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

Washington, DC, June 15, 2023—Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2023 *Report to the Congress: Medicare and the Health Care Delivery System*. Each June, as part of its mandate from the Congress, MedPAC reports on issues affecting the Medicare program as well as broader changes in health care delivery and the market for health care services. This year's report includes 10 chapters:

| Addressing high prices of drugs and biologics covered under Medicare Part B. Medicare Part B covers drugs administered by infusion or injection in physician offices and hospital outpatient departments. From 2009 to 2021, Medicare Part B drug spending grew 9 percent per year on average. Medicare pays for Part B drugs based on a drug's average sales price, which is determined by the manufacturer's pricing decisions. The largest factor driving Part B drug spending growth has been the increase in the average price Medicare pays per drug. The Commission recommends three policies designed to improve Medicare's Part B drug payment system and reduce spending growth for Part B drugs. First, to address high launch prices for drugs and biologics with limited clinical evidence approved by the Food and Drug Administration under the accelerated approval pathway, the Commission recommends requiring the Secretary of Health and Human Services (HHS) to cap the Medicare payment rate for these drugs in certain circumstances. The Commission also recommends that the Secretary be given the authority to cap Medicare payment for such drugs if their price is excessive relative to the upper-bound estimate of their value. Second, to promote price competition, the Commission recommends that Medicare be given the authority to use reference pricing to set a single ASP-based payment rate for groups of drugs and biologics with similar health effects. To improve financial incentives, our third recommendation reduces add-on payments for costly Part B drugs paid based on average sales price while eliminating add-on payments for drugs paid using wholesale acquisition cost.

| Assessing postsale rebates for prescription drugs in Medicare Part D. Insurers that offer Part D 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. CMS refers to these negotiated rebates and postsale fees as direct and indirect remuneration (DIR). DIR has grown rapidly since 2010, increasing from \$8.6 billion to \$62.7 billion in 2021 and expanding as a share of gross Part D spending from 11 percent to 29 percent. This chapter discusses trends and issues associated with the rapid growth in manufacturer rebates received by Part D plan sponsors, which, in 2021, accounted for 80 percent of total DIR. Rebates can have a beneficial effect in keeping premiums low, but can have adverse financial effects on beneficiaries who use rebated drugs. Average beneficiary cost-sharing amounts exceeded average drug costs net of rebates for a subset of drugs representing about 8 percent of gross Part D spending. Drug classes that had strong brand rivalries but lacked generic or biosimilar entry have the largest rebates.

However, rebates can vary widely for the same product among plans operated by the same sponsor. Vertically integrated insurers with their own PBMs and specialty and mail-order pharmacies now control a larger share of the Part D market, providing them with greater bargaining leverage for postsale price concessions from both manufacturers and pharmacies.

| Standardized benefits in Medicare Advantage plans. Enrollment in the Medicare Advantage (MA) program has grown steadily for years, and this year, a majority of beneficiaries with Part A and Part B coverage are enrolled in MA plans. In 2023, Medicare beneficiaries have a choice of an average of 41 MA plans (offered by an average of 8 insurers) available in their area. 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. In this chapter, the Commission discusses the challenges that beneficiaries face and outlines an approach for standardizing MA benefits. For Part A and Part B services, efforts to standardize benefits could be limited to changing enrollee cost sharing since all plans cover the same required set of services. For supplemental benefits, standardizing benefits would be more complicated because it could involve prescribing what services plans should cover and how those services should be defined, in addition to changes in enrollee cost sharing. 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.

| Favorable selection and future directions for Medicare Advantage payment policy. Medicare pays MA plans a capitated rate that is the product of a base payment rate and a risk score. The accuracy of Medicare's payments to MA plans depends in large part on how well the risk-adjustment model predicts the expected costs for plan enrollees. In this chapter, we present analysis that indicates that MA enrollees' risk scores consistently overpredict MA enrollees' spending in part because of favorable selection of beneficiaries who choose to enroll in MA plans. We estimate 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 fee-for-service (FFS) beneficiaries with the same risk scores. These findings raise major concerns about the appropriateness of continuing to base MA benchmarks exclusively on Medicare FFS spending data. Options that policymakers could pursue so that MA benchmarks are less reliant on FFS spending include a competitive bidding system that relies entirely on MA bids to determine benchmarks, basing benchmarks on both FFS and MA spending instead of just FFS spending, and establishing benchmarks at a point in time and updating them using an administratively set growth rate.

| Disparities in outcomes for Medicare beneficiaries with different social risks. Social determinants of health (SDOH) affect a wide range of health, functioning, and quality-of-life outcomes and risks. Addressing SDOH aims to reduce health disparities and achieve health equity across patient populations. This chapter presents findings from a review of the literature, stakeholder interviews, and an analysis of outcome measures for Medicare beneficiaries stratified by race/ethnicity and low-income status. We found that beneficiaries with low incomes or who were Black or Hispanic were more likely to have worse 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. This chapter also discusses the Commission's support for accounting for patient social risk in quality payment programs, supporting safety-net providers, public reporting of provider quality results stratified by social risk factors, and adding a focus on reducing disparities in quality payment programs.

| Congressional request: Behavioral health services in the Medicare program. The Chair of the U.S. House of Representatives Committee on Ways and Means in January of 2022 asked the Commission to analyze Medicare beneficiaries' access to and use of behavioral health care services. In this chapter, we describe use and spending by Medicare's FFS beneficiary population for clinician and outpatient behavioral health services and trends and issues in inpatient psychiatric care for Medicare beneficiaries. Beneficiaries who used Part B behavioral health services are 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 as all FFS beneficiaries. Applying the Commission's indicators of payment adequacy for inpatient psychiatric facilities (IPFs) revealed critical gaps in the available data, contributing to concerns about the ability to assess whether the IPF prospective payment system (PPS) is accurately capturing costs and classifying patients.

| Mandated report: Telehealth in Medicare. The Consolidated Appropriations Act, 2022, mandated that the Commission evaluate the use of telehealth services during the COVID-19 public health emergency (PHE), and the relationship between expanded telehealth coverage and quality of care, beneficiary access, and program costs. In this chapter, we present our findings from quantitative analysis as well as interviews and focus groups conducted in the summer of 2022. Spending on telehealth services for Medicare beneficiaries rose dramatically in the early months of the PHE and peaked in the second quarter of 2020 before declining over the next 18 months. During this time, use of and spending for telehealth services for behavioral health rose. Many clinicians and beneficiaries reported a desire to have the option for these visits to continue. Our ability to assess the impact of telehealth on quality, access, and costs is limited because of data lags and COVID-19 surges in 2021. Acknowledging these limitations, and with substantial caveats, our analysis of telehealth use suggests that during the pandemic, greater telehealth use was associated with little change in measured quality, slightly improved access to care for some beneficiaries, and slightly increased costs to the Medicare program in 2021.

| Aligning fee-for-service payment rates across ambulatory settings. Medicare payment differences for the same service across ambulatory settings—hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding clinician offices—encourage arrangements among providers that result in care being provided in the settings with the highest payment rates, thereby increasing total Medicare spending and beneficiary cost sharing without significant improvements in patient outcomes. In this chapter, we build on prior Commission work and recommend that the Congress more closely align payment rates across these 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 outpatient prospective payment system's (OPPS's) statutory 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.

| Reforming Medicare's wage index systems. Medicare's prospective payment systems use wage indexes to adjust Medicare base payment rates for geographic differences in labor costs. 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 to the inpatient prospective payment systems (IPPS) wage index over time, 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 pay for these exceptions. In this chapter, the Commission recommends that Congress repeal the existing Medicare's wage index

statutes, including current exceptions, and require the Secretary to phase in new wage index systems for hospitals and other types of providers that use all-employer occupation-level wage data, reflect local differences in wages between and within areas, and smooth wage index differences across adjacent local areas.

| Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 mandated that the Commission evaluate a prototype design of a uniform prospective payment system for post-acute care (PAC) providers. In this chapter, we build on prior Commission work over the past decade that concluded that a PAC PPS was feasible and comment on the prototype developed by the Centers for Medicare & Medicaid Services/Assistant Secretary for Planning and Evaluation. We compared the design features needed to keep payments aligned with the cost of care with those included in the prototype. While CMS’s unified PAC PPS is broadly consistent with the Commission’s proposals, CMS’s prototype PPS includes setting-specific adjusters that would undermine the uniformity of the design—although we acknowledge that these adjusters could be useful in the early stages of transitioning PAC providers to a unified payment system. We also outline the companion policies (aligned Medicare’s benefit and coverage rules, cost-sharing requirements, and conditions of participation for providers, and a new PAC value incentive program) that would need to accompany a PAC PPS.

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

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