**MedPAC June 2023 Report to Congress**

**Chapter 3: Standardized benefits in Medicare Advantage plans**

Medicare beneficiaries have an average of 41 MA plans offered by an average of 8 insurers available for this year. Selecting a plan can prove difficult for beneficiaries, as plans differ in many ways such as premiums, cost-sharing rules, provider networks, supplemental benefits, covered drugs, and quality. Standardization of MA benefits (the set of services covered by the plan and the cost sharing that the plan’s enrollees pay for those services) would allow for beneficiaries to compare plans more easily. This has been used in other markets, such as Medigap since 1992 and the ACA’s health insurance exchanges starting in 2023. Requiring MA insurers to modify their plan designs to standardize could lead to some disruption in the market.

Since MA plans are required to cover Part A and Part B services but have flexibility to determine which supplemental benefits to cover, policymakers would likely want to use different approaches to standardize the two types of benefits. Standardization would be limited to changes in enrollee cost sharing, which would likely involve the development of a limited number of distinct benefit packages. Policymakers would also have to decide whether MA insurers would be required to offer one or more of the standardized benefit packages. Standardization could make supplemental benefits more transparent to beneficiaries by clarifying what plans cover and could help ensure that plans provide sufficient value to MA enrollees and taxpayers, which is a particular concern given the lack of utilization and spending data.

**Chapter 4: Favorable selection and future directions for Medicare Advantage payment policy**

Currently, 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 the plans’ enrollees. 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. Over Medicare’s nearly 40-year history of making risk-based payments to private plans, the program has always paid more to private plans than it would have spent to cover the same beneficiaries through FFS.

Policymakers could set MA benchmarks through several approaches. One approach that relies less on FFS spending uses a competitive bidding system that relies entirely on MA bids to determine benchmarks. The assumption with this approach is that competitive bidding would generate more accurate payment rates relative to MA costs and have more potential to generate program savings. Another approach could base benchmarks on both FFS and MA Medicare spending instead of just FFS spending, which would require the calculation of an FFS rate and an MA rate in each local area (both of which would use existing data and processes). The last suggested approach would set benchmarks at a point in time and update them using administratively set fixed growth rates.

**Chapter 7: Mandated report: Telehealth in Medicare**

The Consolidated Appropriations Act (CAA), 2022, mandated that the MedPAC 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. Prior to the PHE, Medicare coverage of telehealth services was limited by statute under the PFS. 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. During the PHE, CMS paid the same rate it would pay if the telehealth service had been provided in person. In the March 2021 Report to Congress, the commission states that CMS should resume paying the lower facility rate for telehealth services as soon as practicable after the end of the PHE.

*Spending and use of telehealth services in Medicare*

Medicare FFS spending for telehealth services was low in 2019, $130 million but increased dramatically during the early months of the PHE, peaking at $1.9 billion in the second quarter of 2020. Telehealth spending declined in the latter half of 2020 and in 2021, falling to $827 million in the fourth quarter of 2021. The MedPAC examined the distribution of PFS telehealth spending in 2020 and 2021 by broad service categories and found that E&M services accounted for 98% of telehealth spending in 2020 and 2021.

The Commission found that during the PHE, 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. The Commission states there should be research done using more recent data as they become available.

**Chapter 8: Aligning Fee-For-Service Payments Across Ambulatory Settings**

Medicare fee-for-service (FFS) payment rates often differ for the same service across ambulatory settings (hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding physician offices). In general, the Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting. The Commission believes that if the same service can be safely and appropriately provided in different settings, a practical payor should not pay more for that service in one setting than in another. In the June 2022 Report to Congress, the Commission discussed a method to identify the services for which it might be appropriate to align payment rates across HOPDs, ASCs, and freestanding offices. The model aligns the payment rates in the outpatient prospective payment system (OPPS) and the ASC payment system with the payment rates from the physician fee schedule (PFS). If ASCs had the highest volume of a service, the MedPAC aligned the OPPS payment rate with the ASC payment rate, with no changes to the PFS. If the HOPDs had the highest volume, the MedPAC determined it was unsafe to provide the service outside of the HOPD.

This year, MedPAC has updated their analysis with more recent data. The MedPAC identified 57 ambulatory payment classifications (APCs) for which freestanding offices had the largest volume. For the services in these APCs, MedPAC aligned the OPPS payment rates and

ASC payment rates more closely with the PFS payment rates. Included in the 57 APCs with freestanding office having the largest volume, was three imaging APCs; Level 1 imaging w/o contrast (5521), Level 2 imaging w/o contrast (5522), and Level 3 imaging w/o contrast (5523).

For nine APCs that ASCs had the highest volume, those services payment rates aligned the OPPS payment rates with the ASC payment rates. The remaining 103 APCs, HOPDs had the highest volume, and no change to the rates in each of the three ambulatory settings.

*Recommendation*

**The Congress should 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 aligning payments across settings, CMS should determine that the service is safe and appropriate to provide in ambulatory settings outside of HOPDs in most circumstances.
* CMS should include only services that would not result in hospitals reducing beneficiaries’ access to care or acting in other unintended and undesirable ways.
* CMS should also ensure that payment rate alignment does not adversely affect hospitals’ ability to maintain emergency care and standby capacity. The budget neutral adjustment that CMS would make to the nonaligned services would support emergency care and standby capacity by raising OPPS payment rates for ED visits.
* CMS could augment the aligned payment rates when one of the aligned services is provided as part of a visit for emergency care.
* CMS should closely monitor the effect that payment rate alignment has on beneficiary access to the services that have aligned payment rates.

The MedPAC determined that the recommendation would have no direct impact on Medicare program spending because CMS would apply budget neutral increases to the OPPS payment rates of the non-aligned services to offset the effects of the lower aligned payment rates.