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MedPAC Releases June 2023 Report to Congress with Recommendations for High-Cost Part B Drugs, Changes to MA, Site Neutral Policies, and Wage Index Reform

The Medicare Payment Advisory Commission (MedPAC) released its June 2023 Report to Congress (press release). The report discusses the following topics:

- High prices of drugs covered under Medicare Part B;
- Post-sale rebates for prescriptions drugs in Medicare Part D;
- Standardized benefits in Medicare Advantage (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 Medicare;
- Telehealth in Medicare;
- Alignment of fee-for-service (FFS) payment rates across ambulatory settings;
- Reforming Medicare's wage index systems; and
- A potential post-acute care (PAC) prospective payment system (PPS).

Additional detail on each chapter follows:

- **Chapter 1**: ***Addressing High Prices of Drugs Covered Under Medicare Part B (p. 27)*** – MedPAC details that in 2021 Medicare and its beneficiaries paid approximately $43 billion for Part B-covered drugs and the largest contributing factor to the growth in Part B drug spending has been the introduction of new, higher-prices drugs, increased prices for existing products, and shifts in the mix of drugs furnished to beneficiaries. This chapter provides recommendations in the following Part B drug areas:
    - **Drugs with high launch prices for certain accelerated approval drugs that have limited clinical evidence:** While MedPAC acknowledges the importance of the accelerated approval program in getting promising treatments to market faster, the Commission also stresses the need for tools to ensure that Medicare is not overpaying for accelerated approval products who clinical benefit has not been confirmed. The Commission details that the following recommendation would maintain financial rewards for innovation, while incentivizing manufacturers to complete required confirmatory trials on time:

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- **Recommendation:** Congress should require the Secretary to cap the Medicare payment rates for Part B drugs and biologics that are approved under the accelerated approval program (with limited circumstances for the Secretary to waive the payment cap) if:
    - Post marketing confirmatory trials for the product are not completed within the deadline established by the manufacturer and the Food and Drug Administration (FDA);
    - The product's clinical benefit is not confirmed in post marketing confirmatory trials; or
    - The product is covered under a "coverage with evidence development" policy.

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

MedPAC details that the cap could be set in the following ways:

- The cap could be set based on a drug's net clinical benefit and cost compared with the standard of care; or
- The payment cap could be put into effect using a rebate under which manufacturers would reimburse Medicare for the difference between the Medicare payment amount and the cap based on claims utilization for the accelerated approval diagnosis.

- **Drugs with little to no price competition among products with therapeutic alternatives:** MedPAC explains that a single ASP system has been effective in promoting price competition among generic drugs and their associated brand products by assigning a single billing code. To this end, the Commission recommends the following in order to promote price competition among drugs with similar health effects:

    - **Recommendation:** The Congress should give the Secretary the authority to establish a single average sales price (ASP)-based payment rate for drugs and biologics with similar health effects.

  The Commission details that to implement the recommendation the Secretary could develop reference groups for the following products:

    - Products that have similar FDA-approved indications or off-label use according to Medicare claims data or have medically accepted off-label use;

  - Products that work in a similar way; and
  - Products that are listed similarly by clinical guidelines.

- **Misaligned incentives associated with the percentage add-on to Medicare's Part B's payment rate:** MedPAC details that the current ASP plus 6 percent methodology may create financial considerations when physicians are selecting which drug to prescribe. To address this incentive, the Commission recommends the following:

  - **Recommendation:** The Congress should require the Secretary to:
    - Reduce add-on payments for costly Part B drugs and biologics paid based on ASP in order to minimize the relationship between ASP and add-on payments, and
    - Eliminate the add-on payments for Part B drugs and biologics paid based on wholesale acquisition cost.

- Chapter 2: ***Assessing Postsale Rebates for Prescription Drugs in Medicare Part D (p. 65)*** – Using newly available direct and indirect remuneration (DIR) data for the first time, the Commission examined current trends in prescription drug rebates and fees. MedPAC details that between 2010 and 2021, DIR increased from $8.6 billion to $62.7 billion, with manufacturer rebates accounting for 23 percent of gross Part D spending. The Commission's preliminary analysis of DIR data revealed the following:

  - DIR constrain premium growth in Part D, as premiums have decreased from 2018 to 2022, but DIR can result in higher cost sharing for enrollees who use rebated drugs;
  - Growth in brand prices has outpaced growth in rebates, with brand name drug gross prices increasing by 67 percent since 2015, while brand name prices net of rebates have increased by 39 percent;
  - Rebates vary across drug classes based on therapeutic competition and formulary coverage policies, with diabetic therapies, anticoagulants, and treatments for asthma and chronic obstructive pulmonary disease (COPD) being the most highly-rebated classes; and
  - Plan sponsors with vertically integrated pharmacy benefit manager (PBMs) have gained market share and negotiating leverage, in which large Part D sponsors receive a disproportionate share of DIR compared to smaller plans.

  The Commission concludes that this preliminary analysis of DIR data will serve as a baseline for future evaluation of how rebates are used in Part D following the implementation of the Inflation Reduction Act.

- **Chapter 3**: ***Standardized Benefits in Medicare Advantage (MA) Plans (p. 133)*** – In the chapter, the Commission highlights that the average number of available MA plans has doubled over the last 5 years and beneficiaries have difficulty comparing plans and deciding which best meet their needs. MedPAC details that this variation can arise due to the following:

    - MA plans can develop their own cost-sharing requirements for required Part A and Part B services, which tend to vary widely between services; and
    - MA plan coverage of non-Medicare supplemental benefits, such as dental, vision, and hearing, vary widely across plans.

    The Commission asserts that one way in improve plan comparability is to require MA plans to have standardized benefits, including the standardization of the set of services covered by the plan and the cost sharing that enrollees pay. MedPAC notes that standardization has been used in Medigap and health insurance exchanges and could be beneficial examples when exploring standardization for MA. The Commission provides the following approach for standardizing MA benefits:

    - For required Part A and B services, plans would be required to use a limited number of benefit packages that specify the plan's maximum out-of-pocket (MOOP) limit and cost-sharing amounts for most major services. The generosity of those benefit packages would vary, but in ways that beneficiaries could easily identify;
    - For certain preferred high-profile supplemental benefits like dental, hearing, and vision, plans would have a limited number of options for providing the benefit, such as "standard" and "high" options. Each option would specify the benefit's coverage limits, cost-sharing rules, and per enrollee spending limit; and
    - For all other supplemental benefits, the current rules would remain the same. Plans could provide the same benefits they do now, including benefits that are not primarily health related, and could still target those benefits to certain types of enrollees.

    MedPAC concludes that this approach would enable all beneficiaries to compare plans and understand plan charges for Parts A and B services, as well as covered supplemental benefits.

- **Chapter 4**: ***Favorable selection and future directions for Medicare Advantage payment policy (p. 177)*** – MedPAC begins by describing Medicare Advantage (MA) payment and risk adjustment. MedPAC notes that MA enrollees' risk scores consistently overpredict MA enrollees; actual spending in part because of favorable selection of beneficiaries in MA compared to fee-for-service (FFS). The Commission estimates that prior to utilization management, spending on

MA enrollees was about 11 percent lower in 2019 compared to FFS enrollees with the same risk scores. MedPAC concludes that favorable selection results in overpayments to MA plans and distorts efforts to assess how MA bids, benchmarks, and payments compare with FFS spending. The Commission also noted its previous work on higher diagnostic coding intensity in MA compared to fee-for-service, and emphasized that the overpayments from favorable selection and higher coding intensity are additive.

The Commission suggests readjusting MA benchmarks to be less reliant on FFS spending by:

- **Setting benchmarks using competitive bidding**, possibly using the enrollment weighted average bid. MedPAC says that this would reduce the impact of favorable selection and coding intensity but would also reduce the rebates that plans receive and plans' ability to offer extra benefits. Also, plans in highly concentrated markets may submit bids higher than their current bids and more plans would likely charge premiums.

- **Basing benchmarks on both FFS and MA spending** by bending average local area FFS and MA pending to better reflect the market average spending. This approach keeps the same bidding and benchmark infrastructure and would have little added administrative burden. MedPAC simulated this proposal and found that actual plan bids were 86 percent of simulated benchmarks on average, so there would still be rebates available for extra benefits. However, this plan would continue to incorporate some impacts of favorable selection and plans in highly concentrated areas could have a large influence on the benchmark.

- **Updating established MA benchmarks with an administratively set growth rate** based on projected changes in Medicare prices, volume and intensity, and beneficiary demographic mix. MedPAC suggests applying a discount factor to growth in volume and intensity. Alternatively, the Commission suggests using US gross domestic product. However, this does not necessarily solve the issue of favorable selection and the fixed growth rate may need to be adjusted if there are any spending shocks in Medicare.

- Chapter 5: ***Disparities in outcomes for Medicare beneficiaries with different social risks (p. 227)*** – MedPAC contracted with a research firm to review the literature and conduct stakeholder interviews to better understand the steps that providers, payers, and other organizations have taken to address social determinants of health (SDOH). The Commission found five broad themes:
  - Many approaches and interventions have been used to try to address SDOH;

- SDOH initiatives are usually aimed at populations that include but are not exclusive to Medicare beneficiaries;
- Participation in value-based payment arrangements such as accountable care organizations (ACOs) may help motivate efforts to address SDOH;
- Most health care organizations are not operating SDOH initiatives by themselves and usually collaborate with community-based organizations like food banks or public housing agencies; and
- Although many organizations are working to address SDOH, objective evaluations of these efforts are limited and findings are mixed.

MedPAC examined ambulatory care-sensitive hospitalizations and emergency department visits, readmissions, and discharges for FFS beneficiaries, stratified by race and ethnicity and low-income status. MedPAC found that race and ethnicity and low income were associated with differential outcomes. For example, enrollees receiving low-income subsidy (LIS) had rates of hospitalization 1.3 times higher than those not receiving LIS. Black and Hispanic beneficiaries also were more likely to have worse outcomes than Asian and Pacific Islander and non-Hispanic White beneficiaries and these differences persisted within income categories. Among non-LIS beneficiaries, Black individuals had a rate of hospitalization 1.8 times higher than that of Asian and Pacific Islander individuals.

MedPAC supports policies to account for social risk in quality payment programs and on payment policies for safety-net providers. The Commission also generally supports public reporting of quality results stratified by social risk factors and adding a focus on reducing disparities in quality payment programs.

- Chapter 6: ***Congressional request: Behavioral health services in the Medicare program (p. 251)*** – The Chairman of the House Committee on Ways & Means requested that MedPAC conduct an analysis of behavioral health services in Medicare. This report explores utilization and spending by FFS beneficiaries for clinician and outpatient behavioral health services, and trends and issues in inpatient psychiatric care.

    - **Clinician and outpatient behavioral health services:** The Commission found that spending on outpatient behavioral health services was $4.8 billion in 2021, and 4.9 million Medicare FFS beneficiaries (16 percent) received services under Part B. The beneficiaries who sued these services were more likely to be disabled, low income, and younger than other beneficiaries and incurred nearly twice as much spending on overall health care. The most common conditions were depression, anxiety, and substance use disorders.

MedPAC also looked at behavioral health clinicians. The Commission found that these clinicians accounted for 40 percent of clinicians who opted out of Medicare and have the highest out-out rates of any clinician type. MedPAC found that the pandemic exacerbated perceived shortages of clinicians, but telehealth helped meet needs. Beneficiaries who used telehealth filled more prescriptions but spent less on overall Part A and B services compared to those who had in-person visits.

- **Trends and issues in inpatient psychiatric care:** In FY 2021, 157,500 FFS beneficiaries had 230,500 stays at a hospital-based or freestanding inpatient psychiatric facility (IPF) which totaled $3 billion in care. Compared to other FFS beneficiaries, these individuals were more likely to be disabled and low income, have more chronic conditions, consume more services, and incur four times as much spending. Part D prescription drug spending was also nearly twice as much for these individuals compared to other beneficiaries. The beneficiaries closest to the 190-day lifetime limit on freestanding IPF days were more likely to be disabled, younger, low income, and Black compared to other beneficiaries who had an IPF stay.
    - MedPAC also examined indicators of payment accuracy for IPFs:
        - **Access to care**: the number of IPFs has declined since 2017 but the number of psychiatric beds has grown due to for-profit IPFs. However, workforce shortages limit the number of staffed beds available, and high occupancy rates at government IPFs indicate insufficient supply for persistently mentally ill beneficiaries. Overall volume has declined over the last several years.
        - **Quality of care:** The Commission says that data on quality of care provided by IPFs are too limited to make meaningful assessments but supports incorporation of more outcomes and patient experience measures into the IPF quality reporting program.
        - **Access to capital:** MedPAC found that access to capital is strong for both hospital-based and freestanding IPFs.
        - **Medicare payments and providers' costs**: The overall aggregate margin for IPFs was -9.4 percent in 2021. Freestanding IPFs had lower costs and higher margins, likely due to scale. MedPAC says more information is needed on patient severity and resource use to properly assess whether

the IPF payment system is accurately capturing costs and classifying patients (more information is required by the Consolidated Appropriations Act, 2023).

- **Chapter 7*: Mandated report: Telehealth in Medicare (p. 327)*** – This chapter details the Commission's evaluation of the use of telehealth services in the Medicare program during the COVID-19 public health emergency (PHE) and notes changes in quality, access, and cost related to expanded coverage. The Commission also discusses approaches to paying for telehealth services, recent trends in spending and use, beneficiary experience, and program integrity. The evaluation was mandated by the Consolidated Appropriations Act, 2022.

  Regarding payment for telehealth services, MedPAC continues to assert (see March 2021 Report to Congress) that the Centers for Medicare & Medicaid Services (CMS) should pay the lower, facility rate for telehealth services beginning in 2024 and collect data from practices about the cost of providing these services. Future rates could be informed by the data collected. CMS is currently paying the same rate it would if the service had been provided in person and will continue to do so through the remainder of 2023. Similarly, MedPAC notes that CMS is currently allowing federally qualified health centers (FQHCs) and rural health clinics (RHCs) to bill for telehealth services as the distant side, thereby permitting services to be provided from any location. FQHCs and RHCs are incentivized to provide in-person care with higher rates than those for comparable Physician Fee Schedule (PFS). However, payment for telehealth services for FQHCs and RHCs is set at PFS rates through the end of 2024 services (with the exception of mental health services which receive the higher rate). MedPAC supports continuing to pay for telehealth services at PFS rates (i.e., a lower rate relative to in-person care), however, the Commission notes that CMS does not believe it has authority to pay FQHCs and RHCs at this rate, so Congressional action is needed.

  MedPAC found that spending on telehealth services for Medicare beneficiaries increased dramatically in the early months of the PHE, peaking in the second quarter of 2020 before falling over the next 18 months. Evaluation and management (E&M) services, particularly behavioral health services, accounted for the vast majority of service use and spending. In regards to beneficiary differences, MedPAC found that use of telehealth varied by age, reason for eligibility, income level and location in 2021. On average, younger beneficiaries who qualified for Medicare because of ESRD or disability, had lower income, and lived in urban areas used more telehealth services. Telehealth use also varied by type of clinician, with specialists making up the highest share and the highest spending among clinical psychologists.

The Commission affirms there is a need for program integrity activities, including medical record review to ensure clinicians are accurately billing for telehealth services. Despite focus group findings indicating that telehealth visits took less time to provide, MedPAC's claims analysis did not find a meaningful difference in the distribution of E&M levels for established patients between in-person and telehealth visits in 2021. Additionally, MedPAC notes that claims for audio-only services could be analyzed in the future. The Commission details that per the Consolidated Appropriations Act, 2023 the Secretary must submit a study on Medicare program integrity related to telehealth services in the form of an interim report (due October 1, 2024) and final report (due April 1, 2026).

Although the Commission acknowledged many limitations impacting its ability to assess the effect of expanded telehealth coverage on the quality of care, access to services, and cost, it was able to provide some insights using population-based outcomes across hospital services areas with disparate levels of telehealth service use. Based on this approach, MedPAC found greater pandemic telehealth use among Medicare beneficiaries was associated with little change in quality, slightly improved access to care for some beneficiaries, and slightly increased costs to the Medicare program in 2021. Given the limitations of its study, the Commission encourages future research using more recent data when available. MedPAC also urges Congress to continue to monitor the impacts of telehealth and use evidence to inform future policymaking. Further, the Commission suggests future work could examine clinical process and intermediate outcome measures and consider the impact of telehealth use on subpopulations of beneficiaries (e.g., rural, urban, those receiving behavioral health care).

- **Chapter 8*: Aligning fee-for-service payment rates across ambulatory settings (p. 377)* –** In this chapter, MedPAC explains that FFS payment rates frequently differ across ambulatory settings (hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding physician offices) which encourages arrangements that can increase Medicare spending and beneficiary cost sharing. The Commission notes that it generally believes Medicare should base payment on the resources required to treat patients in the most efficient setting, meaning that Medicare should align rates when services can safely be provided in a lower-cost-setting. Therefore, it makes the following recommendation:

    - **Recommendation:** The Congress should more closely align 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.

To determine whether an ambulatory service should continue to have different payment rates across setting, MedPAC analyzed ambulatory payment classifications (APCs) used to pay for

services (this is an update of MedPAC's June 2022 analysis). The Commission found that it would be reasonable to align payments to HOPDs and ASCs with the physician fee schedule (PFS) for 57 APCs given freestanding offices provide the largest volume of services. Additionally, MedPAC identified 9 APCs for which it would be appropriate to align HOPD payments with rates paid in the ASC setting. The remaining 103 APCs were delivered at the highest volume in HOPDs, so MedPAC determined that no changes should be made to those payment rates. The Commission notes that because CMS is statutorily required to implement OPPS and ASC payment changes in a budget-neutral manner, payment alignment would reduce payments for the 66 APCs identified but increase payment rates for the remaining 103 APCs, maintaining total spending in the short term. However, MedPAC anticipates that this alignment could result in lower total spending over time since providers would not have a financial incentive to make site-of-care decisions. Similarly, beneficiaries would incur lower cost-sharing for site-neutral services, although total cost-sharing liability would remain unchanged in the short term.

The Commission caveats its recommendation to note that CMS may identify a different set of services through an approach that is informed by stakeholder input and ensures the preservation of emergency care and standby capacity. Additionally, MedPAC acknowledges that its recommendation would impact hospitals differently, with some experiencing Medicare revenue gains and others experiencing losses. Under the proposed policy, rural hospitals would see the largest loss at 2.5 percent, however the Commission does not anticipate this decrease would negatively impact beneficiaries for a variety of reasons which are detailed on p. 394. For-profit hospitals would experience the largest increase at 1 percent. Despite these effects, the Commission reaffirms that it would not anticipate any change in the willingness or ability of clinicians to provide the impacted services. Further, MedPAC advises that concerns about specific hospital categories (e.g., hospitals located in an area with ASCs) should be handled via targeted assistance instead of inflating OPPS rates for certain services.

- **Chapter 9*: Reforming Medicare's wage index systems (p. 399)*** – This chapter details the Commissions concerns with the inaccuracies and inequities of Medicare's wage indexes, including: the use of circular data that can deviate from market-wide labor costs; reliance on labor market areas that mask differences in labor costs within areas and create large difference across adjacent areas; and exceptions that can exacerbate inaccuracies and inequities, be manipulated, and add administrative burden. To address these concerns, MedPAC recommends a new wage index approach for all of Medicare's prospective payment systems:

- **Recommendation:** The Congress should repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers that:
  - Use all-employer, occupation-level wage date with different occupations weights for the wage index of each provider type;
  - Reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
  - Smooth wage index differences across adjacent local areas.

The Commission notes that while its recommendation would not have a direct effect on federal program spending relative to current law or materially impact beneficiaries' access to services or providers' willingness to treat Medicare beneficiaries, there would be meaningful effects for providers. Due to the substantial redistribution effects of the proposal, MedPAC suggests a phase-in or stop-loss policy be implemented.

The Commission estimates inpatient prospective payment system (IPPS) payments would decrease by over 5 percent for roughly 10 percent of hospitals and increase by more than 5 percent for 18 percent of hospitals. Overall, at least a quarter of hospitals would see higher payments and more than a quarter would see lower payments. The largest increase in total payments when excluding the temporary low-wage policy (+2.2 percent) would be toward hospitals in rural, nonmetropolitan areas. MedPAC estimates that three-quarters of hospitals that would experience a more than 10 percent decrease in IPPS payments (when excluding the temporary low-wage exception) are located in areas where the hospital-specific labor costs for RNs are higher than for competing employers in the same area. The Commission anticipates most of the remaining hospitals that would experience a cut of that magnitude currently receive more than a 35 percent increase from a wage index exception.

There would also be substantial effects on skilled nursing facilities (SNFs). Use of SNF-specific occupation weights would increase the accuracy of the SNF wage index due to the variability of labor costs in an area across occupations and the different mix of occupations relative to hospitals paid under the IPPS. MedPAC predicts that SNF PPS payments would drop by over 5 percent for 11 percent of SNFs and climb by more than 5 percent for 27 percent of SNFs. Overall, at least a quarter SNFs would see higher payments and more than a quarter would see lower payments. Similar to IPPS hospitals, the Commission notes that SNF PPS payments would shift away from: SNFs located in areas where hospital-specific labor costs are higher than those of competing employers; SNFs located in areas with the highest current wage index values; and SNFs located in counties with labor costs lower than their broader labor market area average. Additionally, MedPAC explains that the proposed wage index would shift payments

away from SNFs located in areas where the labor costs of nurse aids is low relative to the national average or the relative labor costs of RNs are unusually high.

MedPAC notes that CMS has proposed FY 2024 wage index policy changes for hospitals that reclassify to rural areas in response to recent court cases. The Commission says those changes would impact the estimates provided in the chapter but not its conclusions. Additionally, similar to its assertion regarding concern for certain providers affected by site-neutral changes, MedPAC recommends policymakers target support to providers they deem important for access and vulnerable to closure more directly (i.e., not via the wage index).

- **Chapter 10: Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system (p. 439)** – The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 mandated three reports on the design of a uniform PPS for PAC providers. This chapter constitutes the final report. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). The previous reports had confirmed that a PAC PPS is feasible and identified some basic design features to align payments with the cost of care. These factors include using the PAC stay as the unit of service, a common risk adjustment across provider types, and short-stay and high-cost outlier policies. In this chapter, MedPAC discusses some considerations around implementation of a PAC PPS.

    - **Functional status:** In earlier work MedPAC had excluded functional status as a risk adjustor, but the Commission is concerned about the accuracy of payments for the highest and lowest functioning payments under a PAC PPS that excludes functional status. The Commission is also concerned that providers would have an incentive to record functional status in ways that would raise payments, so CMS would need to monitor and audit the data and make adjustments to address coding.

    - **Payment adjusters:** MedPAC compares its proposed PAC PPS design to that from CMS and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Commission found that most features are consistent, but the CMS/ASPE prototype includes adjusters that account for cost differences across settings which MedPAC believes is unwarranted for settings other than HHAs and undermines the goal of payment alignment. MedPAC supports adjusters as a transition policy but maintains that each adjuster should have an evidence-backed conceptual relationship to the cost of care.

    - **Provider payments:** The Commission expects that a PAC PPS would redistribute payments across providers and recommends a transition period to give providers time to

adjust their costs. However, MedPAC cautions that managing multiple payment systems would be costly and confusing.

- **Oversight:** MedPAC emphasizes that CMS would have to undertake routine maintenance of the PAC PPS to reflect changes in costs and practice patterns. The upkeep should include revisions to the case-mix classification system, rebasing payments so that payments remain aligned with the cost of care, and adjustments to address upcoding.

- **Companion policies:** MedPAC asserts that designing the payment system is straightforward, but developing and implementing companion policies would not be. For example, benefit and coverage rules and cost-sharing requirements would need to be aligned across settings. Conditions of participation would also need to be aligned and there would need to be a new value incentive program.

The Commission highlights that CMS has overhauled the SNF and HHA PPSs and implemented a dual-rate structure for LTCHs which have addressed many of the concerns Congress had when it mandated these reports. Given these changes and the resources that would be required to implement a PAC PPS, MedPAC suggests that policymakers look for opportunities to adopt smaller-scale site-neutral policies instead.