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 10 chapters of the June 2023 report cover the following topics:

- ***Addressing high prices of drugs covered under Medicare Part B.*** The Commission makes recommendations to address high launch prices for certain accelerated approval drugs with limited clinical evidence, the lack of price competition among products with therapeutic alternatives, and the financial incentives associated with the percentage add-on to Medicare Part B's payment rate.
- ***Assessing postsale rebates for prescription drugs in Medicare Part D.*** Using data newly available to the Commission as a result of the Consolidated Appropriations Act, 2021, the Commission discusses trends and issues associated with the rapid growth of negotiated rebates and discounts received by Part D plan sponsors.
- ***Standardized benefits in Medicare Advantage plans.*** The Commission discusses the challenges that beneficiaries face in comparing Medicare Advantage (MA) plan benefits and selecting the plan with benefits that best meet their needs, and we outline an approach for standardizing MA benefits.
- ***Favorable selection and future directions for Medicare Advantage payment policy.*** The Commission discusses the effects of favorable selection on payments to MA plans and alternative approaches to setting MA benchmarks that would be less reliant on fee-for-service (FFS) spending than the current system is.
- ***Disparities in outcomes for Medicare beneficiaries with different social risks.*** The Commission presents an analysis of outcome measures for Medicare beneficiaries stratified by race/ethnicity and low-income status and discusses approaches to account for differences in patients' social risk factors and to encourage providers to focus on reducing health disparities.
- ***Congressional request: Behavioral health services in the Medicare program.*** In response to a congressional request, the Commission presents an analysis of utilization and spending for behavioral health services and discusses trends and issues in inpatient psychiatric care for beneficiaries.
- ***Mandated report: Telehealth in Medicare.*** As mandated by the Consolidated Appropriations Act, 2022, the Commission presents data on the use of telehealth services during the public health emergency and an analysis of the relationship between expanded telehealth coverage and quality, access, and costs.
- ***Aligning fee-for-service payment rates across ambulatory settings.*** The Commission recommends more closely aligning Medicare payment rates across ambulatory settings—hospital outpatient departments, ambulatory surgical centers, and freestanding physician offices—for selected services.
- ***Reforming Medicare's wage index systems.*** The Commission discusses the inaccuracies and inequities of Medicare's wage indexes and recommends a wage index approach for all of Medicare's prospective payment systems that would result in more accurate and equitable payments across providers.
- ***Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system.*** As mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, the Commission presents an evaluation of a prototype design of a uniform prospective payment system for post-acute care providers—skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

Addressing high prices of drugs covered under Medicare Part B

In Chapter 1, the Commission makes recommendations to address high launch prices for certain accelerated approval drugs with limited clinical evidence, the lack

of price competition among products with therapeutic alternatives, and the financial incentives associated with the percentage add-on to Medicare Part B's payment rate.

Medicare Part B covers drugs that are administered by infusion or injection in physician offices and hospital outpatient departments. It also covers certain drugs and biologics furnished by suppliers. In 2021, FFS Medicare and its beneficiaries paid about $43 billion for Part B–covered drugs and biologics. From 2009 to 2021, Medicare Part B drug spending grew at an average rate of about 9 percent per year.

The largest factor contributing to growth in Part B drug spending has been the rise in the average price paid by Medicare. Manufacturers set prices based on what they believe the U.S. health care market will bear and have established increasingly high launch prices for many new treatments, whether or not evidence exists that the product is comparatively more effective than existing standards of care. Likewise, prices have grown rapidly for some older drugs and biologics, even those with therapeutic alternatives, despite a lack of evidence of increased effectiveness.

Addressing high launch prices for drugs with limited clinical evidence by capping the payment of select Part B "accelerated approval" drugs and biologics

Drugs come to the market faster under the accelerated approval pathway than under traditional approval because the Food and Drug Administration (FDA) approves them based on intermediate clinical or surrogate endpoints that are *reasonably likely to predict* a clinical benefit, but before the clinical benefit has been verified. Consequently, some accelerated approval drugs are approved before evidence exists about their effect on the Medicare population, and some manufacturers establish high prices relative to their accelerated approval drug's expected clinical benefit. In addition, some manufacturers' postmarketing studies that are conducted to confirm an accelerated approval drug's clinical benefit are delayed.

The accelerated approval pathway is intended to expedite the approval of promising products. But tools are needed to ensure that Medicare is not overpaying for products approved on an accelerated basis if a product's clinical benefit is not confirmed. Also, manufacturers need an incentive to complete postmarketing confirmatory trials on a timely basis so that information about a product's effects on health outcomes are available as soon as possible.

The Commission recommends that the Congress require the Secretary of Health and Human Services to cap the Medicare payment rate of Part B drugs and biologics (with limited exceptions) that are approved under the accelerated approval program if:

- postmarketing confirmatory trials for the product are not completed within the deadline established by the manufacturer and the FDA,
- the product's clinical benefit is not confirmed in postmarketing confirmatory trials, or
- the product is covered under a "coverage with evidence development" policy.

In addition, the Congress should give the Secretary the authority to cap the Medicare payment rate of Part B drugs and biologics that are approved under the accelerated approval program if their price is excessive relative to the upper-bound estimates of value.

To implement this policy, the payment cap could be set based on a drug's net clinical benefit and cost compared with the standard of care. The policy could be operationalized using a rebate under which manufacturers pay Medicare back for the difference between the Medicare payment amount and the cap, with the beneficiary sharing in the rebate via a reduced cost-sharing percentage.

Spurring price competition by establishing a single payment based on average sales price for Part B drugs and biologics with similar health effects

The current average sales price (ASP) payment system maximizes price competition among generic drugs and their associated brand products by assigning these products to a single billing code. By contrast, products that are assigned to their own billing code and paid according to their ASP—single-source drugs, originator biologics, and biosimilars—do not face the same incentives for price competition.

To promote price competition, the Commission recommends that the Congress give the Secretary the

authority to establish a single ASP-based payment rate for groups of drugs and biologics with similar health effects. To implement this policy, the Secretary could develop reference groups of products that:

- have similar FDA-approved indications or off-label use;
- work in a similar way (e.g., same drug classification, mechanism of action); and
- are listed similarly by clinical guidelines (e.g., classification of products, recommended versus not recommended).

The Secretary could first focus on applying reference pricing to drug groups for which all of a given product's indications could be included in the group. The Secretary could begin with those reference groups for which implementation would be the most straightforward: (1) biosimilars and originator biologics, (2) 505(b)(2) drugs and related brand-name drugs and generics, and (3) drugs for which reference pricing has been implemented or considered previously. In most instances, the Secretary could set the reference price based on the volume-weighted ASP of drugs assigned to the reference group.

Improving financial incentives by modifying add-on payments for Part B drugs and biologics

Under Section 1847A of the Social Security Act, Medicare pays providers for most Part B drugs at a rate of the ASP plus 6 percent (ASP + 6 percent). In addition, Medicare makes a separate payment for drug administration services under the physician fee schedule or outpatient prospective payment system. Like all Medicare services, the Medicare program's payment for Part B drugs (but not beneficiary cost sharing) is subject to the 2 percent sequester through March 2032.

While clinical factors play a central role in prescribing decisions, at the margins, financial considerations can also figure into providers' choice of drugs. Medicare's percentage add-on to ASP may create incentives for use of higher-priced drugs since a percentage add-on generates more revenue for the provider when applied to a higher-priced product than a lower-priced product. The percentage add-on may also affect a provider's decision to initiate or continue drug treatment in some circumstances.

To improve financial incentives under the ASP payment system, the Commission recommends an approach that would minimize the relationship between price (ASP) and add-on payments by reducing add-on payments for costly drugs. The Commission developed a framework to illustrate how such an approach could be operationalized. In developing this approach, we sought to:

- reduce or eliminate the percentage add-on for moderate- and high-priced drugs to minimize the relationship between price (ASP) and add-on payments,
- retain a portion of the percentage add-on for all but the most expensive drugs to accommodate price variation or other factors that might lead to some purchasers acquiring drugs at a price greater than ASP, and
- avoid applying a flat fee for low-cost drugs, which would constitute a substantial increase in payment rates relative to the price of a drug and potentially create incentives for overuse.

Our illustrative approach would maintain the current ASP add-on for lower-priced drugs, reduce the percentage add-on and add a fixed fee for mid-priced drugs, and place a fixed dollar cap on the add-on for the highest-priced drugs. Overall, this approach would improve financial incentives by reducing the difference in add-on payments between differently priced drugs, with the largest reduction occurring among the highest-priced products.

In addition, the Commission recommends eliminating add-on payments for drugs lacking ASP data and paid based on wholesale acquisition cost (WAC). Because WAC is generally a higher price than ASP and does not reflect discounts, eliminating the WAC add-on would reduce excess payments and improve financial incentives.

Assessing postsale rebates for prescription drugs in Medicare Part D

In Chapter 2, using data newly available to the Commission as a result of the Consolidated Appropriations Act, 2021, the Commission discusses trends and issues associated with the rapid growth of negotiated rebates and fees received by Part D plan sponsors.

Insurers that offer plans (plan sponsors) and their pharmacy benefit managers (PBMs) negotiate with drug manufacturers and pharmacies for rebates and fees that take place after a prescription has been dispensed. Consequently, the final amounts that Part D plans pay for the prescriptions that their enrollees fill are often lower than prices at the pharmacy. Collectively, CMS refers to negotiated rebates and postsale fees as direct and indirect remuneration (DIR). Plan sponsors can use their portion of DIR to restrain growth in premiums or reduce cost sharing. Plan sponsors have long believed that Part D enrollees focus most on premiums when making their plan selection, and thus plan sponsors have strong incentives to use the DIR to keep premiums low. Because rebates and fees have become so large, the way in which sponsors apply DIR to constrain premiums or cost sharing has implications for the distribution of Part D costs among all enrollees, particularly those who use rebated drugs, and for the Medicare program at large.

DIR has grown rapidly: Between 2010 and 2021, it ballooned from $8.6 billion to $62.7 billion, expanding as a share of gross Part D spending from 11 percent to 29 percent. Most of that total has consistently been made up of manufacturer rebates, though the share declined as pharmacy DIR grew. In 2010, rebates accounted for 99 percent of DIR, but by 2021, rebates' share of total DIR declined to 80 percent. In 2021, the Medicare program kept about one-third of DIR to offset some of Part D's reinsurance subsidies.

Multiple factors have contributed to growth in manufacturer rebates.

- ***Therapeutic competition and Medicare formulary policies***. Manufacturers negotiate rebates with PBMs for brand-name products that have therapeutic competitors in exchange for putting their drug on a plan's formulary and placing it in a position that helps the drug maker win market share. For certain classes of drugs, regulatory hurdles and extensive patent protection have slowed generic entry. With a lack of generic competition but considerable rivalry among competing brands, manufacturers have chosen to raise gross prices and compete using postsale rebates. In contrast, for protected classes of drugs in which virtually all drugs must be covered, price competition is weakened, hindering plans' ability to negotiate rebates.
- ***Part D's benefit structure and emphasis on premium competition.*** Part D's unusual benefit design—with its coverage gap and provision of Medicare reinsurance in its catastrophic phase—has resulted in plan sponsors bearing relatively little insurance risk for their enrollees' drug spending. Trends in prescription use are also a contributing factor because high-cost biologics and specialty medications account for a mounting share of spending, and Medicare's payments to plans increasingly take the form of cost-based reinsurance. Because the program emphasizes premium competition, sponsors have had incentives to try to maximize rebates and keep premiums low. In some drug classes, sponsors can select high gross-price, high-rebate drugs for their formularies over lower gross-price alternatives. In addition, many entities in the drug supply chain benefit from high gross prices because compensation for their services is often paid as a percentage of price.
- ***Vertical integration of plan sponsors, PBMs, and pharmacies.*** Since the start of Part D in 2006, plan sponsors and their PBMs have consolidated. Vertically integrated insurers with their own PBMs and specialty pharmacies now control a larger proportion of covered lives and the dispensing of higher-priced drug products. Larger market shares of enrollment and dispensing tend to provide sponsors with greater bargaining leverage for postsale price concessions from both manufacturers and pharmacies.

While large rebates help constrain premium increases, using rebates primarily to lower premiums also means that beneficiaries who use such drugs or Medicare (in the case of Part D's low-income subsidy (LIS) enrollees) sometimes pay cost sharing that is higher than the drug's cost. In recent years, for about 8 percent of gross spending aggregated across all phases of the Part D benefit, the cost-sharing amounts set by plan sponsors exceeded net drug costs after deducting rebates, meaning that the beneficiary or Medicare (on behalf of LIS beneficiaries) paid more than the total cost of the drug. For enrollees without the LIS, high cost sharing can affect whether they fill their prescriptions.

Our analysis focused on a range of drug classes and products for prescriptions filled between 2015 and 2021. While rebates vary considerably across drug

classes and over time, we observed large rebates in classes that had strong brand rivalries but lacked generic or biosimilar entry. In contrast, for protected classes of drugs in which virtually all drugs must be covered, price competition was weakened, hindering plans' ability to negotiate rebates and allowing gross and net prices of single-source drugs in many protected classes to grow faster than for drugs in other classes.

We found that rebates can vary widely for the same product among plans operated by the same sponsor and that rebates obtained by large, vertically integrated plan sponsors increased over time and were larger than those received by other plan sponsors.

Vertical integration may pose a particular challenge for Part D as the market becomes increasingly concentrated among the largest sponsors that own (or are owned by) a PBM and pharmacies. For a limited number of drug categories, we found that payments and costs (after manufacturer rebates) were more likely to be higher at vertically integrated (VI) pharmacies compared with costs at other pharmacies, particularly when those prescriptions were filled for their own VI plans. Because Part D's DIR reporting requirements do not include discounts or fees retained by pharmacies that are paid by manufacturers, CMS may lack information about the true benefit costs of plans operated by plan sponsors that are vertically integrated with a PBM and pharmacies.

The Inflation Reduction Act of 2022 includes numerous policies related to prescription drugs and the Part D benefit. As that law is implemented over the next several years, its changes to policy are likely to alter the drug-pricing landscape and affect the degree to which plan sponsors and manufacturers continue to use rebates. The Commission's analyses of DIR data will serve as a baseline for future evaluations of how rebates are used in the Part D program.

Standardized benefits in Medicare Advantage plans

In Chapter 3, the Commission discusses the challenges that beneficiaries face in comparing Medicare Advantage (MA) plan benefits and selecting the plan with benefits that best meet their needs. The chapter outlines an approach for standardizing MA benefits.

This year, Medicare beneficiaries have an average of 41 MA plans (offered by an average of 8 insurers) available in their area. The average number of available plans has more than doubled in the last five years. Plan benefits vary, and research has found that beneficiaries have difficulty comparing plans and deciding which one best meets their needs when they have many choices.

One way for beneficiaries to compare plans more easily would be to require plans to have standardized benefits. This approach is used in both the Medigap market and the health insurance exchanges created by the Affordable Care Act of 2010. We use the term *standardization* to refer to both (1) the set of services covered by the plan and (2) the cost sharing that the plan's enrollees pay for those services. For Part A and Part B services, efforts to standardize benefits would be limited to changing enrollee cost sharing since all plans cover the same required set of services. For supplemental benefits, efforts to standardize benefits would be more complicated because they would raise questions about what services plans should cover and how those services should be defined, in addition to changes in enrollee cost sharing.

The use of standardized benefits in MA would require policymakers to consider a number of complex issues, such as the number and design of any standardized plan benefits and whether insurers could still offer plans that are not standardized. One option would be to develop a limited number of plan benefits for Part A and Part B cost sharing and require insurers to use them in their plans. These packages would specify the plan's annual limit on enrollee out-of-pocket costs and the cost-sharing amounts for all major services.

Standardizing supplemental benefits could make these benefits more transparent and help ensure that plans provide sufficient value to MA enrollees and taxpayers, but policymakers would need to balance the goals of simplifying beneficiaries' plan comparisons and letting plans design their own benefits. One way to realize some of the gains from standardized benefits while giving plans flexibility would be to standardize a limited number of common supplemental benefits, such as dental, hearing, and vision benefits. For example, policymakers could specify the coverage limits, cost-sharing rules, and per enrollee spending limits for those benefits. These requirements would apply only to plans that choose to provide dental, hearing, and vision

benefits. The rules that govern all other supplemental benefits would remain the same.

Using the approach outlined in this chapter, beneficiaries who compare MA plans would be able to understand with relative ease what each plan charges for Part A and Part B services and the major supplemental benefits it provides. Selecting a plan would still involve other important factors—such as the plan's premium, the drugs on its formulary, and its provider network—but these changes would make the process simpler and easier to navigate. In addition, by requiring MA plans to submit encounter data for supplemental benefits, policymakers and researchers can better understand the impact of supplemental benefits on MA enrollees.

Favorable selection and future directions for Medicare Advantage payment policy

In Chapter 4, the Commission discusses the effects of favorable selection on payments to MA plans and alternative approaches to setting MA benchmarks that would be less reliant on FFS spending than the current system is.

Medicare pays MA plans a capitated rate that is the product of a base payment rate and a risk score. A plan's base rate is determined by its bid and a county benchmark. The bid is intended to represent the dollar amount that the plan estimates it will need to cover the Part A and Part B benefit package for a beneficiary of average health status; the benchmark is the maximum amount Medicare will pay for an MA plan to provide Part A and Part B benefits and is set for each county based on Medicare spending for the county's beneficiaries enrolled in Medicare's traditional FFS program, standardized to represent a beneficiary with average health status.

Risk scores increase payment for plan enrollees whose expected health care costs are higher than the costs for the FFS beneficiary of average health status, and the risk scores decrease payment for enrollees whose expected costs are lower. The accuracy of Medicare's payments to MA plans depends in large part on how well the risk-adjustment model (i.e., risk scores) predicts the expected costs for the plans' enrollees. The purpose of risk adjustment is not to accurately predict costs for a particular person, but rather to accurately predict the average costs for a group of people with similar attributes.

Medicare's payments for MA plans assume that after risk adjustment, average spending for MA enrollees is equal to average spending for FFS beneficiaries. However, MA enrollees' risk scores consistently overpredict MA enrollees' actual spending in part because of favorable selection of beneficiaries who choose to enroll in an MA plan rather than FFS Medicare. Favorable selection into MA causes payments to plans to be systematically greater than plans' spending for their enrollees. Consistent with other research, the Commission estimates that, prior to the effects of any utilization management from MA plans, MA enrollees' spending in 2019 was about 11 percent lower than the spending of FFS beneficiaries with the same risk scores. The benefits of favorable selection for MA plans are separate from the effects of MA plans' higher diagnostic coding intensity relative to coding in FFS (which we estimated in our March 2023 report to the Congress resulted in overpayments to MA plans of about 6 percent). Further, the effects of the two phenomena are additive.

Estimates of FFS spending form the basis for MA benchmarks, but these estimates do not align well with MA plans' (lower) costs of providing the Medicare benefit package. In a county with a benchmark set at 100 percent of FFS spending, for instance, the costs of providing Medicare services to the average MA enrollee equal an estimated 89 percent of FFS spending due to the effects of favorable selection alone. (The effects of MA plan benefit design, cost containment efforts, and diagnostic coding could push that percentage down even further.) Favorable selection thus results in overpayments to MA plans, which are made at the expense of taxpayers and beneficiaries (through higher Part B premiums). In addition, favorable selection distorts efforts to assess how efficient MA plans are relative to FFS.

These findings raise major concerns about the appropriateness of continuing to base MA benchmarks exclusively on Medicare FFS spending data. Those concerns are heightened as more beneficiaries enroll in MA and the share of Medicare beneficiaries enrolled in FFS declines. If the number of FFS beneficiaries in a county becomes too small, Medicare's estimates of FFS spending for the county could become unstable, as

small changes in enrollment or health service delivery can cause large shifts in average spending. Further, certain population characteristics—such as whether a beneficiary is eligible for Medicaid or qualified for Medicare due to disability—become skewed if those characteristics are associated with a preference for MA or FFS Medicare coverage.

Policymakers could set MA benchmarks using an approach that relies less on FFS spending. Policymakers could use a competitive bidding system that relies entirely on MA bids to determine benchmarks; they could base benchmarks on both FFS and MA Medicare spending instead of just FFS spending; or they could set benchmarks at a point in time and update them using administratively set rates. Any of these approaches would help address the problems associated with a declining FFS population, but the extent to which they would address the favorable selection of enrollees in MA would vary.

Disparities in outcomes for Medicare beneficiaries with different social risks

In Chapter 5, the Commission presents an analysis of outcome measures for Medicare beneficiaries stratified by race/ethnicity and low-income status and discusses approaches to account for differences in patients' social risk factors and to encourage providers to focus on reducing health disparities.

Social risk factors such as income, housing, social support, transportation, nutrition, and race/ethnicity can influence health outcomes. These factors stem from social determinants of health (SDOH), which are the conditions in which people are born, live, learn, work, play, worship, and age, conditions that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Addressing SDOH aims to reduce health disparities—that is, differences among populations in the burden of disease or in opportunities to achieve optimal health—and achieve health equity across patient populations. Widespread recognition of health disparities has prompted many policymakers and health care organizations to prioritize health equity as a key component of health care quality improvement.

To better understand steps that health care providers, payers, and other organizations have taken to address SDOH, the Commission contracted with L&M Policy Research in the summer and fall of 2021 to review the literature and conduct stakeholder interviews. Five broad themes emerged from this work. First, many approaches and specific interventions have been used to try to address SDOH. Second, SDOH initiatives are usually aimed at populations that include but are not exclusive to Medicare beneficiaries. Third, participation in value-based payment arrangements, such as accountable care organizations, may help motivate efforts to address SDOH. Fourth, most health care organizations are not operating SDOH initiatives by themselves; they usually collaborate with community-based organizations such as food banks or public housing agencies. And finally, though many organizations are working to address SDOH, objective evaluations of the effectiveness of these efforts are limited, and their findings are often mixed.

Recognizing that health outcomes can be influenced by patients' social risk factors, we report findings from an examination of ambulatory care–sensitive hospitalizations and emergency department visits for FFS beneficiaries stratified by race/ethnicity and low-income status in 2019. We also analyzed hospital readmission rates by race/ethnicity and low-income status for beneficiaries who had had a recent hospital stay. For those who had used skilled nursing facilities (SNFs) and home health agencies (HHAs), we examined rates of successful discharge to the community.

We found that both race/ethnicity and low income contributed to differential outcomes. Beneficiaries with low incomes were more likely to have worse outcomes. At the same time, beneficiaries who were Black or Hispanic were more likely to have worse outcomes, while Asian/Pacific Islander and non-Hispanic White beneficiaries were more likely to have better outcomes. Worse outcomes for low-income beneficiaries were seen across race/ethnicity categories for all the measures examined. However, even within income categories, differences across race/ethnicity groups persisted.

In addition to accounting for patient social risk in quality payment programs and supporting safety-net providers, the Commission also generally supports two policies to encourage providers to focus on reducing health disparities: (1) public reporting of quality results stratified by social risk factors and (2) adding a focus on reducing disparities in quality payment programs.

Congressional request: Behavioral health services in the Medicare program

In Chapter 6, in response to a 2022 congressional request, the Commission presents an analysis of behavioral health services in the Medicare program. This chapter explores two main topics: (1) utilization and spending by FFS beneficiaries for clinician and outpatient behavioral health services and (2) trends and issues in inpatient psychiatric facility (IPF) care for beneficiaries. Where possible, utilization by MA enrollees is examined.

Clinician and outpatient behavioral health services

Clinician and outpatient provision of behavioral health services such as psychiatric evaluations, psychotherapy, opioid treatment programs, and behavioral health integration are covered by Medicare Part B for FFS beneficiaries. In 2021, spending for these behavioral health services and conditions was $4.8 billion. In that year, 4.9 million FFS Medicare beneficiaries (16 percent) received these services. Beneficiaries who used Part B behavioral health services were more likely to be disabled, low income, and younger than other FFS Medicare beneficiaries. They also incurred nearly twice as much spending on overall health care (including Part D prescription medications) as all FFS beneficiaries. In 2021, the top three behavioral health conditions were depression, anxiety, and substance use disorders. Between 2019 and 2021, opioid use disorders among FFS Medicare beneficiaries increased annually by 7 percent. In 2020, Medicare began an opioid treatment program benefit, which was used by nearly 40,000 FFS beneficiaries in 2021.

In 2022, behavioral health clinicians accounted for 40 percent of clinicians who opted out of Medicare. Among psychiatrists, the opt-out rate is 7.2 percent, which is the highest across physician specialties. We found large shifts in the behavioral health workforce over time: Between 2016 and 2021, substantial growth in behavioral health services provided by nurse practitioners occurred, while volume by psychiatrists declined. The pandemic exacerbated shortages of behavioral health clinicians, but the rapid take-up of telehealth has helped to meet current needs. Telehealth for behavioral health services continued to grow in 2021, even as use of other telehealth services declined from their high in 2020. Notably, some behavioral health clinicians provided only telehealth in 2021 (i.e., provided no in-person health services in that year)—a trend that should continue to be monitored.

Inpatient psychiatric facility care

Medicare beneficiaries experiencing an acute behavioral health crisis can be treated in specialty IPFs that provide 24-hour care in a structured, intensive, and secure setting. In 2021, 157,500 FFS beneficiaries had 230,500 stays at one of 1,480 hospital-based or freestanding IPFs and incurred $3.0 billion in IPF spending. Compared with the rest of the FFS Medicare population, Medicare beneficiaries using IPF services are much more likely to be disabled and have low incomes, have more chronic conditions, and consume more health care services. In 2021, Medicare Part A and Part B spending per beneficiary for those with an IPF stay was nearly four times higher than for all FFS beneficiaries. Medicare Part D prescription drug spending for beneficiaries who had an IPF stay was nearly twice as much as that of other FFS beneficiaries. As of January 2023, nearly 50,000 Medicare beneficiaries had reached or were within 15 days of reaching the 190-day lifetime limit on freestanding IPF days. These beneficiaries were more likely to be disabled, younger, low income, and Black compared with other beneficiaries who had an IPF stay in 2021.

Using data from 2018, we found a high rate of emergency department visits and acute care hospital admissions before and after an IPF admission. We also found a relatively low rate of visits with behavioral health clinicians, suggesting that many of these beneficiaries were not receiving effective, well-coordinated outpatient behavioral health care.

Our indicators of Medicare payment adequacy for IPFs revealed some concerning trends and identified gaps where additional information is needed to assess the accuracy of payments and the quality of IPF care.

Beneficiaries' access to IPF care—While the number of IPFs has declined since 2017, the number of psychiatric beds has grown, fueled by growth in the number of beds at for-profit IPFs. In 2021, aggregate occupancy rates decreased to 70 percent (from 76 percent in 2017), suggesting IPF availability. However, IPF interviewees agreed that labor shortages limited the number of staffed beds available. Moreover, higher occupancy rates at government IPFs—which frequently function

as providers of last resort—also indicate insufficient supply for persistently mentally ill beneficiaries. Overall Medicare FFS volume at IPFs has been declining for several years. The decline in utilization between 2019 and 2021 was particularly steep, likely related to avoidance or deferral of inpatient stays in response to spread of COVID-19 and to IPFs' limited treatment capacity due to staffing shortages.

Quality of IPF care—Data on the quality of care provided by IPFs are currently too limited to meaningfully assess and compare quality across facilities.

IPFs' access to capital—Access to capital appears to be strong among IPFs. Almost two-thirds of IPF providers are hospital-based units that would access any necessary capital through their parent institutions. Overall, acute care hospitals maintained strong access to capital in 2021. Freestanding IPFs also had access to capital.

Medicare payments and IPFs' costs—In 2021, the overall aggregate margin for IPFs was -9.4 percent, though margins varied substantially across IPFs. The variation tracked with differences in costs by IPF type, with freestanding for-profit IPFs having lower costs (and higher margins (15.0 percent)) and hospital-based IPFs having higher costs (and lower margins (-28.3 percent)). Differences in scale likely account for this pattern (for-profit IPFs tend to be larger). It is not clear whether differences in the mix of patients served or the quality of care provided also plays a role. To properly assess whether the IPF payment system is accurately capturing costs and classifying patients, policymakers need more information on patient severity and resource use, including use of ancillary services.

Mandated report: Telehealth in Medicare

In Chapter 7, the Commission presents an evaluation of the utilization of telehealth services during the public health emergency (PHE) and the relationship between expanded telehealth coverage and quality, access, and costs, as mandated by the Consolidated Appropriations Act, 2022.

Telehealth includes health care services delivered through a range of online, video, telephone, and other communication methods. Medicare has historically been cautious about covering telehealth services broadly because of uncertainties about the impact of telehealth on quality and spending. However, Medicare temporarily expanded coverage of telehealth to allow beneficiaries to maintain access to care and to help limit community spread of COVID-19 during the PHE, which ended on May 11, 2023. The Congress has extended many of Medicare's telehealth expansions through December 31, 2024.

Alternative approaches to paying for telehealth services—Before the PHE, Medicare coverage of telehealth services was limited by statute under the physician fee schedule (PFS). Medicare covered a limited set of telehealth services, modalities, and providers, and only in rural locations (with certain exceptions). For most telehealth services, Medicare required the patient to be located at an "originating site"—specified types of health care providers—in a rural area and required the clinician to be located at a "distant site" without any geographic limitations. During the PHE, Medicare coverage of telehealth was expanded to include additional allowable telehealth services and providers, and originating site and geographic restrictions were lifted.

Medicare pays the clinician at the distant site a PFS payment based on the type of service provided (e.g., an evaluation and management (E&M) office/outpatient visit). Whether provided in person or by telehealth, many PFS services have two payment rates depending on whether they are provided in a facility setting (e.g., a hospital or a skilled nursing facility, which also receives a separate payment for the accompanying non-clinician services) or a nonfacility setting (e.g., a freestanding clinician's office). Before the PHE, CMS paid clinicians performing a telehealth visit the PFS's lower, facility-based payment rate instead of the higher, nonfacility rate regardless of where the clinician was located. However, during the PHE, CMS paid the same rate it would pay if the telehealth service had been provided in person (the PFS's facility rate or nonfacility rate, depending on the clinician's location). CMS has said that the agency will continue this policy through the end of 2023.

As described in our March 2021 report to the Congress, the Commission asserts that CMS should resume paying the lower, facility rate for telehealth services as soon as practicable after the PHE. CMS should also collect data from practices on the costs they incur to

provide telehealth services and adjust future payment rates, if warranted, based on the information gathered.

During the PHE (and continuing until the end of 2024), the Congress has permitted federally qualified health centers (FQHCs) and rural health clinics (RHCs) to bill for telehealth services as the distant site. Clinicians can furnish distant-site telehealth services from any location, including their home, while they are working for an FQHC or RHC. Although Medicare pays higher rates for in-person clinician services provided in FHQCs and RHCs than for comparable services provided under the PFS, during the PHE the Medicare payment rate for FQHC and RHC telehealth services is based on PFS rates for comparable telehealth services, essentially establishing payment parity for telehealth services billed under the two payment systems. If policymakers decide to permanently cover distant-site telehealth services delivered by FQHCs and RHCs, the Commission supports continued payment parity with the lower PFS rates.

Spending and use of telehealth services in Medicare— FFS Medicare spending for telehealth services was very low in 2019 ($130 million) but rose dramatically during the early months of the PHE, peaking at $1.9 billion in the second quarter of 2020, as providers and beneficiaries shifted rapidly from in-person visits to telehealth. Telehealth spending declined in the latter half of 2020 and in 2021, falling to $827 million in the fourth quarter of 2021. In total, Medicare telehealth spending was $4.8 billion in 2020 and $4.1 billion in 2021, more than 30 times greater than spending in 2019. Similarly, between 2019 and 2020, the number of FFS beneficiaries who received at least one telehealth service paid under the PFS accelerated rapidly from 239,000 to 14.2 million (40 percent of Part B FFS beneficiaries), then declined in 2021 to 9.7 million (29 percent of Part B FFS beneficiaries).

In 2020 and 2021, evaluation and management (E&M) services accounted for almost all (98 percent) of PFS telehealth spending. Within the category of E&M services, office/outpatient visits (as opposed to other types of E&M services) accounted for 73 percent of spending for telehealth in 2020, declining to 68 percent of spending in 2021. Between 2020 and 2021, behavioral health services (e.g., psychiatric evaluation) rose from 17 percent of telehealth spending for all E&M services to 23 percent, highlighting the growing significance of telehealth use for behavioral health services.

Beneficiary and clinician experiences with telehealth— In focus groups that we conducted in the summer of 2022, many beneficiaries reported having telehealth visits predominantly with clinicians with whom they had an existing relationship. They were generally satisfied with these visits. Consistent with our analysis of Medicare claims, clinicians in our focus groups reported some continued use of telehealth after initial rapid expansion early in the pandemic. Some clinicians appreciated the convenience and flexibility it allowed in terms of the visit location, while others preferred in-person visits due to perceived better quality of care, or preferred to provide specific services better suited to in-person care. Clinicians reported that telehealth visits generally took less time and cost less. Beneficiaries and clinicians reported continued use of audio-only visits. Many beneficiaries and clinicians in our focus groups reported that they would like to continue the option of telehealth visits after the PHE ends. In the Commission's annual survey of Medicare beneficiaries, 40 percent of telehealth users said they were interested in continuing to use telehealth after the pandemic ends.

Telehealth and program integrity—The Consolidated Appropriations Act, 2023, requires the Secretary to conduct a study using medical records to review program integrity related to telehealth services. Our findings support the need for medical records review and other program integrity activities to ensure that clinicians are accurately billing for telehealth services. If time clinicians spend with patients is typically shorter during telehealth services than in-person visits, a smaller share of telehealth visits should be coded at higher levels (more time spent) than in-person visits. Another area that could be analyzed in the future is the use of audio-only services since, in 2023, clinicians are required to indicate audio-only services on Medicare claims.

Relationship between expanded telehealth coverage and quality, access, and costs during the PHE—We reviewed and summarized the literature on telehealth and quality that was published during the PHE. We found that the body of literature grew during the PHE, but it is still small, and many of the studies have methodological and data issues.

Our ability to assess the impact of telehealth on quality, access, and costs is limited because of the time lag

in claims data. The FFS claims data available at the time of our analysis were from 2021, which overlaps with surges in COVID-19 cases that likely influenced the use of telehealth and patient outcomes, making it impossible to disentangle the effects of telehealth from the pandemic itself. Acknowledging these limitations, we conducted a difference-in-differences analysis using Medicare FFS administrative data to compare population-based outcomes across hospital service areas with different levels of telehealth service use. Our findings suggest that during the pandemic, greater telehealth use was assocated with little change in measured quality, slightly improved access to care for some beneficiaries, and slightly increased costs to the Medicare program. Because our results were confounded by surges in COVID-19 cases, further research should be done using more recent data as they become available. As we stated in our March 2021 report to the Congress, policymakers should continue to monitor the impact of telehealth on access, quality, and cost and should use this evidence to inform any additional permanent changes to policy.

Aligning FFS payment rates across ambulatory settings

In Chapter 8, the Commission presents an analysis of an approach to more closely align the payment rates across ambulatory settings—hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding physician offices—for selected services.

Medicare FFS payment rates often differ for the same service across ambulatory settings. These payment differences encourage arrangements among providers, such as consolidation of physician practices with hospitals. These arrangements result in care being provided in settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without significant improvements in patient outcomes.

Adjusting rates paid for certain services delivered in higher-cost settings to more closely align with the rates paid in lower-cost settings in which it is safe and appropriate to provide the service would reduce incentives to shift the billing of Medicare services from low-cost settings to high-cost settings. The result would be lower Medicare program spending, lower beneficiary cost sharing, and an incentive for providers to improve efficiency by caring for patients in the lowest-cost site that is appropriate for their condition.

To identify the services for which it is potentially appropriate to align payment rates across the ambulatory settings, we modeled an approach based on the volume for each service in each setting. If freestanding offices had the highest volume for a service, it would arguably be safe to provide that service in freestanding offices for most beneficiaries. Therefore, our model aligns the payment rates in the outpatient prospective payment system (OPPS) (the payment system for most services provided in HOPDs) and the ASC payment system with the payment rates from the PFS. If ASCs had the highest volume for a service, we aligned the OPPS payment rate with the ASC payment rate and left the PFS payment rate unchanged. If HOPDs had the highest volume for a service, we determined that it likely was not safe to provide that service outside the HOPD setting for a majority of beneficiaries. Moreover, for these services, aligning OPPS payment rates with those from a lower cost setting could adversely affect beneficiaries' access to those services. Hence, for these services, the payment rates in each setting were left unchanged.

Because of the recent growth in hospital acquisition of physician practices and our own empirical analysis, the Commission recommends that the Congress more closely align payment rates across ambulatory settings for selected services that are safe and appropriate to provide in all settings and when doing so does not pose a risk to access. In the context of the OPPS's current-law budget-neutrality requirement, this recommendation would have no immediate effect on total Medicare revenue for OPPS hospitals in aggregate. Over time, however, this recommendation could indirectly affect program spending because it would reduce incentives for hospitals to acquire physician practices and bill for services under the usually higher-paying OPPS. This recommendation would have differing effects across hospitals, as some would see Medicare revenue gains while others would experience revenue losses. Despite the potential losses for some hospitals, this recommendation would not be expected to affect providers' willingness or ability to furnish the affected services. Any concerns about specific hospital categories being adversely affected should be addressed through targeted assistance to those hospitals rather than maintaining higher payment rates for site-neutral services for all hospitals.

Reforming Medicare's wage index systems

In Chapter 9, the Commission discusses a wage index approach that would result in more accurate and equitable payments across providers. Medicare's prospective payment systems (PPSs) use wage indexes to adjust Medicare base payment rates for geographic differences in labor costs. For the inpatient prospective payment systems (IPPS), the Congress initially specified that the wage index should reflect the labor costs of hospitals in a geographic area relative to the national average hospital level. For other PPSs (such as the PPS for SNFs), the Congress granted CMS the authority to determine how to adjust Medicare PPS base rates for geographic differences in labor costs, and CMS has chosen to use a version of the IPPS hospital wage index. However, because of the limited data sources, the use of broad labor market areas, and the number of wage index exceptions that the Congress and CMS have added over time to the IPPS wage index, Medicare's wage indexes are inaccurate and inequitable. In 2022, about two-thirds of IPPS hospitals' wage index values were affected by exceptions, and, because most of the exceptions are budget neutral, payments to all hospitals—including those not benefiting from any exceptions—were reduced by 2.2 percent to compensate.

To accurately reflect geographic differences in labor costs among IPPS hospitals and other types of providers and to be more equitable across providers, the Commission recommends that Medicare's wage index systems:

- use all-payer, occupation-level wage data with different occupation weights for the wage index of each type of provider;
- reflect local differences in wages between and within metropolitan statistical areas and statewide rural areas;
- cap wage index differences across adjacent local areas; and
- have no exceptions.

This wage index approach would be applied to all PPSs, including those for IPPS hospitals and for post-acute care (PAC) providers such as SNFs. To illustrate how this approach would improve the accuracy and equity of Medicare payments, we developed illustrative IPPS and SNF PPS wage indexes. Using data from all employers in a labor market area instead of just IPPS hospitals would establish a more robust basis for Medicare's wage indexes and mitigate circularity issues that result in current wage indexes reflecting hospitals' historical advantages and disadvantages, such as relative market power. Incorporating local (e.g., county) wage data would allow the wage indexes to recognize differences in labor costs within a broader labor market area, and it allows for a smoother and more equitable distribution of wage index values across adjacent local areas. Furthermore, eliminating all wage index exceptions would remove hospitals' opportunities for wage index manipulation.

Because of the large inaccuracies in the current wage index systems, implementing the Commission's recommended changes would have a material effect on many providers. For example, based on our illustrative models, we estimate that, once the changes were fully phased in, IPPS payments would fall by more than 5 percent for about 10 percent of hospitals and rise by more than 5 percent for 18 percent of hospitals. Therefore, implementation of these changes would need to be phased in over multiple years or managed through a stop-loss policy. Once fully implemented, a wage index system such as the one we modeled would result in more equitable payments across regions and across types of providers. To the extent that policymakers are concerned about certain providers—in particular, those that are important for access and are vulnerable to closure—any additional support should be targeted specifically to those providers to achieve defined and relevant policy goals and not made inefficiently through unrelated policies such as the wage index.

Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system

In Chapter 10, as mandated by the IMPACT Act of 2014, the Commission presents an evaluation of a prototype design of a uniform PPS for PAC providers (SNFs, HHAs, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs)).

Our previous work on this topic confirmed that a PAC PPS was feasible and identified the basic design features that would help keep payments under a PAC PPS aligned with the cost of care. These features

include the PAC stay—not an episode of PAC—as the unit of service, a common risk adjustment across provider types, and short-stay and high-cost outlier policies. In addition, because HHAs have considerably lower costs than institutional PAC providers, an adjuster for home health stays would be needed to guard against overpayments for HHA stays and underpayments for institutional PAC stays. Our analyses indicate that there would be no need for a payment adjustment based on the rural location of the provider, nor would adjustments be needed for beneficiaries who had a preceding hospital stay or for beneficiaries with low incomes. A PAC PPS would likely need to include some measure of functional status as a risk adjuster. We note, however, that providers have an incentive to record functional status information in ways that raise payments rather than capture patients' actual clinical care needs. Therefore, CMS would need to pursue strategies to address the inevitable bias in the recording of this information. CMS would also need to make regular across-the-board adjustments to payments to address the effects of upcoding, as CMS does for hospital and MA payments.

While CMS's work on a unified PAC PPS is consistent with the Commission's proposals, CMS's prototype PPS includes adjusters that account for cost differences across the four settings. Though an adjuster for HHA stays would be needed to account for their very low costs, including other setting adjusters would incorporate into the PAC PPS potentially unwarranted existing cost differences among the PAC settings. Including other setting adjusters would therefore undermine the goal of payment alignment across settings for clinically similar cases. That said, including setting adjusters in an initial design may be a reasonable transition policy to give providers time to adjust to a unified PPS.

The impacts of a PAC PPS on providers' payments would depend on the details of the design but would likely redistribute payments across providers. Given the wide variation in estimated impacts and the expected pattern of changes in payments, a transition to the payment system would give providers time to adjust their costs to anticipated changes in their payments and regulatory requirements but would be costly for CMS to administer. And while not the purpose of a PAC PPS, policymakers should consider lowering the level of aggregate payments to align them with the cost of care, consistent with standing Commission recommendations to lower the base payment rates for HHAs, SNFs, and IRFs.

While designing a payment system is relatively straightforward, developing and implementing the companion policies that would need to accompany a PAC PPS would not be. Medicare's benefit and coverage rules and cost-sharing requirements would need to be aligned across settings so that beneficiaries do not make treatment decisions based on financial considerations. Conditions (or requirements) of participation for providers would also need to be aligned so that providers face the same costs associated with meeting them. (Given the noninstitutional nature of home health care, HHAs would likely need somewhat different regulatory requirements.) A new PAC value incentive program also would be necessary to help counter the incentives inherent in any PPS for providers to stint on needed care or generate unnecessary volume. Developing these companion policies could take many years; implementing them would be complex and possibly controversial.

The changes CMS has implemented to the SNF, HHA, and LTCH PPSs in recent years have helped reduce the incentives these providers had to furnish low-value care (including unnecessary rehabilitation therapy and paying LTCH rates to cases that do not require that level of service). Given the considerable resources that would be required to develop and implement a PAC PPS, policymakers may wish to look for opportunities to adopt smaller-scale site-neutral policies that could address some of the overlap of similar patients in different settings. ■