Justification of Appropriation Request for the Committees on Appropriations

Fiscal Year 2025

MEDPAC | Medicare Payment Advisory Commission

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Table of Contents

Justification of Appropriation Request 3
Activities and Accomplishments 13
Supporting Material 31
- Appropriations Language 33
- Authorizing Legislation 34
- Summary of Changes 35
- Budget Authority by Object Class 36
- Funding Table 37
- Personnel Summary 38
- Staffing Level 39
- Appropriations History 40

Appendixes 41
- Current Commission Members 43
- Outstanding Congressionally Mandated Reports 45
- Commission Meetings and Major Agenda Items 47
- Research Projects Funded Through Contracts 51
- MedPAC Meetings with Stakeholder Organizations 53

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Justification of Appropriation Request

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Summary

The Medicare Payment Advisory Commission (MedPAC) requests appropriations of $14.477 million for fiscal year (FY) 2025. The request amounts to an overall increase of $652,469, or 4.7 percent, from the $13.824 million that MedPAC requested for FY 2024. (MedPAC also received $13.824 million for FY 2023.) Our FY 2025 request reflects the costs of the human capital, policy research, and data management and security that are needed to ensure that MedPAC can provide policy advice and analysis in support of the Congress's ongoing work to oversee and improve the Medicare program. This year's request reflects increased personnel costs from continued wage pressure and would allow the agency to return to our fully staffed full-time equivalent (FTE) level. MedPAC relies on professional staff with expertise in Medicare payment policy and competes for personnel with the Executive Branch, the private sector, and other research organizations. Recognizing the importance of attracting and maintaining expert staff, the Congress lifted MedPAC's wage cap in the Consolidated Appropriations Act, 2022, allowing us to offer more competitive salaries. Our FY 2025 budget request partially offsets this increase in personnel costs by decreasing planned expenditures for external research contracts.

Our requested level of funding will ensure that we can meet the Commission's statutory requirements and respond to increasingly frequent and complex requests for assistance from the Congress. The Commission has work underway to complete two mandated reports that are due in 2024. These mandated reports are in addition to the two standing reports that the Commission produces annually pursuant to our authorizing legislation, as well as several other informational products that we provide each year to support the Congress.

In addition to formal reports, the Commission routinely provides technical assistance and policy advice to the Congress in the form of testimony, feedback on draft legislation, and staff briefings, particularly to staff members of the committees with jurisdiction over Medicare. During 2023, the Commission briefed committee staff both formally and informally on the Medicare program and its funding sources, telehealth policy, hospital payment policy, the physician fee schedule, drug payment policy, outpatient dialysis, ambulance services, durable medical equipment, laboratory services, imaging services, site-neutral payment policy, and the Medicare Advantage (MA) program.

MedPAC received a heavy volume of requests from the Congress in 2023, fielding approximately 200 requests for technical assistance. Throughout the year, the Commission continued its regular order business and submitted 13 comment letters to the Centers for Medicare and Medicaid Services (CMS) in response to proposed regulations. In addition to providing independent, nonpartisan feedback to CMS,

these comment letters help to inform congressional staff of the potential effects of proposed regulations affecting Medicare. The Commission also submitted three letters in response to congressional requests for information on improving access to health care in rural and underserved areas, dual-eligible beneficiaries, and the Medicare Access and CHIP Reauthorization Act. We anticipate a greater level of effort in 2025 regarding the provision of technical assistance, staff briefings, comment letters, and other formal requests for information, based on a large increase in requests in the first half of FY 2024.

The requested budget will provide MedPAC with 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. Our current set of recommendations provides the Congress with policy advice and analysis to shore up Medicare beneficiaries' access to high-quality care, reduce program spending by hundreds of billions of dollars, and improve incentives in Medicare's payment systems to promote value. 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 an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to providers in Medicare's traditional fee-for-service (FFS) program and to private health plans participating in Medicare, MedPAC provides information on access to care, quality of care, and other issues affecting Medicare beneficiaries. The Commission's work in all instances is guided by three principles:

1. Beneficiaries should have access to high-quality care in an appropriate clinical setting;

2. Medicare's payments should support efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary; and

3. Providers should have incentives to supply appropriate and equitable care in an efficient manner.

In its role as an advisor to the Congress, MedPAC provides independent, analytically driven policy advice and day-to-day technical support. This support comprises, in part, a range of deliverables, including two standing mandated annual reports, comments on CMS'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 products, the Commission plays a vital role supporting the Congress in its policy deliberations related to the Medicare program. MedPAC strives to inform policymakers' discussions with reports on emerging issues or trends in Medicare. Commission staff regularly provide briefings and analysis for Members and congressional staff, as well as technical assistance on draft legislation.

Commission deliberations and formal recommendations help inform legislative frameworks and help congressional staff explain and present policy options to Members of the Congress, other congressional staff, 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 2022, Medicare spent over $900 billion to provide care for 65 million beneficiaries.

Identifying policies to constrain growth in Medicare spending and opportunities for savings has been a trademark of MedPAC's work. The Commission's unimplemented recommendations would produce hundreds of billions 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; the 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 of 2010 (ACA); and the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). MedPAC also continued work on issues of high interest to the Congress in 2023, including supporting Medicare's safety-net providers, addressing high prices of drugs covered under Medicare Part B, assessing postsale rebates for prescription drugs in Medicare Part D, reviewing telehealth in Medicare, aligning payment rates across ambulatory settings, reforming Medicare's hospital wage index, assessing behavioral health

services, and estimating the effects of favorable selection on Medicare payments to MA plans.

MedPAC provides timely assistance and value by virtue of being a highly efficient organization. With about 33 staff members and a quarter of our budget devoted to extramural research and analytic contracts, Commission staff carry out the core functions of the organization while responding in a timely manner to congressional requests and additional mandates. Returning to our full FTE level of 35 staff members (plus 2 FTEs for Commissioners' time) will ensure that Commission staff can continue to fully support the Congress's growing demands.

MedPAC's Dual Responsibilities

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

The Commission conducts public meetings most months from September through April. In these public meetings, Commission staff present analyses that touch on nearly all aspects of Medicare payment policy and receive feedback from Commissioners on methods, findings, and policy direction. Commission staff brief the authorizing committees about these analyses before every meeting so that congressional staff are informed of the Commission's work and have an opportunity to ask questions and provide feedback. Organizing and executing this rigorous meeting schedule requires substantial effort from everyone in the organization.

In addition, Commission staff are responsible for producing MedPAC's two annual reports to the Congress, which are required by statute and submitted every March and June. Developing and producing these reports involves an extensive, multi-step process. Throughout the course of a year, staff members generate and refine original analyses; present iterations of these analyses to Commissioners at public meetings; incorporate Commissioner feedback; solicit and incorporate feedback from stakeholders, other researchers, and congressional staff; submit work for external review; and draft final papers for inclusion in the reports. In the March report, the Commission assesses the adequacy of Medicare's FFS payments to providers and makes recommendations on appropriate payment rate updates; we also provide status updates on the MA program, the Medicare prescription drug program (Part D), and ambulatory surgical centers, including recommendations as indicated to improve program performance. In the June report, the Commission reports both on additional refinements to Medicare's various payment systems and on broader issues affecting the Medicare program, including changes to health care delivery and the market for

health care services. These standing reports also provide a vehicle by which we respond to other mandates from the Congress.

Since 2018, the Congress has tasked the Commission with 14 additional mandated reports and 5 formal congressional requests 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 the five outstanding mandated reports, two are due in FY 2024 and three are due in 2026.

The Commission submitted three mandated reports on schedule in 2023: one comparing Medicare's per enrollee spending for beneficiaries enrolled in the MA program with that for beneficiaries in traditional FFS Medicare, another on telehealth in Medicare, and a third on an evaluation of a prototype design for a post-acute care (PAC) prospective payment system. The Commission also responded to a formal congressional request for information about access to behavioral health services for Medicare beneficiaries.

While conducting public meetings and producing MedPAC's mandated reports, Commission staff also provide advice and technical support to congressional staff, working with the committees that have 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. 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. Maintaining a staff of experts is essential to the Commission's ability to provide congressional staff with the timely, technical advice they need as they pursue policies that affect Medicare beneficiaries, providers, and program spending.

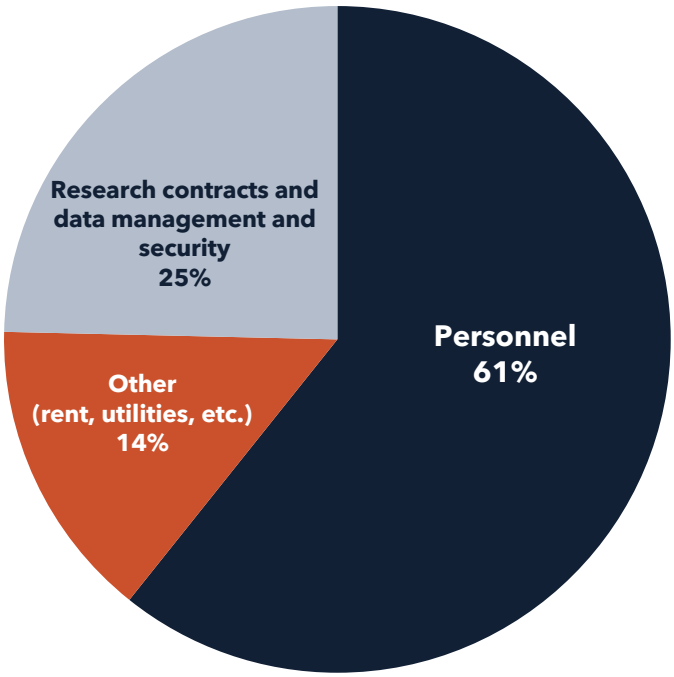
Demand for this latter type of Commission work has increased substantially over the past several years, in terms of the breadth, depth, and complexity of issues we are asked to explore, the data we are asked to produce and analyze, and the number of staff and stakeholders with whom we consult. In 2023, MedPAC fulfilled approximately 200 requests from congressional staff for briefings, technical assistance, data analysis, and consultations on a wide variety of topics, including the Medicare program and its funding sources, telehealth policy, hospital payment policy, the physician fee schedule, drug payment policy, outpatient dialysis, ambulance services,

durable medical equipment, laboratory services, imaging services, site-neutral payment policy, and the MA program.

Cost Centers

MedPAC's budget has relatively few major cost centers: personnel; research contracts and data management and security; and other costs, such as rent and utilities. Our FY 2025 request reflects 61 percent in personnel costs, travel, and benefits; 25 percent in research contracts and data management and security costs; and 14 percent in other costs including rent, communication, and utilities, as well as equipment and supplies. The concentration of costs in these areas makes it difficult to continuously find additional efficiencies; however, we continue to constrain spending within our control.

FY 2025 request: Allocation of MedPAC's cost by major cost center



Personnel

Our FY 2025 budget request reflects a human capital strategy that will enable us to support the Congress as effectively as possible. Our request reflects higher expected personnel costs stemming largely from two sources: continued wage pressure from

offering competitive salaries and adding two FTE analysts to return to the full staffing levels MedPAC experienced in 2011 and 2012.

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, in accordance with our statute, we fund Commissioners' travel and per diems when on MedPAC business. The management and analytic staff are highly trained health policy analysts and economists who 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.

Increased wage pressure. As a labor-intensive organization that relies on expert analysts, MedPAC must offer salaries within the 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. Staff recruitment has become increasingly difficult over the past several years given the highly competitive market for health care analysts. Recognizing the importance of offering competitive salaries to attract and retain staff with this expertise, the Congress (in the Consolidated Appropriation Act, 2022) increased MedPAC's salary cap. That flexibility has helped us to retain and recruit staff but also has increased our personnel costs.

Return to full staffing level. As the Medicare program has grown, so too has demand for MedPAC's analyses and the Commission's workload. The need for analysis and advice has been particularly important during the pandemic and its aftermath, as policymakers grapple with issues of beneficiary access to care, stress on the health care system and its workforce, and the long-term fiscal status of the Medicare program. We have experienced a particular increase in Congressional requests for MedPAC work thus far in FY 2024.

Historically, MedPAC has aimed to employ a full-time staff of 35 (plus 2 FTEs for Commissioners' time). However, MedPAC last achieved that staffing level in 2011 and 2012, operating at a reduced FTE-level with the assistance of part-time contractors. The proposed budget would allow MedPAC to return to a full staffing level and better enable us to respond nimbly to a growing number of congressional requests. Building our staff capacity is particularly important as we have incurred the retirements of several key analysts over the last year and expect several more in the coming years. We expect new staff to work on a range of Medicare payment issues, including clinician and hospital payment issues, prescription drugs, post-acute care, outpatient dialysis

services, and technological changes affecting Medicare, including telehealth and artificial intelligence.

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 and the complexity of our analyses, access to external research contractors has been critical to providing timely and accurate advice to the Congress on key Medicare policy issues. However, with the addition of new staff, we will be able to bring some additional research projects in house. The budget request will fund MedPAC's national beneficiary survey and beneficiary focus groups (which are key indicators of the adequacy of Medicare's payments for physicians and a data set of considerable interest to Medicare policymakers), as well as new analyses needed to help staff execute our mandated reports.

Data Management and Security

In addition to its research contracts, the Commission contracts with a data management firm to supplement its data programming capacity and to ensure the security of sensitive data. 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 FFS claims files; provider cost reports; Part D claims files; MA plan bids, quality, and encounter data; and commercial insurer claims data. The data sets contain information about beneficiary health conditions, business intelligence, and other sensitive information. Contracting with an outside data management firm enhances our ability to process large data sets in a timely, secure manner. Working with this outside firm has also helped ensure that we fully comply with increased government 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

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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 2023, 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 CHIP Payment and Access Commission (MACPAC) on beneficiaries dually eligible for Medicare and Medicaid;
- Submitted three additional mandated reports: one comparing Medicare's per enrollee spending for beneficiaries enrolled in the MA program with that for beneficiaries in traditional FFS Medicare, another on telehealth in Medicare, and a third on an evaluation of a prototype design for a PAC prospective payment system;
- Responded to a formal congressional letter request for information on behavioral health services in the Medicare program;
- Published 20 payment basics briefs, an annually updated series widely used by congressional staff;
- Responded to approximately 200 requests for technical assistance from the Congress;
- Submitted written comments on 13 proposed rules and other policy solicitations from CMS;
- Held six public meetings;[1]

[1] Due to meeting space availability at the Ronald Reagan Building, we shifted our typical October meeting to the end of September; this scheduling anomaly resulted in MedPAC's

- Made presentations at five stakeholder meetings and conferences;
- Conducted 24 in-person focus groups with nearly 110 beneficiaries and about 60 physicians in three states, as well as virtual focus groups with beneficiaries residing in rural areas across the U.S, and conducted four site visits to better understand the experience of Medicare beneficiaries and their health care providers;
- Interviewed discharge planners at 10 hospitals that serve a large share of vulnerable beneficiaries to better understand access to skilled nursing facility services; and
- Held over 75 meetings with a wide range of stakeholders and policy analysts in order to gather input for policy consideration.

The following subsections, as well as Appendixes 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 since 2018 include:

- The Budget Reconciliation Act 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. This provision 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.

conducting eight public meetings in fiscal year 2022 and six in fiscal year 2023. We expect the schedule to return to its typical seven public meetings during fiscal year 2024 and beyond.

- Modifying the average sales price (ASP) system. In its June 2017 report, the Commission made recommendations on modifying the Part B drug ASP system. The law 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, 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, 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 remove the financial incentives that favor originator products and promote price competition between originator products and biosimilars , which could 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 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 of 2018 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. In its June 2012 report to the Congress on serving rural Medicare beneficiaries (mandated by the Patient Protection and Affordable Care Act of 2010)

the Commission 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 of 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. In its June 2013 report on the ambulance fee schedule (mandated by the Middle Class Tax Relief and Job Creation Act of 2012), the Commission supported requiring ground ambulance providers to submit cost reports.

In addition, CMS has adopted several of the Commission's recommendations through its rule-making process. Selected policies adopted through rulemaking since 2018 include:

- The hospital inpatient prospective payment systems (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 calendar year (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 DMEPOS products from the DME fee schedule to the CBP in our June 2018 report to the Congress.
- The MA and Part D final rule for CY 2021 implemented restrictions on dual-eligible special needs plan (D–SNP) "look-alike" plans. In its June 2019 report to the Congress, the Commission raised concerns over the growing use of look-alike plans to circumvent D–SNP requirements.
- 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 we 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 that the Congress reduce or eliminate differences in payment rates between hospital outpatient departments and physician offices.
- In the 2019 MA and Part D rate announcement and call letter, CMS adjusted the payment rate for MA 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 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 of the methodology used for paying long-term care hospitals for short stays, and it improved incentives for providers to base discharge decisions on clinical needs rather than 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 through September of each fiscal year, the Commission holds seven public meetings to develop and approve reports and recommendations to the Congress. (Due to a scheduling anomaly, MedPAC held eight public meetings in FY 2022 and six meetings in FY 2023.) The Commission briefs staff from each committee that has jurisdiction over Medicare before each meeting to ensure that the staff are informed of the items that compose each meeting's agenda.

The Commission contracts with the Ronald Reagan Building and International Trade Center (RRB) in Washington, DC, as the venue for its live-streamed public meetings, given our statutory mandate to hold deliberations in public. Throughout FY 2023, each live-streamed session was attended virtually by approximately 300 to 400 attendees. There is broad interest from staff on our committees of jurisdiction, stakeholders across the county, other government personnel, and members of the public to continue to view the Commission's deliberations virtually. Live-streaming incurs a substantial additional cost to our public meetings. The agenda for each meeting over the past year is described in Appendix C.

Research Reports

In 2023, the Commission completed all requested/mandated reports and presented them to the 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 and develop draft decision memoranda, background documents, and other materials. Further, staff gathered additional information for these reports through meetings with a wide range of external groups, described below.

March 2023 Report to the Congress

On March 15, 2023, the Commission submitted its annual mandated report to the Congress on Medicare payment policy, complying with a statutory requirement each year to provide the 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 and other health professional services, outpatient dialysis services, skilled nursing facility services, home health services, inpatient rehabilitation facility services, and hospice services;
- The status of ambulatory surgical center services;
- The status of the 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; and
- Historical comparison showing that MA payments are consistently above FFS spending (mandated report, as described below).

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

June 2023 Report to the Congress

On June 15, 2023, 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 fulfilled a statutory requirement to each year provide the Congress with a report examining the issues facing the Medicare program. Topics included:

- Addressing high prices of drugs covered under Medicare Part B;
- Assessing postsale rebates for prescription drugs in Medicare Part D;
- Standardized benefits in MA plans;

- Favorable selection and future directions for MA payment policy;
- Disparities in outcomes for Medicare beneficiaries with different social risks;
- Behavioral health services in the Medicare program (congressional request);
- Telehealth in Medicare (mandated report, as described below);
- Aligning FFS payment rates across ambulatory settings;
- Reforming Medicare's wage index systems;
- Evaluation of a prototype design for a post-acute care prospective payment system (mandated report, as described below).

Other Mandated Reports Completed in FY 2023

In addition to our standing annual reports to the Congress, the Commission publishes specific reports that directly respond to congressional mandates in legislation or formal requests. In 2023, the Commission published three reports in compliance with mandates in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT); the Consolidated Appropriations Act, 2022; and the Consolidated Appropriations Act, 2023. The Commission also published one report in response to a January 2022 formal request from the Chairman of the House Committee on Ways and Means.

- *The Consolidated Appropriations Act, 2023. Report on comparing FFS and MA spending per enrollee:* The Consolidated Appropriations Act, 2023, mandates that the Commission compare 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 compare MA payments to FFS spending as calculated for MA benchmarks and as calculated using beneficiaries enrolled in both Part A and Part B. For this analysis, we used our long-standing prospective method of comparing MA payments with FFS spending (as calculated for MA benchmarks) from 2004 through 2023. We also supplemented this analysis with a new retrospective method using available data from 2016 to 2019 for beneficiaries enrolled in both Part A and Part B that used actual FFS and MA spending, avoiding the uncertainties intrinsic to projecting FFS spending and plan bids. Our prospective and retrospective methods yielded very similar results: Both found that MA payments were higher than what Medicare would have spent had MA enrollees remained in FFS Medicare over these periods of time. This finding is consistent with previous Commission analyses that have found that private plans have never yielded aggregate savings for the Medicare program.

- *The IMPACT Act of 2014. Evaluation of a prototype design for a post-acute care prospective payment system:* IMPACT mandated that the Commission evaluate a prototype design of a uniform prospective payment system for post-acute care (PAC) providers. In this chapter, we built on prior Commission work over the past decade that concluded that a PAC PPS was feasible and commented on the prototype developed by CMS and the Assistant Secretary for Planning and Evaluation. We compared the design features needed to keep payments aligned with the cost of care with the design features 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 outlined the companion policies (aligning Medicare's benefit and coverage rules, cost-sharing requirements, conditions of participation for providers, and a new PAC value incentive program) that would need to accompany a PAC PPS.

- *Consolidated Appropriation Act, 2022. Report on telehealth utilization 2022:* The Consolidated Appropriations Act, 2022, mandated that the Commission evaluate the use of telehealth services during the COVID-19 PHE and the relationship between expanded telehealth coverage and quality of care, beneficiary access, and program costs. In this chapter, we presented 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.

- *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 2022 asked the Commission to analyze Medicare beneficiaries' access to and use of behavioral health care services. In this chapter, we described 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 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 as the average FFS beneficiary. 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 PPS is accurately capturing costs and classifying patients.

Other Publications

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

- *MedPAC and MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (February 2023). In collaboration with 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 2023). 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 2023). *Payment Basics* is a series of brief overviews of how 20 of Medicare's payment systems function.

Reports to be Submitted to the Congress in 2024

We will release our March and June reports 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 two additional mandated reports by June 2024:

- A report mandated by the BBA of 2018 to study the performance of MA special needs plans (SNPs) (March 2024).
- A report mandated by the Consolidated Appropriations Act, 2021, to review data on payments to rural emergency hospitals as part of the March report beginning in 2024 (March 2024).

We plan to submit our Medicare data book in July 2024 and *Payment Basics* on each of the Medicare payment sectors in October 2024, as we have in past years. In February 2024, in collaboration with 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, such as 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 various 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 the Congress for their policy priorities.

National Survey of Beneficiaries

Every year, MedPAC commissions a survey to assess beneficiaries' reported access to clinician care. We survey about 4,000 Medicare beneficiaries ages 65 and over and over 4,000 privately insured people ages 50 to 64. Survey data are weighted to produce nationally representative results, which are available to us within two months of fielding. The survey provides insight into beneficiary access to care and use of health care services relative to privately insured patients. Findings from this survey are key to our annual assessment of the adequacy of Medicare payments to clinicians.

Dialogue with Stakeholder Groups

In FY 2023, the Commission met with over 75 stakeholder groups. A partial list of the groups the Commission met with in 2023 is included in Appendix E. In 2024, 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 use focus groups with Medicare beneficiaries and health care providers to gain additional qualitative understanding of their respective experiences with the Medicare program. In 2023, we held 24 in-person focus groups with Medicare beneficiaries and physicians residing in Baltimore, MD; Denver, CO; and Chicago, IL. Additionally, we held three virtual focus groups with beneficiaries residing in rural areas across the country. We asked those groups about beneficiaries' access to care, beneficiaries' coverage choices, the delivery of care, clinician telehealth adoption and beneficiary use, and quality measurement.

Site Visits

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. In 2023, staff conducted site visits in Baltimore, MD; Denver, CO; and Chicago, IL to gain insights into beneficiary access and the provision of health care services in those areas. Staff also conducted site visits to two inpatient rehabilitation facilities to better understand the facilities' resources and capabilities. In addition, staff visited three rural hospitals that recently converted to rural emergency hospital (REH) status or were considering converting to become an REH. Finally, staff visited a hospital-at-home program to better understand the model of care provided, the screening of beneficiaries, and trends on enrollment.

MedPAC Comments on CMS Regulations

In addition to our mandated reports, during the past year, the Commission has submitted written comments on 13 proposed rules 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 website. The proposed rules on which the Commission submitted comments are listed below:

- Proposed rule on policy and technical changes to the Medicare Advantage Program and Medicare Prescription Drug Benefit Program for 2024 (02/10/23)
- Advance notice of methodological changes for CY 2024 for Medicare Advantage capitation rates and Part C and Part D payment policies (03/01/2023)
- Proposed rule on hospice for FY 2024 (05/26/2023)

- Proposed rule on the payment system for inpatient rehabilitation facilities for FY 2024 (06/01/2023)
- Proposed rule on the payment system for inpatient psychiatric facilities for FY 2024 (06/02/2023)
- Proposed rule on the payment system for skilled nursing facilities for FY 2024 (06/02/2023)
- Proposed rule on the hospital inpatient prospective payment systems for FY 2024 (06/09/2023)
- Notice on transitional coverage for emerging technologies (08/25/2023)
- Proposed rule on the end-stage renal disease payment system for CY 2024 (08/25/2023)
- Proposed rule on the home health prospective payment system for CY 2024 (08/25/2023)
- Proposed rule on the remedy for the 340B-acquired drug payment policy for calendar years 2018–2022 (09/01/2023)
- Proposed rule on the payment systems for hospital outpatient departments and ambulatory surgical centers for 2024 (09/11/2023)
- Proposed rule on CY 2024 revisions to payment policies under the physician fee schedule and other changes to Part B payment policies (09/11/2023)

In 2024, we expect to comment on between 10 to 15 proposed rules, regulations, and other requests for information from CMS; we expect to comment on a similar number for 2025.

MedPAC Comments on Congressional Requests for Information

The Commission has submitted written responses to three congressional requests for information. Our response letters serve as a resource for committee staff, leadership, and Member staff on targeted questions. All of our response letters are posted on our website. The congressional requests for information for which the Commission submitted comments are listed below:

- Medicare Access and CHIP Reauthorization Act (MACRA) (10/28/2022)
- Dual-eligible beneficiaries (01/13/2023)
- Improving access to health care in rural and underserved areas (09/29/2023)

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 party, formally and informally. This support took several forms.

The Commission briefed congressional staff on a wide range of Medicare issues as well as ongoing analytic work by the Commission, including two formal staff briefings addressing the Medicare program broadly and site-neutral payments. 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 policy, the physician fee schedule, outpatient dialysis services, ambulance services, payment for durable medical equipment, laboratory services, imaging services, 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 2023, Commission staff fulfilled approximately 200 requests for technical assistance from the Congress.

In September 2023, the Commission submitted a statement for the record to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health regarding policies to improve seniors' access to innovative drugs, medical devices, and technology.

Collaboration with Other Government Entities

In 2023, as in previous years, MedPAC worked collaboratively with other government entities involved in assessing and implementing the Medicare program. These interactions include exchanging information about health service delivery, quality measurement, 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: Discussions with the Office of Inspector General, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Federal Office of Rural Health Policy.

Presentations

In 2023, 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.

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Supporting Material

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Appropriations Language

For expenses necessary to carry out Section 1805 of the Social Security Act, $14,477,000 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 2024 appropriation	FY 2025 authorized	FY 2025 request
$13,824,000	$13,824,000[a]	N/A	$14,477,000

Note: FY (fiscal year), N/A (not applicable).

[a] *At the time of budget preparation, MedPAC was operating under a continuing resolution. Therefore, the amounts included for fiscal year 2024 reflect the annualized levels provided by the continuing resolution.*

Summary of Changes

	FY 2024 Base[a]		FY 2025 Request Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
Personnel compensation	35	$5,420,679	37	+669,321
Personnel benefits		2,248,668		+209,732
Professional and consultant services		305,400		+148,400
Rent (lease)		808,243		+41,757
Trainings and conferences		6,000		+24,000
LOC support services		86,928		+13,072
Publications		84,820		+12,420
Cell/telephone/courier/internet		37,680		+2,200
Leased equipment		800		+400
Decreases:				
Research contracts		1,774,000		-345,854
Misc. other services: Commercial contracts		480,504		-30,604
Security payments/DHS		144,000		-24,000
Supplies/materials		34,740		-22,440
Computer programming		1,815,220		-15,220
Software/equipment/furnishings		282,410		-13,616
Travel		250,600		-7,800
Printing and reproduction		18,000		-6,000
Other government services (GSA, NFC, OPM)		23,800		-2,300
Postage		2,000		-1,000
Net change:				+652,469

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

[a] *At the time of budget preparation, MedPAC was operating under a continuing resolution. Therefore, the amounts included for fiscal year 2024 reflect the annualized levels provided by the continuing resolution.*

Budget Authority by Object Class

Object classification	FY 2023 Actual	FY 2024 Appropriation[a]	Change	FY 2025 Request
	(In thousands of dollars)			
Personnel compensation				
Full-time staff	$5,140	$5,100	+650	$5,750
Commissioners	268	321	+19	340
	5,408	5,421	+669	6,090
Personnel benefits	2,085	2,249	+210	2,458
Travel				
Staff	24	36	+7	43
Commissioners	113	210	–10	200
Consultant	-	5	–5	-
	137	251	–8	243
Rent (lease)	753	808	+42	850
Cell/telephone/courier/internet	35	38	+2	40
Leased equipment	1	1	-	1
Postage	-	2	–1	1
	789	849	+43	892
Printing and reproduction	9	18	–6	12
Misc. other svcs: Commercial contracts	516	481	–31	450
Computer programing	1,602	1,815	–15	1,800
Research contracts	2,199	1,774	–346	1,428
Other government (GSA, NFC, OPM)	26	24	–2	22
LOC support services	124	87	+13	100
Training and conferences	5	6	+24	30
Security payments to DHS	115	144	–24	120
Professional and consultant services	295	305	+148	454
	4,882	4,636	–233	4,403
Office supplies/services	6	35	–22	12
Publications	121	85	+12	97
	127	120	–10	110
Software	91	132	–19	114
Equipment	52	130	+25	155
Furnishings	20	20	–20	-
	163	282	–14	269
Subtotal	$13,600	$13,824	652	$14,477
Lapsing	224	-	-	-
Total	**$13,824**	**$13,824**	**652**	**$14,477**

Note: 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). Components may not sum to totals because of rounding.

[a] *At the time of budget preparation, MedPAC was operating under a continuing resolution. Therefore, the amounts included for fiscal year 2024 reflect the annualized levels provided by the continuing resolution.*

Funding Table

	(In thousands of dollars)			
	FY 2023 Actual	**FY 2024 Appropriation[a]**	**Change**	**FY 2025 Request**
Administration and management (primarily staff and Commissioner salaries and benefits)	$9,505	$9,930	+$865	$10,795
Data development, analysis, and research (primarily data management and security and outside contractor costs)	$4,095	$3,895	–$213	$3,682
Lapsing	$224	-	-	-
Total	**$13,824**	**$13,824**	**$652**	**$14,477**

Note: FY (fiscal year). Components may not sum to totals because of rounding.

[a] *At the time of budget preparation, MedPAC was operating under a continuing resolution. Therefore, the amounts included for fiscal year 2024 reflect the annualized levels provided by the continuing resolution.*

Personnel Summary

	FY 2023 Actual	FY 2024 Appropriation[a]	Change	FY 2025 Request
Executive level[b]	3	3	0	3
GS/GM-13 to GS/GM-15	26	26	+2	28
GS-6 to GS-12	6	6	-	6
Staffing level (FTEs)	35	35	+2	37

Note: FY (fiscal year), GS/GM (General Schedule), FTEs (full-time equivalent). 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] *At the time of budget preparation, MedPAC was operating under a continuing resolution. Therefore, the amounts included for fiscal year 2024 reflect the annualized levels provided by the continuing resolution.*

[b] *The number of executive level staff 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
2025	37

[a] *The total full-time equivalent (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	$13,824,000[e]
2025	$14,477,000	

[a] *For fiscal year (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] *FY 2013 reflects the appropriated amount after the sequester.*

[e] *At the time of budget preparation, MedPAC was operating under a continuing resolution. Therefore, the amounts included for fiscal year 2024 reflect the annualized levels provided by the continuing resolution.*

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Appendixes

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APPENDIX A
Current Commission Members

Member and Affiliation	Appointed	Term Expiration
Michael Chernew,[a] Ph.D., Chair Harvard Medical School Boston, MA	5/21/2020	4/30/2026
Amol Navathe,[a] M.D., Ph.D., Vice Chair University of Pennsylvania School of Medicine Philadelphia, PA	5/23/2019	4/30/2025
Betty Rambur,[a] Ph.D., R.N., F.A.A.N. University of Rhode Island Kingston, RI	5/21/2020	4/30/2026
Brian Miller, M.D., M.B.A., M.P.H. Johns Hopkins University Baltimore, MD	5/31/2023	4/30/2026
Cheryl Damberg, Ph.D. RAND Corporation Santa Monica, CA	5/26/2022	4/30/2024
Gina Upchurch, R.Ph., M.P.H. Senior PharmAssist Durham, NC	5/31/2023	4/30/2024
Gregory Poulsen, M.B.A. Intermountain Healthcare Salt Lake City, UT	5/26/2022	4/30/2025
Jaewon Ryu,[a] M.D., J.D. Geisinger Health System Danville, PA	5/29/2018	4/30/2024
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

Lawrence Casalino,[a] M.D., Ph.D. Weill Cornell Department of Healthcare Policy and Research New York, NY	5/23/2019	4/30/2025
Lynn Barr, M.P.H. Barr-Campbell Family Foundation Incline Village, NV	6/2/2021	4/30/2024
Robert Cherry, M.D., M.S. UCLA Health Los Angeles, CA	5/26/2022	4/30/2025
Scott Sarran, M.D., M.B.A. Harmonic Health; Triple Aim Geriatrics Cook County, IL	5/26/2022	4/30/2025
Stacie B. Dusetzina, Ph.D. Vanderbilt University School of Medicine Nashville, TN	6/2/2021	4/30/2024
R. Tamara Konetzka, Ph.D. University of Chicago Chicago, IL	5/31/2023	4/30/2026
Wayne J. Riley,[a] M.D. State University of New York Downstate Brooklyn, NY	5/21/2020	4/30/2026

[a] *Member was reappointed to a second term.*

APPENDIX B
Outstanding Congressionally Mandated Reports

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

Due date: March 15, 2024

Description: The Medicare Payment Advisory Commission shall submit to the 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, the Medicare Payment Advisory Commission shall include a review of payments to a new designation of hospitals 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 the 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 subsection, and geographic variations in the cost of furnishing such services.

APPENDIX C
Commission Meetings and Major Agenda Items

Fiscal year 2023

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
- Supporting Medicare 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; supporting Medicare safety-net hospitals
- Status report: Ambulatory surgical center services
- Assessing payment adequacy and updating payments: Physician and other health professional services; 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; supporting Medicare safety-net hospitals
- Assessing payment adequacy and updating payments: Physician and other health professional services; supporting Medicare safety-net hospitals
- Assessing payment adequacy and updating payments: Outpatient dialysis services; hospice services; skilled nursing facility services; home health care services; inpatient rehabilitation facility services

- Congressional request: Medicare clinician and outpatient behavioral health services
- Mandated report: Updates on telehealth use and beneficiary and clinician experiences
- The Medicare Advantage program: Status report
- Addressing high prices of drugs covered under Medicare Part B
- Medicare Part D: Status report

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

April 13-14, 2023

- Addressing high prices of drugs covered under Medicare Part B
- Reforming Medicare's wage index systems
- Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system
- Assessing postsale rebates for prescription drugs in Medicare Part D
- Assessing the need for Medicare safety-net payments for skilled nursing facilities and home health agencies
- Mandated report: Telehealth in Medicare
- Congressional request: Behavioral health in Medicare
- Aligning fee-for-service payment rates across ambulatory settings

September 7-8, 2023

- Context for Medicare payment policy
- Medicare Advantage: MedPAC workplan
- Standardized benefits in Medicare Advantage plans
- Improving MedPAC's estimate of Medicare Advantage coding intensity
- Medicare's Acute Care Hospital at Home program
- Ambulatory surgical centers: A primer

Fiscal year 2024 (October through March)

October 5, 2023

- Considering current-law updates to Medicare's payment rates for clinician services
- Examining staffing ratios and turnover rates in nursing facilities
- An alternative method to establish Medicare payments for select conditions treated in inpatient rehabilitation facilities
- Workplan: Prices of generic drugs under Part D

November 2–3, 2023

- Mandated report: Rural emergency hospitals
- Mandated report: Dual-eligible special needs plans
- Hospice: MedPAC work plan
- Medicare coverage of and payment for software as a medical device: An overview
- Favorable selection in Medicare Advantage
- Evaluating access in Medicare Advantage: Network adequacy and prior authorization

December 7–8, 2023

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services
- Assessing payment adequacy and updating payments: Hospice services
- Assessing payment adequacy and updating payments: Physicians and other health professional services
- Assessing payment adequacy and updating payments: Outpatient dialysis 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, 2024

- Assessing payment adequacy and updating payments: Hospital inpatient and outpatient 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: Outpatient dialysis 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; and improving the accuracy of payment in the IRF prospective payment system
- The Medicare Advantage program: Status report
- Medicare Part D: Status report
- Ambulatory surgical centers: Status report
- Standardized benefits in Medicare Advantage plans

March 2–3, 2024

- Rural hospital and clinician payment policy: A work plan for 2024–2025
- Medicare's Acute Hospital Care at Home program
- Update on trends and issues in Medicare inpatient psychiatric services
- Preliminary analysis of Medicare Advantage quality
- Assessing data sources for measuring health care utilization by Medicare Advantage enrollees: Encounter data and other sources

April 11–12, 2024

- Topics forthcoming

For the 2024–2025 meeting cycle, the Commission plans to meet in September, October, November, and December of 2024 and January, March, and April of 2025.

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 2023 include:

Post-Acute Care

- Examination of how social risk factors affect post-acute care costs
- Replication of inpatient rehabilitation facility prospective payment system payments and simulation of an alternative payment weight method
- Interview with acute care hospital discharge planners

Physician and other health professionals

- Focus groups on beneficiary and clinician perspectives on Medicare and other issues
- Comparison of the use of rural health clinics (RHCs) and the payment rates RHCs received over time in both FFS Medicare and Medicare Advantage

Drugs and Devices

- Constructing Part D price indexes: Update using 2022 data
- Analysis of Part D data to understand the extent to which prices paid to pharmacies vary
- Stakeholder interviews with key participants in the pharmaceutical supply chain to gain a better understanding of how the generic drug market operates
- Analysis of 2021 Medicare Current Beneficiary Survey data related to Part D satisfaction and costs
- Part B drug spending and price index contract; Part B spending growth decomposition

Hospice

- Interviews with representatives of hospice facilities about nonhospice spending for beneficiaries in hospice
- Study of hospices' effect on Medicare spending

Quality

- Use of population-based outcome measures to assess the impact of telehealth expansion on Medicare beneficiaries' access to care and quality of care
- Updating quality measures: Risk-adjusted ambulatory care–sensitive hospitalizations and emergency department visits

Assorted

- Interviews with representatives of inpatient psychiatric facilities
- Data book on dually eligible beneficiaries
- Exploring the effects of supplemental coverage on Medicare spending

APPENDIX E
MedPAC Meetings with Stakeholder Organizations

MedPAC spends a substantial amount of staff time meeting with stakeholder organizations to gather data and information and to be accessible to these groups. These meetings may be initiated by MedPAC, interested stakeholder organizations, or through referrals to MedPAC by congressional staff. Below is a list of stakeholders with whom we met in 2023:

340B Health
3-Axis Advisors
AccentCare
Adventist Health
Alliance for Connected Care
Alliance of Community Health Plans
Alliance of Specialty Medicine
American Academy of Actuaries
American Academy of Family Physicians
American Academy of Ophthalmology
American Action Forum
American Clinical Laboratory Association
American Health Care Association
American Hospital Association
American Medical Association
American Medical Group Association
American Medical Rehabilitation Providers Association
Arnold Ventures
Association of Community Affiliated Health Plans
Bio Reference Laboratories
Blue Cross Blue Shield Association
California Hospital Association
Cara Therapeutics
Centers for Dialysis Care
Compassus
Crystal Run Health
DaVita
Dialysis Center of Lincoln
Dialysis Clinic Inc.
Emanate Health
Encompass
Epic
George Washington University School of Public Health
Georgetown University
Guardant Health
Horizon
Independent Dialysis Foundation
Infectious Diseases Society of America
Infusion for Health
Intermountain Healthcare
Invitae
KFF
Kidney Care Partners
LHC Group
Marshfield Clinic Health System
Mayo Clinic
MedStar National Rehabilitation Hospital
National Association for Home Care and Hospice
National Association of Community Health Centers
National Association of Freestanding Emergency Centers
National Association of Rural Health Clinics
National Community Pharmacists Association
National Hospice and Palliative Care Organization
National Infusion Center Association
National Partnership for Healthcare and Hospice Innovation
Nonprofit Kidney Care Alliance
NORC
Northwest Kidney Centers
Novant Health
Partnership for Quality Home Healthcare
PhRMA
Private Essential Access Community Hospitals
Puget Sound Kidney Centers
Pure Healthcare
Restructured BETOS Technical Expert Panel
Saint Louis Area Business Health Coalition
Security Health Plan
Sharp HealthCare
Siskin Hospital for Physical Rehabilitation
The John A. Hartford Foundation
The Rogosin Institute
The Vascular Care Group

Trinity Health
University of Alabama at Birmingham
University of California San Diego
University of Pittsburgh Medical Center (UPMC)
VITAS Healthcare