eliminated the number of in-person therapy visits as a factor in the payment system. A new case-mix system was created to implement this change called, the Patient-Driven Groupings Model (PDGM). The legislation required the Commission to submit an interim report to Congress on the application of the new unit of service by March 15, 2022. The report was required to include an analysis of the level of payments provided as compared to the cost of delivering care and any unintended consequences as they relate to quality and behavioral changes. Our assessment of the change in case-mix system was difficult due to the coronavirus pandemic, but overall we found that HHAs served similar beneficiaries after the implementation of PDGM and the patient mix stayed almost the same. The Commission's report was included in our March 2022 report to the Congress.

- *Evaluating the extension of the increased inpatient hospital payment adjustment for low-volume hospitals (LVH):* The Bipartisan Budget Act of 2018 required that LVH eligibility be based on all-payer volume rather than Medicare volume. The legislation required that MedPAC submit a report to Congress on the extension of the increased inpatient hospital payment adjustment for certain LVHs. Our assessment found that the BBA of 2018 raised the number of LVHs by 5 percent and increased aggregate payments to LVHs by about 19 percent. The Commission remains concerned that the policy does not target isolated hospitals well and is duplicative for the majority of LVHs that already receive cost-based payments through their designation as a sole-community or Medicare-dependent hospital. The Commission's report was included in our March 2022 report to the Congress.

- *Analyzing the performance of special needs plans (SNPs):* The Bipartisan Budget Act of 2018 permanently authorized dual-eligible special needs plans (D-SNPs) and required them in 2021 to meet new standards for integrating the delivery of Medicare and Medicaid services. The plan must meet one of three additional criteria for integration such as care coordination, qualify as a highly integrated dual-eligible SNP (HIDE-SNP), or assume "clinical and financial responsibility" for both Medicare and Medicaid benefits provided to enrollees. The Commission was mandated to periodically compare the performance of different types of D-SNPs and other plans that serve dual-eligible beneficiaries. The results from our analysis were mixed—each plan performed relatively well on some measures and relatively poorly on others—and do not clearly favor one plan type over others. The challenges of using HEDIS measures to assess performance also reflect larger difficulties in assessing the quality and performance of MA plans (both in terms of how well individual plans perform compared with each other and how well MA plans perform compared with the FFS program). The Commission has recommended in the past several years that plans be required to submit encounter data, which could be a rich source of information about the services that MA enrollees use, and our findings from this report support that recommendation. The Commission's report was included in our March 2022 report to the Congress.

- *Establishing a prototype value-based payment program (VBP) under a unified prospective payment system (PPS) for post-acute care (PAC) services:* The Consolidated Appropriations Act, 2021, required the Commission to report on a prototype VBP under a unified PPS for PAC services and analyze the impacts of the prototype's design. Such report was required to consider design elements and required the Commission to analyze the effects of implementing such prototype program and discuss the possible effects on program spending, post-acute care providers, and patient outcomes. The prototype that we developed (the PAC Value Improvement Program, or PAC VIP) would include five design elements: a small set of performance measures,

strategies to ensure reliable measure results, a system to distribute rewards with minimal "cliff" effects, an approach to account for differences in patients' social risk factors using a peer-grouping mechanism (if necessary), and a method to distribute the entire provider-funded pool of dollars. The Commission's report was included in our March 2022 report to the Congress.

- *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 medically underserved areas (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 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 were 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. The Commission's report was included in our June 2022 report to the Congress.

Other Publications

In addition to the congressionally mandated reports, the Commission also published the following publications frequently used by congressional staff:

- MedPAC and MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid (February 2022). In collaboration with the Medicaid and Children's Health Insurance Program Payment Advisory Commission (MACPAC), this Data Book provides tables and graphs that present information on the demographic and other personal characteristics, expenditures, and health care utilization of individuals who were dually eligible for Medicare and Medicaid coverage.
- A Data Book: Health Care Spending and the Medicare Program (July 2022). The MedPAC Data Book provides tables and graphs describing the Medicare program, Medicare beneficiaries and their utilization of health care services, and Medicare's

payment systems. The Medicare Data Book is the result of discussions with congressional staff members regarding ways that MedPAC can better support them.

- Payment Basics: Primers on each of the Medicare payment systems (October 2022). Payment Basics is a series of brief overviews of how 21 of Medicare's payment systems function.

Reports to be Submitted to the Congress in 2023

We will release our March report to the Congress and our June report to the Congress by their statutory deadlines. The March report will focus on Medicare payment policy and the June report will focus on specific issues in payment and delivery system reform. We will submit three additional mandated reports and one formal Congressional request by June 2023:

- A report mandated by the Consolidated Appropriations Act, 2023, to compare MA and FFS per enrollee spending (March);
- A report mandated by the Improving Medicare Post-Acute Care Transformation Act (IMPACT) of 2014 to recommend a technical prototype on a post-acute care prospective payment system (June);
- A report mandated by the Consolidated Appropriations Act, 2022, to report on telehealth utilization and the implications of expanding Medicare coverage for telehealth services (June);
- A report responding to a January 2022 formal request from the Chairman of the House Committee on Ways and Means that asked MedPAC to review access to mental health services for Medicare beneficiaries (June).

We plan to submit our Medicare Data Book in July 2023, and Payment Basics on each of the Medicare payment sectors in October 2023 as we have in past years. In February 2023, in collaboration with the Medicaid and Children's Health Insurance Program Payment Advisory Commission (MACPAC), we published the MedPAC and MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid.

Primary Source Data Collection

Gathering primary source data and information is an essential activity for the Commission to fulfill its statutory mission. To that end, the Commission engages in a wide range of primary source data collection efforts, including: meetings with key stakeholders, including individual health care providers, associations of health care providers, beneficiaries, and experts in health care policy and medicine; purchasing non-Medicare proprietary data; conducting a national survey of Medicare beneficiaries; convening focus groups with beneficiaries and providers;

and conducting site visits to different health care providers to better understand their experience with the Medicare program.

These interactions both inform the Commission's recommendations and help Commission staff better anticipate and respond to congressional requests, since many of the stakeholder groups with whom MedPAC meets are the same groups that lobby Congress for their policy priorities.

National Survey of Beneficiaries

Every year, MedPAC commissions an annual survey to assess beneficiaries' reported access to clinicians. Historically, the Commission has sponsored a survey over the phone to Medicare beneficiaries ages 65 and over and privately insured people. However, in FY 2022, our incumbent survey firm stopped offering a multi-client phone survey so the Commission recompeted our survey and it is now self-administered online and by mail. The nationally representative random sample collects data on two groups: Medicare beneficiaries ages 65 and over and 4,000 privately insured people ages 50 to 64. The survey provides insight into beneficiary access to care and use of health care services. Data collected from this survey is key to our annual assessment of the adequacy of Medicare payments to clinicians.

Dialogue with Stakeholder Groups

In FY 2022, the Commission met with over 70 stakeholder groups. A partial list of the groups the Commission met with in 2022 is included in Appendix E. In 2023, members of the Commission staff will continue to meet with outside groups in order to gather insights to inform MedPAC's findings and recommendations. These interactions are supplemented by written statements submitted by stakeholders to the Commission members and staff.

Focus Groups

Commission staff employ focus groups with Medicare beneficiaries and health care providers to gain additional qualitative understanding of their respective experiences with the Medicare program. In 2022, we held 21 in-person focus groups with Medicare beneficiaries and physicians residing in Atlanta, GA; Boston, MA; and Las Vegas, NV. Additionally, we held three virtual focus groups with beneficiaries residing in rural areas of Alabama, Mississippi, and West Virginia. We asked those groups about beneficiaries' access to care, beneficiaries' coverage choices, the delivery of care, the changing organization of medical care, clinician telehealth adoption and beneficiary use, and prescription drug use.

Site Visits

In addition, to increase our understanding of the health care market and the impact of Medicare payment policy on providers, Commission staff make annual site visits to a range of providers across the country, visiting different locations and types of facilities each year. Staff conducted site visits in Atlanta, GA, and Boston, MA to gain insights into the treatment and cost of low-income beneficiaries as well as their access to care, social risk factors, participation in accountable care organizations (ACOs), and post-acute care referrals. In each city, staff observed two hospitals, one of which was a deemed safety-net hospital, and one primary care physician group.

MedPAC Comments on CMS Regulations

In addition to our mandated reports, during the past year, the Commission has submitted written comments on 14 regulations proposed by the Secretary of the Department of Health and Human Services. Our comment letters serve as a resource for committee staff, providing a stronger understanding of the proposed regulations and their larger potential policy implications, and are all posted on our public website. The proposed regulations on which the Commission submitted comments are listed below:

- Proposed rule on changes to the requirements that ESRD facilities must meet to participate in Medicare programs (1/28/2022)
- Proposed rule for national coverage determination decision memorandum on anti-amyloid monoclonal antibody drugs (2/10/2022)
- Proposed rulemaking notice for MA coding pattern adjustment (3/3/2022)
- Proposed rulemaking notice for contract year 2023 policy and technical changes to MA and Part D (3/4/2022)
- Proposed rule on hospice for FY 2023 (5/27/2022)
- Proposed rule on inpatient psychiatric facility prospective payment system for FY 2023 (5/27/2022)
- Proposed rule on inpatient rehabilitation facility prospective payment system for FY 2023 (5/27/2022)
- Proposed rule on skilled nursing facility prospective payment system for FY 2023 (6/8/2022)
- Proposed rule on the hospital inpatient prospective payment system and the long-term care hospital prospective payment system for FY 2023 (6/16/2022)

- Proposed rule on conditions of Medicare participation for rural emergency hospitals and critical access hospitals (7/27/2022)
- Proposed rule on the home health prospective payment system for CY 2023 (8/15/2022)
- Proposed rule on the ESRD prospective payment system for CY 2023 (8/19/2022)
- Proposed rule on CY 2023 revisions to payment policies under the physician fee schedule and other changes to Part B payment policies (9/2/2022)
- Proposed rule on the payment systems for hospital outpatient departments and ambulatory surgical centers for 2023 (9/12/2022)

In 2023, we expect to comment on between 10 to 15 proposed rules, regulations, and other requests for information.

MedPAC Briefings, Assistance to Congressional Staff, and Testimony

Over the last year, MedPAC was called upon regularly to provide technical support and advice to the Congress—both Members and staff, majority and minority, formally and informally. This support took several forms.

The Commission briefed congressional staff on a wide range of Medicare issues as well as on ongoing analytical work by the Commission, including five formal staff briefings addressing the Medicare program broadly, telehealth policy, the physician fee schedule, site-neutral payments, and the Medicare Advantage program. Commission staff also conducted a series of less formal briefings with staff of the committees of jurisdiction on a variety of topics in addition to those mentioned previously including hospital payment and Medicare drug payment policy.

Commission staff responded to numerous requests from congressional staff on a wide variety of topics. These interactions included conference calls and briefings prior to each public meeting to discuss research, gather feedback, and provide information about Commission deliberations and upcoming recommendations. Commission staff provided data, background materials, and other substantive analyses. In 2022, Commission staff filled approximately 200 requests for technical assistance from the Congress.

In June of 2022, the Commission provided oral testimony and submitted a statement for the record to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Oversight and Investigations regarding improvements to the Medicare Advantage program.

In February of 2022, the Commission provided oral testimony and submitted a statement for the record to the U.S. Senate Committee on Finance Subcommittee on Fiscal Responsibility and Economic Growth regarding the hospital insurance trust fund and the future of Medicare financing.

Collaboration with Other Government Entities

In 2022, as in previous years, MedPAC worked collaboratively with other government entities involved in assessing and implementing the Medicare program. These include exchanging information about health service delivery, quality measurement, oversight initiatives, and other topics. These collaborations are mutually valuable and contribute to greater coordination and minimized redundancy among government initiatives. Collaborations with the following other government entities included:

Congressional Support Agencies: Coordination and consultation with the Medicaid and CHIP Payment and Access Commission, the Congressional Budget Office, the Congressional Research Service, and the Government Accountability Office.

Centers for Medicare & Medicaid Services (CMS): Monthly briefings on a range of issues, as well as ad hoc meetings to discuss specific topics such as Medicare demonstration programs, actuarial estimates, and other Medicare policy issues; consultations with the Center for Medicare and Medicaid Innovation and the Office of the Actuary.

Agencies within the Department of Health and Human Services: Collaborations with the Office of Inspector General, the Health Resources and Services Administration, Office of the Assistant Secretary for Planning and Evaluation, the Agency for Healthcare Research and Quality and the Federal Office of Rural Health Policy.

Other Executive Branch Agencies: Consultations with the Department of Justice, Department of Veterans Affairs, the Office of Management and Budget, the Federal Trade Commission, and the Office of Personnel Management.

Presentations

In 2022, Commission staff extended public outreach through speaking at four meetings hosted by key stakeholder organizations. Members of the staff will continue to reach out to external groups through professional and academic meetings. Such efforts increase staff knowledge of the Medicare policy context and expand public understanding of the Commission's work.

Supporting Material

Appropriations Language

For expenses necessary to carry out section 1805 of the Social Security Act, $13,824,000 to be transferred to this appropriation from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds.

Authorizing Legislation

The Commission's authorization is contained in section 1805 of the Social Security Act (42 U.S.C. 1395 b–6). This legislation authorizes "such sums as may be necessary."

FY 2023 authorized	FY 2023 appropriation	FY 2024 authorized	FY 2024 request
$13,824,000	$13,824,000	N/A	$13,824,000

Note: FY (fiscal year).

Summary of Changes

	2023 Base		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
Personal compensation	35	5,150,000	35	+270,679
Personal benefits		2,163,400		+85,268
Misc. other services – Commercial contracts		413,000		+67,504
Equipment/furnishings		222,725		+59,685
Travel		199,000		+51,600
Security payments/DHS		114,000		+30,000
Professional and consultant services		292,840		+12,560
Supplies/materials		30,000		+4,740
Decreases:				
Research contracts		2,259,600		-485,600
Computer programming		1,876,564		-61,344
Publications		101,233		-16,413
LOC support services		100,000		-13,072
Leased equipment		4,750		-3,950
Other government services (GSA, NFC, OPM)		24,536		-736
Cell/Telephone/Courier/Internet		38,184		-504
No Change:				
Rent (lease)		808,243		-
Trainings and conferences		6,000		-
Postage		2,000		-
Printing and reproduction		18,000		-
Net change:				-

Note: FTE (full-time equivalents), DHS (Department of Homeland Security, LOC (Library of Congress), GSA (Government Services Administration), NFC (National Finance Center), OPM (Office of Personnel Management).

Budget Authority by Object Class (in thousands)

Object classification	FY 2022 Actual	FY 2023 Appropriation	Change	FY 2024 Request
Personal compensation				
Full-time staff	$4,623	$4,850	+250	$5,100
Commissioners	282	300	+21	321
	4,905	5,150	+271	5,421
Personal benefits	1,912	2,163	+85	2,249
Travel				
Staff	14	37	-1	36
Commissioners	57	157	+53	210
Consultant	1	5	-	5
	72	199	+52	251
Rent (lease)	668	808	-	808
Cell/Telephone/Courier/Internet	37	38	-1	38
Leased equipment	18	5	-4	1
Postage	1	2	-	2
	725	853	-4	849
Printing and reproduction	19	18	-	18
Misc. other svcs - Commercial contracts	515	413	+68	481
Computer programing	1,569	1,877	-61	1,815
Research contracts	2,467	2,260	-486	1,774
Other government (GSA, NFC, OPM)	32	25	-1	24
LOC support services	99	100	-13	87
Training and conferences	-	6	-	6
Security payments to DHS	110	114	+30	144
Professional and consultant services	279	293	+13	305
	5,070	5,087	-451	4,636
Office supplies/services	9	30	+5	35
Publications	78	101	-16	85
	87	131	-12	120
Software	112	127	+6	132
Equipment	153	96	+34	130
Furnishings	14	-	+20	20
	278	223	+60	282
Subtotal	$13,069	$13,824	-	$13,824
Lapsing	223	-	-	-
Total	$13,292	$13,824	-	$13,824

Note: Numbers may not add to totals because of rounding. FY (fiscal year), GSA (General Services Administration), NFC (National Finance Center), OPM (Office of Personnel Management), LOC (Library of Congress), DHS (Department of Homeland Security).

Funding Table (in thousands)

	FY 2022 Actual	FY 2023 Appropriation	Change	FY 2024 Request
Administration and management (Primarily staff and commissioner salaries and benefits)	$8,755	$9,395	+$535	$9,930
Data development, analysis, and research (Primarily data management and security, and outside contractor costs)	$4,314	$4,429	-$534	$3,895
Lapsing	$223	-	-	-
Total	$13,292	$13,824	-	$13,824

Note: FY (fiscal year).

Personnel Summary

	FY 2022 Actual [a]	FY 2023 Appropriation	Change	FY 2024 request
Executive level [b]	3	3	-	3
GS/GM-13 to GS/GM-15	24	27	-1	26
GS-6 to GS-12	6	6	-	6
Staffing level (FTEs)	33	35	-	35

Note: FY (fiscal year), GS/GM (General Schedule), FTEs (full-time equivalents). Components may not sum to totals due to rounding. This schedule is for comparison purposes only. MedPAC does not use the formal government system of grading and salaries. Each salary is determined individually following U.S. Senate personnel rules and MedPAC's personnel policies and procedures.

[a] *The number of employees during 2022 was 33. The grades reported reflect averages for the year.*

[b] *The number of executive level staff for FY 2022 includes two FTEs allocated among MedPAC's 17 part-time Commissioners. MedPAC's authorizing legislation requires that Commissioners be paid the per diem equivalent of the rate provided for level IV of the Executive Schedule for the time they devote to Commission business. The other position is the Executive Director.*

Staffing Level

Fiscal year	Number of full-time permanent positions [a]
2006	35
2007	34
2008	32
2009	34
2010	35
2011	37
2012	37
2013	36
2014	35
2015	34
2016	36
2017	35
2018	33
2019	35
2020	33
2021	32
2022	33
2023	35
2024	35

[a] *The total FTE level includes two FTEs representing the part-time work of the 17 commissioners.*

Appropriations History

Fiscal Year	Budget Estimate to the Congress	Appropriation
2008[a]	$10,748,000	$10,560,000
2009	$11,403,000	$11,403,000
2010	$11,800,000	$11,800,000
2011[b]	$12,749,000	$12,425,000
2012[c]	$13,100,000	$11,778,000
2013[d]	$12,210,000	$11,162,000
2014	$12,087,000	$11,519,000
2015	$12,300,000	$11,749,000
2016	$12,100,000	$11,925,000
2017	$12,234,000	$11,925,000
2018	$12,295,000	$12,545,000
2019	$12,471,000	$12,545,000
2020	$12,645,000	$12,545,000
2021	$13,142,000	$12,905,000
2022	$13,310,000	$13,292,000
2023	$13,440,000	$13,824,000
2024	$13,824,000	

[a] *For FY 2008, the Commission received an appropriation of $10,748,000 that was reduced to $10,560,000 by an across-the-board rescission.*

[b] *For FY 2011, the Commission received an appropriation of $12,450,000 that was reduced to $12,425,000 by an across-the-board rescission.*

[c] *For FY 2012, the Commission received an appropriation of $11,800,000 that was reduced to $11,778,000 by a rescission.*

[d] *For FY 2013, reflects the appropriated amount after the sequester.*

Appendixes

APPENDIX A
Current Commission Members

Member and Affiliation	Appointed	Term Expiration
Lynn Barr, M.P.H. Barr-Campbell Family Foundation Incline Village, NV	6/2/2021	4/30/2024
Lawrence Casalino[a], M.D., Ph.D. Weill Cornell Department of Healthcare Policy and Research New York, NY	5/23/2019	4/30/2025
Michael Chernew, Ph.D., Chair Harvard Medical School Boston, MA	5/21/2020	4/30/2023
Robert Cherry, M.D., M.S. UCLA Health Los Angeles, CA	5/26/2022	4/30/2025
Cheryl Damberg, Ph.D. RAND Corporation Santa Monica, CA	5/26/2022	4/30/2025
Stacie B. Dusetzina, Ph.D. Vanderbilt University School of Medicine Nashville, TN	6/2/2021	4/30/2024
Marjorie Ginsburg[a,b], B.S.N., M.P.H. Sacramento, CA	5/29/2018	4/30/2023
David Grabowski[a], Ph.D. Harvard Medical School Boston, MA	5/24/2017	4/30/2023
Jonathan Jaffery[a], M.D., M.S., M.M.M. Association of American Medical Colleges Washington, DC	5/29/2018	4/30/2024

Kenny Kan, F.S.A., C.P.A., C.F.A., M.A.A.A. Horizon Blue Cross Blue Shield Newark, NJ	5/26/2022	4/30/2025
Amol Navathe[a], M.D., Ph.D., Vice Chair University of Pennsylvania School of Medicine Philadelphia, PA	5/23/2019	4/30/2025
Gregory Poulsen, M.B.A. Intermountain Healthcare Salt Lake City, UT	5/26/2022	4/30/2025
Betty Rambur, Ph.D., R.N., F.A.A.N. University of Rhode Island Kingston, RI	5/21/2020	4/30/2023
Wayne J. Riley, M.D. State University of New York Downstate Brooklyn, NY	5/21/2020	4/30/2023
Jaewon Ryu[a], M.D., J.D. Geisinger Health System Danville, PA	5/29/2018	4/30/2024
Dana Gelb Safran[a], Sc.D. National Quality Forum Washington, DC	5/24/2017	4/30/2023
Scott Sarran, M.D. MoreCare Cook County, IL	5/26/2022	4/30/2025

[a] *Member was reappointed to a second term.*
[b] *Effective 4/30/2023, member resigned prior to completing full term.*

APPENDIX B
Outstanding Congressionally Mandated Reports

Mandate: **Consolidated Appropriations Act, 2023. Comparison of per enrollee spending for beneficiaries enrolled in FFS and MA.**

Due date: March 15, 2023

Description: The Consolidated Appropriations Act, 2023, mandated that the Commission submit a report that compares MA and FFS per enrollee spending for at least the last five years for which data are available. The Act requests that the Commission's analysis use the FFS spending method used to calculate MA benchmarks and compare MA payments with beneficiaries enrolled in both Part A and Part B.

Mandate: **The IMPACT Act of 2014. Recommendations for PAC prospective payment.**

Due date: June 30, 2023

Description: Not later than the first June 30th following the date on which the Secretary of Health and Human Services submits a report to the Congress mandated by the IMPACT Act that includes recommendations and a technical prototype on a post-acute care prospective payment system, the Commission shall submit a report to the Congress that assesses such recommendations and technical prototype on a post-acute care prospective payment system.

Congressional letter request: Access to mental health services for Medicare beneficiaries

Due date: June 15, 2023

Description: The Chair of the Committee on Ways and Means requested the Commission study access to mental health services for Medicare beneficiaries. Specifically, the Commission was asked to update its June 2010 report to the Congress and includes several additional analyses related to mental health services and substance use disorders including an inpatient analysis studying the 190-day limit per beneficiary on inpatient psychiatric facility care, inpatient psychiatric facilities' Medicare margins and quality of care measures, the utilization of Medicare outpatient mental health services, characteristics of beneficiaries who

use tele-mental health services, and the use of mental health services for beneficiaries enrolled in Medicare Advantage.

Mandate: **Consolidated Appropriations Act, 2022. Telehealth utilization**

Due date: June 15, 2023

Description: The Consolidated Appropriations Act, 2022, requested that MedPAC conduct a study on the expansions of telehealth including: the utilization of telehealth services under the Medicare program; Medicare program expenditures on telehealth services; Medicare payment policy for telehealth services and alternative approaches to such payment policy, including for federally qualified health centers and rural health clinics; and the implications of expanded Medicare coverage of telehealth services on beneficiary access to care and the quality of care, to the extent reliable data are available.

Mandate: **BBA of 2018. Performance of special needs plans (SNPs).**

Due date: March 15, 2024

Description: The Medicare Payment Advisory Commission shall submit to Congress a study on the performance of Medicare Advantage (MA) SNPs. Initial report due March 15, 2022, and mandated biennially thereafter through 2032 and every five years beginning in 2033.

Mandate: **Consolidated Appropriations Act, 2021. Review payments to rural emergency hospitals.**

Due date: March 15, 2024

Description: Beginning in 2024, as part of its March report, include a review of payments to a new designated of hospital known as "rural emergency hospitals."

Mandate: **BBA of 2018. Report on the effects of home health payment reform.**

Due date: March 15, 2026 (Final report)

Description: Final report on the application of a 30-day unit of service for home health payment.

Mandate: **BBA of 2018. Performance of special needs plans (SNPs)**

Due date: March 15, 2026

Description: The Medicare Payment Advisory Commission shall submit to Congress a study on the performance of Medicare Advantage (MA) SNPs. Initial report due March 15, 2022, and mandated biennially thereafter through 2032 and every five years beginning in 2033.

Mandate: **BBA of 2018, as updated by the Consolidated Appropriations Act, 2022. Costs of providing ambulance services**

Due date: June 15, 2026

Description: The Medicare Payment Advisory Commission shall assess information submitted by providers and suppliers of ground ambulance services, the adequacy of payments for ground ambulance services under this sub-section, and geographic variations in the cost of furnishing such services.

APPENDIX C
Commission Meetings and Major Agenda Items

Fiscal year 2022

October 7-8, 2021

- Addressing high prices of pharmaceutical products (and other technologies) covered under Medicare
- Data on Medicare's net prices for prescription drugs and other drug pricing metrics
- Congressional request: Vulnerable Medicare beneficiaries' access to care (final report)
- Exploring features of Medicare's alternative payment models
- Improving Medicare Advantage risk adjustment by limiting the influence of outlier predictions
- Medicare hospital wage index

November 8-9, 2021

- Benchmark incentives for accountable care organizations
- Medicare payment policies to support safety-net providers
- Telehealth: Updates on use, beneficiary and clinician experiences, and other topics of interest
- Aligning fee-for-service payment rates across ambulatory settings
- Part D for residents in long-term care facilities

December 9-10, 2021

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and mandated report on Bipartisan Budget Act of 2018 changes to the low-volume hospital payment adjustment
- Assessing payment adequacy and updating payments: Ambulatory surgical center services
- Assessing payment adequacy and updating payments: Outpatient dialysis services
- Assessing payment adequacy and updating payments: Physician and other health professional services
- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Skilled nursing facility services

- Assessing payment adequacy and updating payments: Home health care services; and mandated report on Bipartisan Budget Act of 2018 changes to the home health payment system
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services
- Assessing payment adequacy and updating payments: Long-term care hospital services

January 13-14, 2022

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and mandated report on Bipartisan Budget Act of 2018 changes to the low-volume hospital payment adjustment
- Assessing payment adequacy and updating payments: Physician and other health professional services
- Assessing payment adequacy and updating payments: Ambulatory surgical center services; outpatient dialysis services; hospice services
- Assessing payment adequacy and updating payments: Skilled nursing facility services; home health care services; inpatient rehabilitation facility services: and long-term care hospital services
- Mandated report: Designing a value incentive program for post-acute care
- Developing a multi-track population-based payment model with administratively updated benchmarks
- The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans
- The Medicare prescription drug program (Part D): Status report

March 3-4, 2022

- Findings from MedPAC's annual beneficiary and clinician focus groups
- Medicare payment policies to support safety-net providers
- Opportunities to strengthen the geriatric workforce
- Integrating episode-based payment with population-based payment
- Improving Medicare Advantage risk adjustment by limiting the influence of outlier predictions

April 7-8, 2022

- Addressing high prices of drugs covered under Medicare Part B
- Initial findings from MedPAC's analysis of Part D data on drug rebates and discounts
- Segmentation in the stand-alone Part D prescription drug plan market

- Leveraging Medicare policies to address social determinants of health
- An approach to streamline and harmonize Medicare's portfolio of alternative payment models
- Aligning fee-for-service payment rates across ambulatory settings

September 1-2, 2022

- Context for Medicare payment policy
- Standardizing benefits in Medicare Advantage plans: Cost sharing for Part A and Part B services
- Medicare Advantage encounter data
- Reforming Medicare's wage index systems
- Addressing high prices of drugs covered under Medicare Part B

September 29-30, 2022

- Supporting safety-net clinicians
- Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system
- Nursing facility staffing
- Mandated report: Study on the expansion of telehealth
- Congressional request: Medicare and inpatient psychiatric facility care
- Analysis of Part D data on drug rebates and discounts

Fiscal year 2023 (November through March)

November 3-4, 2022

- Differences in quality measure results across Medicare populations
- Policy options for increasing Medicare payments to primary care clinicians
- Aligning fee-for-service payment rates across ambulatory settings
- Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system
- Support safety-net hospitals
- Standardizing benefits in Medicare Advantage plans: Non-Medicare supplemental benefits

December 8-9, 2022

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and supporting Medicare safety-net hospitals
- Status report: Ambulatory surgical center services
- Assessing payment adequacy and updating payments: Physicians and other health professional services; and supporting Medicare safety-net clinicians
- Assessing payment adequacy and updating payments: Outpatient dialysis services
- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Skilled nursing facility services
- Assessing payment adequacy and updating payments: Home health care services
- Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

January 12-13, 2023

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and supporting Medicare safety-net hospitals
- Assessing payment adequacy and updating payments: Physician and other health professional services; and supporting Medicare safety-net clinicians
- Assessing payment adequacy and updating payments: Outpatient dialysis services; hospice services; skilled nursing facility services; home health agency services; inpatient rehabilitation facility services
- The Medicare Advantage program: Status report
- Congressional request: Medicare clinician and outpatient behavioral health services
- Mandated report: Updates on telehealth use and beneficiary and clinician experiences

- Medicare Part D: Status report
- Addressing high prices of drugs covered under Medicare Part B

March 2-3, 2023

- Reforming Medicare's wage index systems
- Addressing the high prices of drugs covered under Medicare Part B
- Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system
- Favorable selection and future directions for Medicare Advantage payment policy
- Aligning fee-for-service payment rates across ambulatory settings

For the 2023-2024 meeting cycle, the Commission will meet in September, October, November, and December of 2023 to discuss the March 2024 report. The Commission will subsequently meet in January, March, and April of 2024 to discuss the June 2024 report.

APPENDIX D
Research Projects Funded Through Contracts

Research projects funded through contracts cover a variety of issues, including updating quality indicators, cost predictors in several settings, access to care, and more. Specific contracts in fiscal year 2022 include:

Physician and Other Health Professional Services

- Update measures of low-volume care
- Analysis of changes in physician compensation

Post-Acute Care

- Model cost predictors for a unified post-acute care prospective payment system
- Examine coding of conditions, patient characteristics, and service provision in skilled nursing facilities before and after the new payment system was implemented
- Key informant interviews with hospital discharge planners about access to SNF care with a focus on access for dual eligibles
- Measure case mix differences between Medicare and non-Medicare NF users
- Cost analysis of the inpatient rehabilitation facility prospective payment system

Drugs and Devices

- Update of Part B drug price index and spending and development of spending decomposition analysis
- Analysis of Part B drugs with accelerated approval
- Analysis of Part B drug groupings with similar health effects
- Creation of Part D net indexes
- Update of our Part D drug price index and exploration of comparable Parts B and D indexes

Assorted

- Literature review and interviews regarding interventions to address the social determinants of health
- Analysis of the impact of telehealth expansion on Medicare beneficiaries' access to care and quality of care
- Analysis of secondary coverage on Medicare spending

- Create linked Medicare-Medicaid dataset and update analysis for a Data Book on dually-eligible beneficiaries
- Interview project of non-hospice spending for hospice enrollees
- Interviews with inpatient psychiatric facility medical officers and financial officers to better understand costs associated with stays

APPENDIX E
MedPAC Meetings with Stakeholder Organizations

MedPAC spends approximately 20 percent of its staff time meeting with stakeholder organizations. These meetings may be initiated by MedPAC, interested stakeholder organizations, or through referrals to MedPAC by congressional staff. Below is a selected list of stakeholders with whom we met in 2022:

Acumen, LLC
Alliance for Connected Care
Alliance of Specialty Medicine
Ambulatory Surgery Center Association
AMDA-The Society for Post-Acute and Long-Term Care Medicine
America's Essential Hospitals
American Academy of Actuaries
American Academy of Home Care Medicine
American Academy of Physical Medicine and Rehabilitation
American Association of Nurse Practitioners
American Health Care Association
American Hospital Association
American Medical Association
American Medical Rehabilitation Providers Association
ASC Association
Association of American Medical Colleges
Better Medicare Alliance
Brookings Institute
California Hospital Association
Danone North America
Davita
Dobson DaVanzo & Associates
Emory Healthcare
ExactCare
George Washington University
Hospice Compassus
Infectious Diseases Society of America
Infusion Providers Alliance
Institute for Clinical and Economic Review
Kaiser Family Foundation
Milliman
National Alliance of Safety-Net Hospitals
National Association for Home Care and Hospice
National Association of ACOs
National Association of Community Health Centers
National Association of Freestanding Emergency Centers
National Association of Long-Term Hospitals
National Association of Rural Health Clinics
National Hospice and Palliative Care Organization
National Infusion Center Association
National Partnership for Healthcare and Hospice Innovation
Neurocrine Biosciences
Nonprofit Kidney Care Alliance
Oregon Rural Hospitals
Physician Clinical Registry Coalition
Premier, Inc.
RTI International
Senior Care Pharmacy Coalition
Sound Physicians
Sutter Health
Trinity Health
Watson Policy Analysis