MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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P R O C E E D I N G S

[11:50 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to the first of two September MedPAC meetings for this year. This is the first meeting of our cycle so the first meeting of the year. We are welcoming five new, wonderful Commissioners. We are very much looking forward to the meeting today. We're going to talk a bit about Medicare Advantage, a bit about drugs, a bit about wage indices.

For those of you watching, it is not the case that all of us have the same interior decorator. It just turns out that we're in the same room and we've adopted a new system where we both meet in person and we stream our meetings.

Every year, in the March report, we have what is known as the context chapter, where we outline sort of bigger issues facing the Medicare program and the status of the Medicare program on a number of dimensions. So we are going to start with that sort of context-setting chapter, and to lead us in that discussion is Rachel Burton. So Rachel, I am turning it over to you.

MS. BURTON: Good morning. In this presentation,

I'll provide some contextual information, meant to serve as a backdrop for Commissioner discussions over the coming cycle. This information will be included in our March report to the Congress, along with our annual payment update recommendations. For those watching online, a PDF of these slides is available from the webinar's control panel on the right side of your screen.

In this presentation I'll touch on COVID-19's impact on Medicare beneficiaries, on health care providers, and on the Medicare program's finances. I'll describe spending trends for health care nationally, for Medicare, and for Medicare's three main components. I'll cover trends in Medicare's revenue sources, and talk about beneficiary cost-sharing. And I'll close with some trends in beneficiaries' reported health status and their most common and costly chronic conditions.

COVID-19 has had a disproportionate impact on Medicare beneficiaries. People ages 65 and over have constituted 75 percent of COVID-19 deaths. Medicare beneficiaries with disabilities have had a 50 percent higher risk of having a COVID-19 hospitalization, compared to beneficiaries who qualify for Medicare due to age alone.

Beneficiaries with end-stage renal disease have been six times more likely to be hospitalized for COVID-19 than beneficiaries who qualify for Medicare due to age alone.

Health care providers have adjusted to new care delivery approaches and priorities during the pandemic. A CDC survey found that 30 percent of respondents ages 65 and over reported avoiding routine care in the early months of the pandemic, while 4 percent avoided urgent or emergency care. Medicare beneficiaries' health care utilization rates began to rebound after the first few months of the pandemic, although utilization rates for some services are still below pre-pandemic levels. Use of telehealth is up, of course, with nearly half of beneficiaries ages 65 and over reporting having had a telehealth visit in the past year, when we surveyed them about this last summer.

To keep health care providers financially stable, and ensure they remained viable sources of care during the pandemic, Congress has appropriated hundreds of billions of dollars. The Provider Relief Fund is estimated to have paid out $122 billion in 2020 and $28 billion in 2021, while the Paycheck Protection Program is estimated to have paid health care providers $53 billion in 2020, and $22

billion in 2021. Congress also enacted payment policy changes during the pandemic that have increased payments for some services and relaxed rules about when other services can be provided.

The Medicare program is now in a slightly better position financially than it was a year ago. After initially contracting at the start of the pandemic, the U.S. economy subsequently experienced strong growth, yielding higher-than-expected Medicare payroll tax revenues. This has contributed to a delay in the projected insolvency of Medicare's Hospital Insurance Trust Fund by a few years, to 2028, according to CMS's actuaries.

CMS actuaries have found that the Medicare beneficiaries who died of COVID-19 in 2020 tended to be high-cost beneficiaries with multiple medical conditions. As a result, the remaining beneficiaries are estimated to be 2 percent less costly, on average. By 2028, actuaries project that this effect will subside, and beneficiary case mix will return to a more typical composition.

The pandemic relief funds that I mentioned a few slides ago contributed to a sharp increase in the share of GDP spent on health care in 2020, as shown in the yellow

line at the top of this graph. Spending on public health activities during the pandemic also contributed to this spike, as did the fact that GDP shrank in 2020, as businesses closed and people stayed home. National health care spending as a share of GDP declined in 2021 and 2022 as pandemic relief funds tapered off and GDP began to grow again.

Moving to the blue line, which shows Medicare spending as a share of GDP, we don't see a decline in 2020 because overall Medicare spending increased in 2020, despite a drop in service utilization. This is partly because capitated payments to Medicare Advantage plans, which cover almost half of all Medicare beneficiaries, were set before the pandemic began, and assumed pre-pandemic utilization trends would continue.

I should also mention that a reason why the blue, Medicare line grows more quickly in coming years than the red, private health insurance line is that the number of people with Medicare coverage is expected to grow much faster than the number of people with private health insurance, as the baby boom generation shifts out of private health insurance and into Medicare.

This graph shows actual Medicare spending, rather than Medicare spending as a share of GDP. We see a bump-up in spending in 2020 due to another source of pandemic funds for providers -- $104 billion that was fronted to providers through the Medicare Accelerated and Advance Payments program. These funds will be recouped by Medicare in 2021 and 2022.

Medicare beneficiaries have already begun catching up on missed services, and CMS actuaries expect their care patterns to be fully back to pre-pandemic levels by 2024. From 2023 to 2030, actuaries project Medicare spending to grow by about 6 to 7 percent per year. The end result is Medicare spending is expected to double over the next 10 years, rising from approximately $850 billion in 2021 to $1.8 trillion in 2031.

Medicare's projected spending growth in the next 10 years is driven by general economy-wide inflation, the number of beneficiaries entering the program, and the volume and intensity of services delivered per beneficiary, which is expected to grow by an average of 3.3 percent per year over this period.

This table disaggregates Medicare spending into

its three main components to show how fast spending per beneficiary has grown over time for fee-for-service Medicare, Medicare Advantage, and Medicare Part D. The bottom row shows that from 2013 to 2021, MA spending per beneficiary increased 3 percent per year on average, while fee-for-service spending increased 2.3 percent, and Part D spending increased 1.9 percent. This table also shows that in 2020, fee-for-service Medicare spending per beneficiary decreased by 2.4 percent due to the pandemic, but then increased by 10 percent in 2021 as patients resumed care.

I'm now going to switch to the other side of Medicare's ledger and talk about revenues used to pay for program spending. Medicare's most pressing financial challenge is illustrated by this graph, which shows the number of workers who pay Medicare payroll taxes for every one current Medicare beneficiary.

As you can see, this ratio has been declining over time. At Medicare's inception, there were about 4 ½ workers per Medicare beneficiary, but by 2021 there were only 2.9 workers per beneficiary.

Medicare payroll taxes are the main source of funding for Medicare's Hospital Insurance Trust Fund, which

in turn pays for Part A services like inpatient stays and post-acute care. In some years, Medicare has spent more on Part A services than it has collected through trust fund revenues, creating annual deficits. In other years, including 2021 and 2022, trust fund revenues have exceeded Part A spending, creating annual surpluses.

Medicare's trustees currently estimate that the trust fund will experience annual deficits from 2023 on, and use up the positive balance it has accrued from prior years' surpluses by 2028. CBO also tracks the trust fund's financial status, and projects a similar depletion date of 2030.

To keep the trust fund solvent over a longer, 25-year period, Medicare's trustees estimate that the Medicare payroll tax would need to be raised from its current rate of 2.9 percent to 3.66 percent, or Part A spending would need to be reduced by 16.9 percent, or about $69 billion in 2023. Reducing Part A spending by this magnitude would require major changes to the Medicare program and is not likely to be achieved through incremental approaches.

For example, our recommendation to replace the Medicare Advantage quality bonus program with a redesigned

value incentive program would have saved $10 billion in 2022, through a mix of Part A and Part B savings, but this is only a fraction of the $69 billion in Part A savings needed to extend the solvency of the trust fund.

I should note that in addition to the two options shown on this slide, some combination of smaller tax increases and smaller spending reductions could also be pursued.

Medicare payroll taxes are only one of Medicare's financing sources, and cover only about a third of the program's spending, as shown in the green layer of this graph. Its other two main funding sources are Medicare premiums, shown in orange, and general tax revenues, shown in blue. These two sources pay for Part B services, like clinician and outpatient care, and Part D prescription drug coverage. When spending on Part B services and Part D drugs increases, it automatically causes premiums and transfers of general tax revenues to rise.

The large and growing share of Medicare spending funded through general tax revenues is a problem because it reduces resources available for other government priorities,

and it increases the amount the federal government needs to borrow each year.

As Medicare spending increases, so too does beneficiary cost-sharing. Medicare beneficiaries typically do not pay premiums for Part A coverage, but the annual cost of Part B and Part D premiums as well as cost-sharing can be substantial, as illustrated on this slide. The typical Medicare beneficiary has relatively modest resources to draw on, when paying for these expenses. Researchers estimate that Medicare beneficiaries' median income in 2019 was about $30,000 and their median savings was about $74,000.

Taking into account their ability to pay for all of their various health care costs, a 2019 CMS survey found that 10 percent of beneficiaries who had received care in the past year had a problem paying a medical bill.

Turning to beneficiaries' health, data suggests that it has been improving over time. In particular, the shares of different types of people who report being in only "fair" or "poor" health have declined by 2 to 3 percentage points since 2010. This is true for people ages 65 to 74, people ages 75 and over, as well as for people

who have difficulty with mobility, self-care, or other functional domains, and may thus serve as a proxy for disabled people.

Another contextual fact about beneficiaries' health is, the most common chronic conditions are relatively inexpensive to treat, while the most expensive conditions are relatively rare. The most prevalent chronic conditions among Medicare beneficiaries are high blood pressure, high cholesterol, arthritis, diabetes, and enlarged prostate. The most expensive conditions are heart attacks, lung cancer, strokes, heart failure, and colorectal cancer.

With that, I'll wrap up. In your discussion, I'll be looking to see if anything in the chapter needs to be clarified,
or if you have any other guidance as we finalize the chapter for the March report.

I want to note that the draft chapter Commissioners received for today's meeting will be updated in the coming months as newer data become available. Commissioners will have an opportunity to review a revised version of this chapter in the winter.

I'll now turn things back over to Mike.

DR. CHERNEW: Rachel, thanks. That was outstanding. We're about to go through the Round 1 and Round 2 queues to discuss this chapter. I do want to say something for those that are listening. There is a lot in this chapter that emphasizes the fiscal situation that Medicare faces, which is obviously important and admittedly in the back of our minds. Although I want to emphasize that when we make our recommendations, particularly our update recommendations but our recommendations in general, we are, by and large, applying the MedPAC criteria which focus on making sure that we pay efficiently to ensure that the beneficiaries have access to high-quality care. We are not trying to solve a much broader set of Medicare challenges that is outlined in this chapter. Or as I sometimes say in shorthand, MedPAC is not IPAB.

So I think it is useful to keep in mind the information about beneficiary health and the fiscal health of the program and where we're going, but understand that that's sort of background information. It is not the criteria that we apply going forward to the recommendations that we make.

With that said, Dana, I think you're keeping the queue.

MS. KELLEY: Yes, and I have Marge first, with a Round 1 question.

MS. MARJORIE GINSBURG: Thank you. Okay, anyway, great job of putting this together. Fabulous work. On the report, on page 5, I have a question. Sorry. Let me flip to it. It just surprised me. It says, near the bottom of the page, after initially contracting at the start of the COVID-19 pandemic, the U.S. economy subsequently extended strong growth, yielding higher than expected Medicare payroll tax revenues.

I'm seeing everywhere that there's such a labor shortage in every other industry that would obviously generate tax revenues. People are having a very hard time getting staff. Some businesses are closing. They're cutting back. But is this not true at all in the Medicare realm? And that seems inconsistent with what I've heard about the shortages even within the health care industry, of having staff, nurses and others, that are basically leaving work.

So I wondered, is this somehow different? Am I

looking at this in different way than I should be?

MS. BURTON: I'm not sure I'm the best person to comment on this. But the sentence you're referring to is just talking about wages nationally, and they're seeing more people paying payroll taxes, their wages are higher than expected and the amount of payroll taxes they're paying is higher, also. I can't really speculate on the other stuff.

MS. MARJORIE GINSBURG: Okay. Thank you.

Another question. On page 25 there's a pie chart that shows -- so this is Figure 1-8. Sorry, wrong one. Figure 1-9. So this surprises me. According to this figure, since we're assuming that MA plans, most of them include a Part D coverage, obviously traditional Medicare does not include a Part D coverage. So if you look at this, 11 percent of people sign up for Part D, according to my rudimentary math. That means that only about a quarter of the people who sign up for traditional Medicare also sign up for a Part D plan.

MS. BURTON: Sorry. Is that the pie chart that's showing what percent of Medicare spending pays for MA versus fee-for-service versus Part D?

MS. MARJORIE GINSBURG: Yes.

MS. BURTON: Okay. So that's not enrollment. That's just dollars.

MS. MARJORIE GINSBURG: Oh. I completely misinterpreted this.

MS. BURTON: No problem.

MS. MARJORIE GINSBURG: Okay. Sorry. So that would not be the case, that the number of people who sign up, also a high percentage of that sign up for Part D.

MS. BURTON: It is correct that more than 11 percent of beneficiaries have Part D.

MS. MARJORIE GINSBURG: Okay. That was my question.

My last statement, which is kind of Round 1 and Round 2, on page 23 and 24. So here it says it minimizes the impact of Medicare managed care plans and their cost-sharing, suggesting that, in fact, there's too much cost-sharing going on -- no, sorry, that there's not enough cost-sharing going on in MA plans.

I'm curious as to why that is the conclusion. And granted I'm only familiar with Sacramento County MA plans and their cost-sharing, and that cost-sharing is not

in any way minimal. So I don't know what more one would want to do. If you're an OM and you've got 20 percent Part B cost-sharing without a supplemental, we're not expecting MA plans to also institute 20 percent cost-sharing for their Part D. Otherwise, why would anybody ever sign up for an MA plan unless there is some kind of meaningful cost-sharing?

MS. BURTON: We were not recommending that cost-sharing needs to be increased in MA or any other policy there. We were just trying to note that, in general, cost-sharing as a concept helps put a brake on utilization because patients have little skin in the game. And we were just pointing out that for 90 percent of beneficiaries the effect of cost-sharing as a braking mechanism is kind of blunted because they have supplemental or they have MA coverage that shields them from cost-sharing. It was just sort of an observation.

MS. MARJORIE GINSBURG: Okay. So I shouldn't make more of it than is stated here. Because to me the big issue is those in OM who have a supplemental plan where their cost-sharing is practically zip. And I don't know whether, or maybe I'm proposing that if that's not stated

clearly here we really need to make that point, I think, personally, that that's where we've got to measure lack of cost-sharing for people with supplemental plans.

MS. BURTON: I'm sorry. I'm not quite following the last sentence that you just said. What did you want us to add to the chapter?

MS. MARJORIE GINSBURG: Well, I know this chapter is context and it's not necessarily recommendations for changing this. But given the percent of people with OM who also have a supplemental, whose cost-sharing is extremely low, if it exists at all, and if part of our point is that the public needs to feel the effects of the costs of health care more acutely than they are now, given the way we've got this, that our focus should really be on those with supplemental plans and OM, that if we want the public to have more skin in the game then we have to see where they don't have skin in the game and think about whether we want to recommend any changes to that, such as requiring Medigap plans to incorporate some more significant cost-sharing than exists now.

MS. BURTON: That's certainly a policy direction that Commissioners could pursue if you want.

DR. MATHEWS: If I could interject here, Marge. The most recent explicit statement along these lines that the Commission has made was, several years back, we had a series of report chapters on redesigning the Medicare fee-for-service benefit, and it had multiple components combining the A/B deductible, imposing an out-of-pocket cap on beneficiary cost-sharing liability, and as part of that set of work, we did include a discussion of the need for -- we used a fairly awkward term -- a "supplemental charge" on Medigap in order to offset the inductive effects of supplemental coverage. So we have gone on record on that kind of a policy approach.

DR. CHERNEW: So I'm going to impose what I'm going to call "Round 1 discipline." So what is meant here is this is a context chapter. So all that's being presented is facts of what's what. We can have a discussion about what that means either in Round 2 or in the relevant discussions on the chapters that matter, MA, for example, or whatnot. But I do want to move us around now and keep the Round 1 questions to clarifying questions.

MS. KELLEY: Okay. I have Dana next.

DR. SAFRAN: Thanks.

Rachel, adding my compliments for a really outstanding chapter. The clarity is just so valuable.

I have a question about the points that you make about how to extend solvency of the hospital insurance trust fund because you present sort of the option of increasing the payroll tax or reducing spending, and I was curious with the raising of the payroll tax from 2.9 to 3.66 percent, would it be possible to share some data on what would that look like for employees and understanding that it will depend on comp, some kind of distribution curve that shows us on a pay-period-by-pay-period basis how much extra spending or annually how much extra spending is that for employees and maybe even putting that in a context of overall, like what percent of overall income then is going to taxes of various sorts by different income categories? Something like that just to make this more tangible for us to understanding the tradeoffs between the increasing the payroll tax versus the reduction in Medicare utilization.

Thanks.

MS. BURTON: I'll be honest. That might be kind of tough for us to identify. We can certainly see what we

can do, but I just want to temper expectations.

MS. KELLEY: Greg?

MR. POULSEN: Thank you. Let me add my appreciation. I think that the whole context is extremely helpful and very, very good.

On slide 14, I do wonder if what we're talking about, prevalent versus costly items, and what this really shows, I think, is chronic versus acute or, in this case, things that may have multiyear cost impact versus things that may be an episode and done. If we want to keep this information in front of people, we should maybe also look at how long it's going to persist because many of the items in the costly but infrequent condition, it may be that that happens and then it's done versus the items, I think, in the prevalent condition tend to persist essentially into perpetuity or at least till death. And so I think just for clarification, if we're going to keep this, we probably ought to look at the cumulative impact of these, because we have a lot of people with long-term impacts, I think, here.

Thanks.

MS. BURTON: I can see what we can say on that. Thanks.

MS. KELLEY: Lynn, Round 1?

MS. BARR: Thank you so much.

A terrific chapter. I have a question about you were looking at the supplemental insurance as a percentage of the population that has supplemental insurance. I'm doing this from memory. I'm sorry. But I believe you said that 10 percent of the total has supplemental insurance, but I believe you're combining Medicare Advantage. I believe it's more like 15 to 20 percent of fee-for-service beneficiaries don't have supplemental insurance, not 10. That's a really big jump. If it's otherwise, I'm like where's the historical data? Because I've been operating with a different number in my head for the last few years, and so I could be completely wrong about that. But I was just really curious.

And then if it is true that now it has jumped all the way to only 10 percent of fee-for-service don't have any kind of supplemental insurance, I'd like to see the trend on that because the trend on supplemental insurance may really show an affordability issue that we're not seeing, as we're thinking about payment adequacy and things like that. So I was just really curious about that.

MS. BURTON: I can look into what we can say about the percent of beneficiaries that have no supplemental coverage and how that's changed over time, so yes.

MS. BARR: Thank you very much.

MS. KELLEY: Cheryl.

DR. DAMBERG: I've decided to withdraw my Round 1 question, other than to say great chapter.

MS. KELLEY: Okay. That's all I have for Round 1, unless I've missed anyone.

DR. CHERNEW: I just want to say one thing.

I think -- and, Rachel, correct me -- the 10 percent number is of the whole Medicare population, including Medicare Advantage people, the denominator, and I think what you're referring to is if you take them out, all the Medicare Advantage people accounting is --

MS. BARR: [Speaking off mic.]

DR. CHERNEW: Right. Just to give some context, I think the point that's trying to be made is the standard Medicare benefit package leaves a lot of cost-sharing responsibility on Medicare beneficiaries, and in many cases, it can be quite significant for reasons that have

been discussed in past MedPAC reports and I think are well known.

One way beneficiaries can get around that cost-sharing requirement is to enroll in an MA plan, which is for a separate topic. Another way is they can buy Medigap coverage, or they can be given -- or qualify for med supp coverage through their employer, which isn't really Medigap in a technical sense.

So, in this sense, I think the number, 10 percent, is more indicative of how many Medicare beneficiaries really are faced with the sort of core Medicare benefit package as opposed to the Medicare benefit package with some -- I'm going to use this word loosely -- "supplemental protection," whether it be what is technically a supplemental plan, a Medigap plan, or an MA plan, or there's also issues, the duals, and there's other programs that fill in for that cost sharing. But that's what I think the question is, because we are concerned about Medicare beneficiary out-of-pocket burden.

MS. BARR: Right. So a quick follow-up point on that. The only reason this is important is because Medigap actually covers the full copay in rural, but other plans

don't. And so there's a big difference in the effect on rural patients that are paying up to 50 percent copays on outpatient services and don't have that full coverage through these other plans that are not Medigap, like employer plans.

DR. CHERNEW: Yeah, that's right. In fact, so, as an aside in the Medicare Advantage world, let's save that discussion. We're going to talk about Medicare Advantage benefit design later today, and I think that's actually a very strong point because even in that chapter, we talk about the changes, not just to Medicare Advantage, but in that chapter, there's some discussion about what's happened in other areas.

DR. CASALINO: It might be good to give both numbers, with and without Medicare Advantage, in the denominator. That should be simple enough, right?

MS. GINSBURG: One last comment on this theme is that I think what would really strengthen this part of the chapter is really making it clear that we're talking about two different groups of people, one on MA and one on OM, and there is no link, none between the two, and that's not always clear for the uninformed that these are really very

distinct populations and what they pay is very different and depends on other factors within those two columns of services.

So that's all. Thank you.

MS. KELLEY: Okay. All right. We are moving to Round 2, and Stacie is first.

DR. DUSETZINA: So thank you for this fantastic chapter. Maybe we'll refer to it as the "shock-and-awe chapter" of the packet.

[Laughter.]

DR. DUSETZINA: I think that you did a great job of laying out the situation we're going to find ourselves in, and I was kind of just astounded by the doubling of spending in 10 years. That just is, like, okay, great.

And then you keep going, and it's like you keep hitting us with statistic after statistic that looks terrible and worse, and then you say this is probably an optimistic set of expectations. And it's like, oh, no. Okay. So we need to do something.

I guess thinking about the chapter, I did want to say I really appreciate the context you put in about the effect on premiums and beneficiaries because I think often

when we just think about "Oh, well, let's just absorb this," well, absorbing it means that someone else is going to be paying for it. So I really appreciated that part.

I guess for a suggestion, there is a section where you talk about private payers and what they're paying, and it kind of implies we have good access for beneficiaries now, but if we keep seeing private plans paying more and more, beneficiaries may lose access or get crowded out. And I think that that kind of implies, well, we might need to pay more to account for that.

But I also kind of wondered, like, what if we got out of that game and instead thought about like other penalties that should be paid for being an organization that denies access to Medicare beneficiaries instead? Like, maybe you get some special privileges like 340B discounts or other things that we as a country are paying for that maybe you shouldn't get if you are discriminating against Medicare beneficiaries. So I just was kind of thinking I wonder if we should also frame this not only in we might have to pay more, but we should also think about other ways of keeping access for beneficiaries without getting into a little bit of a pricing bidding war with

private plans.

I also thought it was wonderful, the discussion about low-value services and some low-hanging fruit where we could achieve some savings, even though it doesn't feel like it's going to be nearly enough based on the setup of the chapter.

And then the last comment is really around the MA piece, and maybe it follows up a little bit on what Marge had just emphasized. I wonder if we do need to draw a little bit more of a distinction between MA and fee-for-service, because some of the solutions are a little bit different or the ways that we're thinking about payment are different.

Again, on page 28 of the chapter, there was kind of a laundry list of things that we're overpaying for, but it doesn't seem like we should. So I appreciated you outlining kind of some of that low hanging fruit.

But, all in all, a phenomenal chapter. Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks, Dana.

Great work, Rachel. This was really super. I

really appreciated the more streamlined version of the context chapter.

So I wanted to make one comment and then one suggested addition to the chapter. So my comment, this is my sixth and last time hearing this presentation. The reaction in the room always ranges between, I think, sobering and alarming. I don't know where Stacie's "shock and awe" fit along that continuum.

I also highlighted not only that point about the Medicare budget projected to double over the coming 10 years. I appreciate this growth is largely about demographics with the aging boomers, but I think given our various financing sources, this is not sustainable. And I think our charge at MedPAC is to ensure that our investment in Medicare is maximized, that we're encouraging high-value services.

And so that really leads into my suggestion. The chapter does a really wonderful job of setting up the major issues in Medicare. There's this very brief paragraph on page 36. We have lots of recommendations of how to kind of address some of these problems or "challengers," as Mike called them, in Medicare. I think we should be more

detailed here. Medicare's problems, we have lots of recommendations and solutions.

Jim, we've had that table in the past with kind of here's our solutions. Let's not make people go through a URL to find them. We should put them right there: Here are the big sort of issues within Medicare. Let's direct them to the report, and Jim has memorized every recommendation we've ever had and can do that from memory as to what year they're in.

Once again, great, great report. I would love to see us kind of just tie this together at the end with kind of here's where we should go. Here's where MedPAC thinks we should go moving forward.

Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Really, really good, Rachel. They're so readable. Almost like reading a dystopian science fiction novel. All it's really lacking, you need like a family, you know, with the hero that gets separated from their child and gets reunited, and Medicare is saved.

[Laughter.]

DR. CASALINO: But I just have one suggestion. On page 12 and I think in one other place too, you do a very good job of, I think, explaining how although consolidation in health care system doesn't directly affect Medicare prices, you explain how it can indirectly affect what Medicare pays, and I think that's great.

But I think as long as we're mentioning consolidation, it probably would be worth a short paragraph or a few sentences just mentioning that to the extent that the consolidation decreases competition in markets, it could theoretically -- and there is some empirical evidence -- also reduce quality for Medicare beneficiaries, perhaps access, and perhaps Medicare beneficiaries' experience of care.

And we did have a chapter about consolidation a couple years ago, and so I think some of this is referred to in there, maybe just take an update to look at the literature as well. But I think it's incomplete to just mention indirect effect on prices and not some other possible effects on beneficiaries that could be more important really to quality and experience.

MS. KELLEY: Lynn.

MS. BARR: Thanks.

I'm going to pile on Larry here again with the consolidation section of the chapter. It was the one I had the most concern about as well because, depending on whether you're rural or urban, consolidation could actually save a community. And we think about consolidation clinically, integrated networks versus affiliation versus purchasing.

I can tell you that the rhetoric of hospitals are out buying physician practices so they can raise prices, I'm sure happens in urban areas. I don't work there, so I don't really know, but everywhere that I work, I see physicians lined up outside the CEO's office asking to be employed because of the pressure that we put on the physicians.

So you mentioned MIPS being a factor, and I'd like you to also mention some of the other factors that we've done that are driving consolidation that are beneficial, but they're still drivers. For example, electronic medical records, I'm really glad we have them, but independent physicians, the stuff they bought is terrible, and then once the incentives went away, they

can't sustain them. And so that's one of the main reasons they end up going to hospitals and asking for employment.

Also, with value-based care, you have to have scale and infrastructure. These physician practices cannot participate in these programs without some sort of external support, and so frequently, that's the local hospital. So while there's, you know, certain concerns about consolidation and pricing, there's also we have driven this. We have made this happen, and I worry that we are sending out a message that consolidation is bad. Policymakers prevent that without really educating. You know, we created this mess, and our physicians can't survive on their own. So, if we're going to say don't consolidate, well, what's the alternative that we're going to provide them?

And the billing complexities that they live through is another great example. As more and more payers are requiring prior authorization, they can't handle the billing situation, and all of the different payers and claims data they get, it's unsustainable. So consolidation is not -- I don't believe consolidation is being, outside of urban areas, a vehicle for price increases. Most of the

places I work in, they're price takers, they're not price makers, even if they're fully consolidated.

So I just wanted to make those points. Thank you.

MS. KELLEY: Kenny.

MR. KAN: Outstanding chapter, Rachel.

Some suggest additions to the chapter. On page 29, you mentioned that reported health status has been improving. Would it be possible to show how that differs between MA and traditional fee-for-service?

MS. BURTON: No. Sorry.

MR. KAN: As a corollary to that, would it be possible so that we provide a balanced perspective to policymakers and the public regarding the pay if the average MA plan is paid 4 percent more than traditional fee-for-service? What do they get for that? Do they get better quality of care? So, for example, you know, if we can examine some of those underlying that, there's been like a study done by, you know, the Better Medicare Alliance, which actually suggests that MA plans actually offer -- quality of care is actually better than traditional fee-for-service, especially in the areas of

preventive care. This is because MA health plans offer better care management interventions that meet complex care needs of vulnerable beneficiaries in ways that produce robust, positive outcomes and greater value for high-need, high-cost beneficiaries, a cite verbatim from the study. So, if we can examine something like that so we can provide a balance perspective, that would be helpful.

DR. CHERNEW: So I just want to say one thing to be clear. There is going to be a Medicare Advantage status chapter, which will address many of these things, so, again, just to provide some context. We're trying to keep the context chapter largely limited to things that aren't showing up in other places, not because they're not important, because we ended up having this sort of cycle between a chapter that just became incredibly unruly and difficult to read. But just because you haven't yet been through the Medicare Advantage status chapter, Kenny, you will see explicitly this issue dealt with in the Medicare Advantage chapter, and I know you've already put yourself in the queue for it, so we're good. Right after Stacie talking about wages. Okay. I do appreciate those points.

MS. KELLEY: Jaewon.

DR. RYU: Thanks, Dana.

And thank you, Rachel. I would echo it's such an expansive area of ground to cover, and I think the chapter really did a good job covering it, so thank you to you.

I just have one comment/feedback suggestion, if you will, and I think it really has to do with this notion of consolidation and the overall text box that starts on page 8. I think there's an opportunity here to dig maybe one or two clicks deeper. It sort of has the narrative of focusing almost exclusively on provider consolidation.

And to Lynn's point and some others, I think there are a lot of wrinkles and different layers and nuances to that. For example, I think there's just a mention around payer consolidation, but how much of that is driving price? If you go back a decade, there were two payers in the Fortune 40. I believe now there are six, and that's just the span of a decade. And so I think it raises questions around chicken and egg, you know, payer consolidation, provider consolidation, what's driving what, but I think -- suffice it to say, I think the two feed on each other, and probably, each play a role in some of what we're seeing with price.

I think there's also some dynamics around consumers and expectations, and maybe partly this is technology as well. I just think there's multifactorial layers and nuances to what might be feeding into increased price, certainly provider consolidation, you know, one aspect of it. But I think there are some others that bear mentioning as well.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. I certainly agree with my fellow Commissioners' comments and I will only add a few more. First of all, wonderful chapter, very readable. I agree with the shock and awe and the terrifying experience of looking at this, and I also support Stacie's idea of how do we prevent a bidding war.

But I really want to stress something David brought up and the issue of low-value care and value-based care. This, to me, makes it very clear that it's not just an economic imperative. It is an ethical imperative to address low-value care, costs, and waste. And I hope this is a clarion call to nurses to embrace value-informed practice, to physicians, administrators. You are living in a world in which a radiation oncology bundle was just

cancelled. So to me this links very much with our work on payment reform.

I know this is context and not recommendations, but that is just so important, particularly given some evidence of the magnitude of unnecessary care that happened during COVID. I mean, that's phenomenal to me.

So thank you for highlighting this, and hopefully it's alarming enough that we can all get working a little harder.

MS. KELLEY: All right. Robert.

DR. CHERRY: Thank you, and also complements to all the staff that contributed to this. I think it's really very well-done and quite sobering, too, as well.

My comment really refers to page 23, where, in 2019, it mentions that 40 percent of the beneficiaries have traditional Medicare plus also a supplemental private insurance as well, which could either be a Medigap plan or otherwise maybe a health plan that's supplemental from a former employee as well.

I think it will be nice to know in future reports too what the trend will look like, and the reason why I mention it is because in your presentation you did mention

that as there are more Medicare beneficiaries that are expected to enroll in the program that they will probably be dropping their private insurance, which is true, but many may be choosing to enroll in private supplementary insurance plans as well. So that 40 percent number may, in fact, increase over time.

The reason why that's also important is because I think the report also did a very good job of outlining some of the disparities that exist among different demographic groups, whether through life expectancy or just their own personal experiences navigating through the health care environment and whether they're having appropriate access to care or not.

So I don't know if, over time, there are actually differences in these two groups, you know, those that have supplemental private insurance for their Medicare versus those that don't. But it would be good to know whether differences do exist and whether the disparities are exacerbated by those that don't have opportunity to actually purchase a private insurance plan or not.

MS. KELLEY: Stacie, did you have something you wanted to add here?

DR. DUSETZINA: Yeah. But I just wanted to piggyback on something that Robert was just saying with this trend question, because it came up in a conversation that I was having with someone around the Inflation Reduction Act and the cap on Part D and how we know, over time, that employers offering some sort of retiree benefit have declined over time, if you're looking at the Part D market, and wondering if this cap now gives employers additional incentives to just drop that coverage, because that, I think, is one thing that really differentiated retiree benefits from the traditional program.

So I completely agree that tracking the ways that people are covered, which programs are in over time would be nice context for now and for moving forward.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. I wanted to echo my fellow Commissioners' comments about how great this chapter is, both in terms of exposition and in terms of bringing attention to the salient issues of fiscal uncertainty for the Medicare program.

I have a couple of comments which hopefully we can be fairly brief about. On page 22 of the chapter, and

I think there's corresponding slides, basically talking about the premiums and cost-sharing component, what I was wondering is, as this is a context chapter, I think there is some nice context in the chapter, not in the slides but in the chapter, about how the cost-sharing relates, for example, to average income, and I think that's very helpful context.

The other part that I think could be helpful is, for example, on Slide 12, where you have a snapshot essentially of the figures that cited, if we could show a longitudinal trajectory of what the cost-sharing and the premiums have been over the past, I don't know, decades, similar to other longitudinal trends that you have. I think that would be very helpful, especially because the subsection title is "As Medicare Spending Increases, So Too Does Beneficiary Cost-Sharing." That implies this kind of trajectory, and I think that would be very helpful for the context chapter to include that. So that suggestion there.

And then the other suggestion I had is somewhat related to Larry's point, but starting on page 8 there's the text box that talks about private sector prices. There's an explicit link to the beneficiary access to care.

I think there is some work that some of the staff have done previously that shows that there's also resulting pressure on the Medicare price side, which is essentially Medicare spending. And so again, in the context of this being heavily about Medicare spending it would be nice to draw a direct link there, where I think right now we stop short. We say in the context of beneficiary access but not the resulting push on Medicare spending, if that makes sense, Rachel.

MS. BURTON: I'm sorry. I don't quite follow.

DR. NAVATHE: So starting on page 8 there's the text box that talks about private sector prices, so rapid growth in private sector prices has not affected Medicare beneficiary access to care. But we know that private sector price growth likely has an impact on provider cost structure, such as hospital cost, and that then influences Medicare "prices," in quotes, and therefore spending.

And so I was making a suggestion --

MS. BURTON: I follow what you're saying now. I'll see what we can do.

DR. NAVATHE: Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Yes. And let me first echo how helpful and cogent this was.

Just one comment. Although it's outside our purview, this is, by definition, a contextual chapter and what we put out there is read by people who have purviews greater than ours. So when we look at your Slide 10, with essentially the two large levers to increase the sustainability of the Medicare hospital trust fund, it might be worth just calling out -- there is a third preferable lever which is to improve the health status of new Medicare beneficiaries. So it's explicitly outside of our purview because they're not our members, if you will, at that point in time.

But then just to reinforce from a public health perspective, the healthier people are when they first enroll in Medicare -- and that's accentuated by Slide 14, by the interactions of what you labeled as fairly inexpensive, chronic diseases but really result in the expense of acute episodes. Right? It's the hypertension, hyperlipidemia, and diabetes that result in the heart attacks, heart failure, et cetera. So just calling out, from a public policy, public health perspective, that if we

can have people be a healthier cohort when they turn 65 -- and a separate discussion could be had about reducing unnecessary, broadly defined, incidences of earlier disability by similar public health measures -- will be extending the Medicare trust fund and will be improving health status, and we're not asking anyone to pay any more.

MS. KELLEY: Dana.

DR. SAFRAN: Yeah, thanks. I won't repeat my phrase from Round 1. I'll just jump right to a couple of comments that build on things a couple of my colleague Commissioners have mentioned. And so first it's starting with I think the importance of underscoring value-based payments as a lever for addressing these issues. You know, we can point to our chapter from last year and the evidence there of the value-based payment programs that have been particularly helpful and those that have not, and just the role that those can play.

And I'll tie that to the comments that Lynn and Jaewon made about consolidation because I think there we really need to point out the tie between consolidation and value-based payments and the tradeoffs that we see there, and contemplate the mechanisms for addressing how to have

the benefits of consolidation to enable value-based payment without some of the worrisome downsides of it with respect to quality, access, and costs.

And, in particular, I know we're planning some work around workforce, and I think that consolidation, really, we're seeing some of the impacts on workforce. On the one hand some opportunities for nurses and other professionals who kind of like being associated with larger facilities because it creates a career path that might not otherwise exist. But at the same time some, I think, new and very important trends around nursing and the intensity of burnout from being in those larger settings, and then physician workforce issues as well that we're seeing.

So I think the importance of value-based payment as a lever for addressing all of this and the ties between that and consolidation and the impacts that consolidation is having on quality and access via workforce issues, I think is something important for us to try to build in here. So just offering that as a set of comments. Thanks.

DR. CHERNEW: I get from those eyes, Dana, that I'm correct that we are now done. I got the two thumbs up.

Oh, I'm sorry. Lynn.

MS. BARR: So just getting back to the table on cost-sharing, the interesting thing is obviously I'm very concerned about the cost-sharing for rural beneficiaries, and I think it would be important to, as we're looking at trends and looking at what that cost-sharing is, to break out, for everybody to see what the rural cost-sharing is versus urban. And if we could start possibly correlating this drive-by thing that we're seeing with rural, how much of that is being affected by cost. And that's something that we've never really looked into, but I think it would be very illuminating. Thank you.

DR. RAMBUR: Quickly, if you could go to Slide 13, I just wanted to sort of follow up on Scott and Dana. Oh, I'm sorry. The one that had the two pieces. I thought it was 13 -- 10, 10.

I was wondering, given these excellent points, if it would be helpful to have that reducing Part A spending, actually the ways that could be done graphed. Because if I'm a person who is casually looking at this, I'm thinking, oh, they're going to give my organization a haircut, when actually there's a number of ways to reduce the spending, and that might easily be able to be in there with sort of a

trifold arrow. I thought those were good points. Thanks.

DR. CHERNEW: Take 2. I think now we are going to wrap this – oh, Stacie?

DR. DUSETZINA: It was just one thing that I wondered if it should be in the context chapter or not, and it's related to the payback of the 340B spending, which I think has been estimated to be about $1 billion per year for the 2018 through 2022, I guess. I don't know how much that should go in here, but it does seem like it also -- it just adds another billion or so. It's already a big enough problem.

DR. RAMBUR: Oh, that is very small potatoes.

DR. CHERNEW: So this has been a good discussion, and as I expected there was a lot of engagement with this material and a lot of concern.

I want to reemphasize a point that I made at the beginning that our challenge is not to solve all of the fiscal problems with the Medicare program or to make decisions about whether we should solve those problems by payment approaches or by revenue-increasing approaches or any of those types of things. I think the context is important to keep in mind, but at the end of the day what

is going to dominate our decisions is trying to set payment policies in ways to make sure that beneficiaries have access to high-quality care.

And the demographic issues that were raised in the slide that has the three people standing on top of each other, those are problems that are going to be challenging for policymakers in general.

To Scott's point, it is true that it's outside of our purview to do a lot of policy suggestions related to health before people get onto Medicare, but it is also the case that thinking about improving people's health when they're on Medicare is very front and center to what we are concerned about, and that will continue to be something that will factor into all of our decisions.

So to manage some expectations, some of the things we will go back and look through the chapter and see where we can add things, but I think we're going to try and avoid broader, in-depth picking of topics which will then, next year, be supplemented by other in-depth topics that will be added, and then we'll go through the cycle.

So I think the staff, we will take the comments into account, but I am going to push for anyway to be

relatively disciplined in how we build this into the context chapter. But many of these topics are really salient for a whole range of other aspects of what we do. And so I think we'll have to make sure that we convey -- consolidation is a perfect example, where it is what I will call a cross-cutting theme, with administrative costs as well, which relates in some ways to some of the comments on consolidation. We have put in a lot of administrative costs which forces people into delivery systems in complicated ways.

But in any case, for those at home, thank you for joining us. We would like to hear your thoughts on this topic, and you can reach us by sending a message to meetingcomments@medpac.gov, or if you go onto our website, you will find a way to leave comments for us there. This is a public meeting. We are virtual, but that does not mean that we are trying to avoid hearing or reacting to public comments. I know we get some from many folks anyway, but please feel free to reach out to us.

Do you want to add anything Jim? No? So that's going to conclude our morning session. We have a Medicare Advantage-dominated afternoon session. We hope those you

at home can join us. And for the Commissioners, we will not have what is actually a Commissioner lunch, which is kind of fun to say.

So again, thank you all, and we'll be back at 1:00. No. We will be back at 2:15.

Okay. 2:15, Medicare Advantage. Thanks.

[Whereupon, at 12:55 p.m., the meeting was recessed, to reconvene at 2:15 p.m. this same day.]

AFTERNOON SESSION

[2:16 p.m.]

DR. CHERNEW: Hello, everybody. Welcome back to our afternoon sessions. It's managed care afternoon today here at MedPAC.

We're going to start with a topic, it is very specific to Medicare Advantage, which is how the Medicare Advantage benefit package is designed. In particular,

we're going to look at issues related to the standardization of the benefits in the Medicare Advantage program.

This is the beginning of a discussion. We are far from the end of where this will all go. So I think right now, we're just going to sort of set the stage, and to do that, we have Eric. So, Eric, you're up.

MR. ROLLINS: Thanks, Mike.

I'm going to start the afternoon with the first of two presentations on the Medicare Advantage program. During this session, we'll look at the potential use of standardized benefits in MA plans. We anticipate that this material will appear as a chapter in our June 2023 report. Before I begin, I'd like to remind the audience that they can download these slides in the handout section on the right-hand side of the screen. I'd also like to thank Luis Serna and Andy Johnson for their help.

Before we get started, I'd like to emphasize that when we use the term "standardized benefits," we're referring to both the set of services covered by the plan and the cost sharing that the plan's enrollees pay for those services. This presentation focuses on Part A and B

services, which MA plans are required to cover, with the exception of hospice.

We're not proposing to change that requirement. So our discussion today will largely focus on the second element of that definition: enrollee cost sharing.

We plan to make another presentation later in the fall that focuses on non-Medicare supplemental benefits, where coverage is entirely optional and can vary widely across plans. As a result, that presentation will involve both elements of our definition of standardized benefits.

The MA program relies on beneficiaries to select plans in a regulated market where competing insurers offer a variety of plans. A fundamental assumption of this model is that beneficiaries are in the best position to decide which plan meets their needs. However, selecting a plan is difficult because they differ on many dimensions, such as their premiums, cost-sharing rules, provider networks, drug formularies, and quality.

The growth in MA plans adds to the difficulty. The number of plans has grown sharply in recent years, and beneficiaries now have an average of 36 plans available.

Researchers have found that individuals have more

difficulty selecting a health plan when they have a large number of choices. For example, they are less likely to review all of their coverage options and less likely to correctly identify the lowest-cost plan. One way that policymakers could address these challenges is by requiring MA plans to have standardized benefits. This approach would make it easier for beneficiaries to compare plans by giving them a more clearly defined set of choices.

Standardized benefits have been used in other health insurance programs. One of the best-known examples is the Medigap market, which sells private insurance policies that cover some or all of the cost sharing for Part A and B services.

All Medigap policies have been required to use standard benefit packages since the early 1990s. This reform is generally viewed as a success that made it somewhat easier for beneficiaries to compare plans and reduced marketing abuses.

Standardization is also used in the ACA's insurance exchanges. The ACA standardized its plans by grouping them into four so-called "metal tiers" based on their actuarial value. However, this approach gives

insurers a lot of flexibility to develop their own benefit packages and has raised concerns that individuals will still find it hard to compare plans. As a result, some states specify the exact deductible, cost-sharing amounts, and annual out-of-pocket limit to be used by the plans in each metal tier. CMS will require insurers to sell standardized ACA plans on the federally-run exchange starting in 2023.

Let's now turn our attention to Medicare Advantage. The MA program serves as an alternative to traditional Medicare, and plans can develop their own cost-sharing rules instead of using fee-for-service rules.

There are three general differences between MA and fee-for-service cost sharing that are worth highlighting. First, fee-for-service has uniform cost-sharing rules, but plans can use either copayments or coinsurance for most services. Second, when fee-for-service beneficiaries receive services in a facility such as a hospital, they make separate cost-sharing payments to each provider involved, while plans charge a single bundled cost-sharing amount for the entire service. Third, nearly all plans use some of the rebates they receive under the MA

payment system to reduce cost sharing for Part A and B services.

However, the greater flexibility for MA plans is subject to a number of limitations aimed at ensuring plan designs are not discriminatory. Some of those limits apply to aggregate cost sharing. Plans must ensure their total cost sharing for Part A and B services is actuarially equivalent to fee-for-service cost sharing. Plans must also have an annual cap on out-of-pocket spending for in-network services, known as a maximum out-of-pocket or MOOP limit.

Other limits apply to cost sharing for specific services. Conceptually, there are three major types of limits. First, there are some services, such as inpatient acute care and dialysis, where plans cannot charge more than fee-for-service. Second, there are other services, such as physician services, where plans can charge more than fee-for-service but are still subject to some type of specific limit. Finally, for any services where CMS does not put any specific limits on cost sharing, such as outpatient hospital services, plans cannot charge coinsurance of more than 50 percent.

Let's now take a closer look at MA cost sharing for some major services, starting with inpatient acute care. The material I'll present on the next four slides is for regular MA plans and does not include employer-sponsored plans or special needs plans. Under fee-for-service, beneficiaries typically pay the Part A deductible, which is $1,556 this year, and 20 percent coinsurance for any Part B services they receive during the stay. In contrast, most regular MA plans use daily copayments. Plans likely prefer daily copayments because they are more attractive to beneficiaries than the Part A deductible and may be particularly appealing to healthier beneficiaries.

For 2022, plans usually charge copayments for the first five to seven days of an inpatient stay, and the amounts typically range from $200 to $400 per day. These amounts cannot be directly compared to the Part A deductible because they also cover any Part B services received during the stay. CMS prohibits plans from charging more than fee-for-service for inpatient care and administers this limit by comparing plan cost sharing for stays of different lengths with average cost sharing in fee-for-service.

This slide shows how cost sharing for inpatient acute care varies among regular MA plans. These graphs show total cost sharing by length of stay and the plan's MOOP limit. Plans with so-called mandatory MOOPs have higher out-of-pocket limits than plans with voluntary MOOPs. We've separated plans this way because they have different cost-sharing limits, which are marked with the white diamonds.

As you can see, cost sharing typically rises for the first five to seven days of the stay and then flattens out. Nearly all plans charge less than the CMS cost-sharing limits, with many plans charging much less, which suggests that most MA enrollees pay less for inpatient acute care than they would in fee-for-service. Nonetheless, cost sharing still varies substantially across plans. Although plans with voluntary MOOPs can charge higher cost sharing than other plans, you can see they actually tend to charge much less.

Compared to inpatient acute care, there are fewer differences between fee-for-service and MA cost sharing for SNF care. In fee-for-service, there is no cost sharing for the first 20 days of a stay, followed by daily copayments

for days 21 through 100. Most plans also charge daily copayments starting on day 21, but some plans charge lower amounts, charge copayments for fewer than 80 days, or both.

This year, about a third of regular MA plans essentially use fee-for-service cost-sharing rules because their copayments are similar to the fee-for-service amount, and they charge copayments for the entire 80-day period. The other plans have lower cost sharing than fee-for-service, but the differences are often relatively small. For example, plans that charge copayments for less than 80 days may still charge them for a period that is longer than a typical SNF stay.

We also looked at cost sharing for some major Part B services. Regular MA plans largely use copayments for these services, but there are exceptions, such as primary care, where almost three-quarters of plans have no cost sharing, and dialysis, where almost all plans follow fee-for-service rules and charge 20 percent coinsurance.

The relationship between MA and fee-for-service cost sharing varies by service, with plans charging less than fee-for-service for primary care and emergency services, about the same as fee-for-service for specialist

visits, and more than fee-for-service for dialysis and urgent care. In the case of dialysis, fee-for-service and MA both charge 20 percent coinsurance, but MA cost sharing is likely higher in dollar terms since the rates plans use to pay dialysis facilities are often higher than fee-for-service rates.

We also found that copayments for a given service vary across plans. In several cases, plans at the 90th percentile charge two to three times more than plans at the 10th percentile.

We looked separately at special needs plans because they have different incentives with respect to cost sharing. SNPs are specialized plans that serve beneficiaries who are dual eligibles, live in a long-term care facility, or have certain chronic conditions.

A key difference between regular plans and SNPs is that the vast majority of SNP enrollees are dual eligibles. For regular plans, using MA rebates to lower Part A and B cost sharing helps attract enrollment. For SNPs, the same strategy provides less payoff because Medicaid covers cost sharing for most duals, so many SNPs, particularly D-SNPs, focus more on non-Medicare

supplemental benefits.

This means that cost sharing for Part A and B services can differ significantly between regular MA plans and SNPs. For many services, we found that the share of SNPs that either use fee-for-service cost-sharing rules or have no cost sharing is much higher than for regular plans.

I'm now going to shift gears a bit and highlight some of the policy issues that would need to be considered before using standardized benefits in MA. As in the Medigap and ACA markets, MA plans could be required to use a limited number of benefit packages, but how many packages would there be? Using a larger number of packages would give beneficiaries more choices but would do less to simplify the process of comparing plans.

One factor to consider is whether insurers could offer plans with the same benefit package but different provider networks. For example, if insurers can offer HMO and PPO versions of each benefit package, there should arguably be fewer benefit packages to keep the overall number of plans manageable.

Plans could also be standardized at a relatively high level or a more granular level. The ACA provides

examples of both approaches. Its system of metal tiers is a higher-level approach that relies on differences in actuarial value to distinguish plans, while the detailed plan designs that some states use to standardize their plans are a more granular approach.

Here are some purely illustrative MA benefit packages to give you a sense of what standardized cost sharing for Part A and B services could look like. In this example, there are three benefit packages: lower generosity, medium generosity, and higher generosity. The more generous packages would have lower MOOP limits and lower cost sharing for many services. While these benefit packages are illustrative, their parameters are based on the cost-sharing rules for regular MA plans. Since most of those plans use rebates to reduce Part A and B cost sharing, enrollees would pay less in cost sharing, at least in aggregate, under each package than they would in fee-for-service.

For simplicity, these illustrative packages cover the subset of Part A and B services discussed in your mailing materials. Any actual benefit package might cover more services. Keep in mind that MA plans would still

provide all Part A and B services except hospice. The benefit package would simply specify which services have standardized cost sharing. Policymakers would also need to consider whether the existing service-specific limits on cost sharing would remain in place. If they did, there might be little or no variation in cost sharing for services such as SNF care, emergency services, and dialysis.

Policymakers would also need to decide what types of plans would be offered. One question is whether insurers would have to offer any of the standardized packages. This requirement would aim to ensure a minimum level of access to standardized plans, but its impact could be limited if the plans that insurers are required to offer are unpopular.

Another question is whether insurers could offer plans that don't have standardized benefits. Policymakers could place no restrictions on non-standardized plans, allow insurers to offer a limited number of non-standardized plans, keep existing plans on the market but close them to new enrollees, or require all MA plans to have standardized benefits.

Letting insurers offer both types of plans would reduce disruption for existing enrollees but also reduce the potential gains from standardization. This approach could even make the process of selecting a plan more difficult because the number of plans on the market would increase. On the other hand, requiring all plans to have standardized benefits would cause some disruption for current enrollees, although the extent of the disruption would depend on how closely the benefit packages resemble current plan designs.

Finally, I'd like to touch on some potential payment implications. With standardized benefits, plans would change their bidding behavior in ways that are difficult to predict. For example, we don't know how plans would respond in situations where the rebates they receive now differ from the amount needed to offer a given benefit package. If a plan does not have enough rebates, it might lower its bid or decide to not offer that benefit package, while a plan that has more rebates than it needs might increase its bid.

The use of standardized benefits would also give plans fewer ways to respond to changes in payment rates,

which means that any changes in payment rates might have a particularly large impact on any services that are not part of the benefit package.

Finally, MA plans receive more rebates in some markets than they do in others, which could affect the mix of standardized plans offered in each area. For example, insurers might be less likely to offer a more generous benefit package in an area with relatively low rebates.

That brings us to the discussion portion of the session. We'd like to know if you think MA plans should have standardized benefits. For example, do the illustrative packages that we showed you on slide 13 seem like the right approach? If so, how do you think existing MA plans and enrollees should be treated? For today's discussion, I'd like to emphasize that we're only looking for your initial impressions on this issue rather than specific policy judgements. Benefit standardization is a complex topic, and today's presentation has only looked at its potential use for Part A and B cost sharing.

Just as a reminder, we'll return to this topic later in the fall with another presentation that focuses on non-Medicare supplemental benefits. We'll incorporate your

comments today in our future work on this topic, and as part of that, we'd like to know what kinds of additional information would be helpful to you in the future.

That concludes my presentation, and I'll now turn it back to Mike.

DR. CHERNEW: Thanks, Eric.

We're about to go through the queue. So I want to give a few broad or contextual points.

First, I want to echo what Eric said. Even though the slide says should plans used standardized benefits, we're not voting on that anytime soon. So I want to emphasize the general impressions about how you feel about this issue, not that we're expecting to go around and we're going to get to some sort of "Yes, I support that." We are a long way from that. There's a lot of issues that need to be considered. So surfacing what those issues are, what your general sense is, that's, I think, really what we're going to be looking for.

The second thing you may ask is what problem are we trying to solve with all of this, and that's a reasonable question. So I'm going to give you an answer, and again, you can feel free in your comments to correct me

on my answer or just explain where I'm wrong.

One is to simplify choice. I think there's some issues, and I think there's reasonable evidence about the challenges of choice. There's some interesting stuff in the materials about what's happened in Medigap or the exchanges, for example, on that.

The second one is to support competition, although the academic work at the extent to which that happens for standardizing benefits remains to be explored, but nevertheless, at least conceptually, standardizing the produce can support competition in a range of ways.

And the third one, which is probably the most vague, is that there's other things at some point that we might want to do, for example, rely on bidding in ways of setting benchmarks or other type of things, that might be facilitated if we had a set of standardized benefits as opposed to the way we currently do the benchmarking process. So, again, for those that are listening, we are a long way, both substantively and temporally from getting to where we're going to make recommendations. So we are at the beginning in getting a general sense of how you feel about all this and how you feel we should be going and

information you'd like to see is probably what is going to be the most helpful at this stage.

So, with that, I am going to turn it over to Dana to run the queue.

MS. KELLEY: I have Stacie first.

DR. DUSETZINA: Thanks, Eric. This was a really very interesting chapter. I just have one Round 1 question.

You mentioned the doubling of plan options between 2017 and 2022, and I just wondered if you'd be able to produce that by year. My impression from reading the text is that a lot of this might have changed after 2018 when the meaningful differences had shifted. And I just wondered kind of without that information, I'm not sure if this problem is getting worse or it already got worse and now we're just at steady state.

MR. ROLLINS: So we can provide that information. That is certainly gettable.

I think the increase has been pretty -- it has increased every year since 2017 and '22. You did see a jump when the meaningful difference rule was eliminated. I think Kenny may know. I think you saw it more in 2020 than

you saw int 2019, which is the first year it took effect. So there was that, which was kind of a regulatory change specific to a particular point in time.

But you also have a broader phenomenon of we have new companies entering the MA market that weren't in there a few years ago. So that is another factor that's contributing to the increase in plans.

DR. CHERNEW: Just another clarifying answer. Plans here means actual benefit packages. There will be carriers, say, United, Humana, that offer multiple plans. So we're talking about the number of plans that's distinct from the number of companies that are offering those plans, although obviously, with more companies, you will, in fact, get more plans.

MR. ROLLINS: And I think on average this year, the average beneficiary has access to plans from eight distinct insurers.

MS. KELLEY: Betty, did you have a Round 1 question?

DR. RAMBUR: Yes. Thank you very much. Very interesting. I have one basic question. Throughout the document we talk a lot about MOOPs for in-network, and I

was curious, and maybe it's just not clear to me, are there MOOPs for out-of-network or no maximum at all, and in either case does the No Surprises Act have any particular implications? Or maybe that's a Round 2.

MR. ROLLINS: So in terms of how the out-of-pocket limits work, if you are an HMO style plan your MOOP limit only applies to in-network care. There is no limit on what you could spend of out-of-network care. That is something that is out of the plan's purview.

To the extent that you are enrolled in a plan that is a PPO-style plan, they are required to have two separate limits, one of which is for in-network care and then a second network that is on sort of everything, both in- and out-of-network care. That second limit is usually higher, in very, very rough terms. It varies a lot from plan to plan. You can think of it is as being roughly 50 to 60 percent higher than the in-network limit. So if it was $5,000 for in-network care, maybe it's $7,500 or $8,000 for in- and out-of-network.

In terms of the impact of No Surprises, I would need to look into that. I'm not sure that has a lot of implications for Medicare, but I don't know off the top of

my head, but I can look into it.

DR. RAMBUR: I think maybe a clarifying, at least for me, I wasn't clear on the out-of-network piece. Just a very brief annotation about what you shared would be helpful. Thanks.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: Great work, Eric. Wonderful. Wonderful start for what's going to be a very interesting discussion over the next five years, right Mike?

I just want to quibble, on page 3, at the very beginning, the intro paragraph, where it says, "MA plans can design their own benefits package, which usually includes extra benefits which are not offered in the fee-for-service programs such as reduced cost-sharing for Part A and Part B."

So my quibble is, I don't consider these extra benefits. That's the reason they exist is to have lower, reasonable cost-sharing for A and B outside of the MOOP that they've got, which is different than original. So I'm not sure that accurately, to my mind, describes what that role is of reduced cost-sharing for A and B. It's not

extra. It's part of their genetic makeup. That's all.

MR. ROLLINS: I see your point, and I think it's a fair point. In this sense it's extra, vis-à-vis fee-for-service. You are getting access to lower cost-sharing in the MA plan than you would have if you were in fee-for-service and didn't have supplemental coverage. So it's extra in that sense.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Eric. So I have a couple of hopefully quick questions. The first one is you noted in the paper that the lower MOOP plans, in general, tend to have lower cost-sharing, and I was curious, is that also related to more likely getting the premium subsidies, for example, or is that just conditional on utilization of services?

MR. ROLLINS: Could you run through that again for me, please?

DR. NAVATHE: Sorry. I didn't ask that very elegantly. So the question is, there are the plans that have higher maximum out-of-pocket and plans that have lower maximum out-of-pocket, and in the paper there's a note that the lower maximum out-of-pocket plans are more likely to

have lower cost-sharing. And I was wondering if that cost-sharing is referring to lower sort of premium offsets or is it entirely conditional on utilization, cost-sharing conditional on utilization?

MR. ROLLINS: It's cost-sharing tied to actual service use.

DR. NAVATHE: Okay. So it's not necessarily related to offsetting the Part B premium, for example.

DR. CHERNEW: Right. So the cost-sharing is the deductible co-insurance and copays. The out-of-pocket that you pay for your premium, like Part B reductions on any of those things, that's not counted part of your MOOP, or towards your MOOP.

DR. NAVATHE: Right. No, no, I understand that. But what I was just saying is that are lower MOOP plans more likely to have premium subsidies also? "Subsidy" is not the right word.

MR. ROLLINS: That is a knowable issue, so we can look into that. My intuition would be that, again, I think at a fairly high level of generality, your plans that have lower out-of-pocket limits are getting more in rebates. And so I think they're sort of generally going to have more

attractive features. Their cost-sharing may be lower. Their out-of-pocket limit may be lower. So they may be more likely, for example, to buy down the Part D premiums. You see a lot of ads for MA products that tout you will get drug coverage for no additional premium. So that could be the case, and like I said, we can look into that.

As a general rule, very few plans offer reductions in the Part B premium. It's not been something that you see very often. So I'm not sure that that varies a whole lot. But again, that is something that we could look into.

DR. NAVATHE: Okay. So potentially in the Part D, but that's something that you can look into. Okay. Thank you for that.

My second question is, so on Slide 8, and perhaps also in some of the other kind of analogous distributional charts, I was curious if we know -- so if I understand this, this is looking at the distribution across all plans that are offered.

MR. ROLLINS: For this slide it's regular MA plans, so the SNFs are not in here.

DR. NAVATHE: Right. So in some sense the

percentiles are based on plan offered, not based on enrollment. Is that correct?

MR. ROLLINS: They are weighted based on each plan's enrollment.

DR. NAVATHE: They are weighted by enrollment. Okay. So my question is -- I'll ask the conceptual question and then I'll ask the specific question. The conceptual question is, how much of this variation is happening cross-geographic area and how much of this variation is happening intra-geographic area? And I was curious, for example, if you look within markets and stratify this based on the percentiles, what would that look like?

MR. ROLLINS: I'm going to file that under stuff that we would like to see in the future. My intuition would be that, like you want to know what this looks like for a specific like, you know, the Denver metropolitan area or something like that, a specific market, my intuition would be that you will still see some variation but it will be less.

You know, I was saying that the rebates that you see vary from market to market. So you may have a market

where, on average, the rebates are very high, and I think in that case, generally speaking, you're going to see lower cost-sharing. So like in this example, inpatient acute care, still some spread, but my guess would be it's going to be lower than what you see on this slide.

DR. NAVATHE: Got it. Okay. Thank you.

MS. KELLEY: Larry, Round 1?

DR. CASALINO: Just two quick comments or questions. One is, Eric, somebody asked about number of plans, and maybe it was Stacie. I'll just follow up on that. I think in other chapters you maybe have mentioned the number of plans, but it would be good when we're doing the 32 or 36, whatever it is, different plans that are offered by -- good to mention the number of carriers too, which you said on average is 8, just a good piece of information to have here, I think, in this chapter.

But more substantively, I want to make sure that we're all thinking about the same thing when we talk about offering standardized plans. And let me see if I have this right. In standardized plans, each standardized plan would have the same benefits clinically, "clinically" meaning that Medicare covers. So they're not going to vary on

that, although potentially they could vary on the network of providers. Is that correct so far?

MR. ROLLINS: So they already don't vary now on the set of services. Again, we're talking for today about Part A and B services, so all plans are subject to the same requirement. They have to cover basically --

DR. CASALINO: Right. So that's already the same.

MR. ROLLINS: We already have that as part of the program now.

DR. CASALINO: And that's why you're suggesting in today's discussion, by standardization we're really just talking about cost-sharing standardization. Correct?

MR. ROLLINS: For these services, yes. When we get to supplemental benefits, that's a broader --

DR. CASALINO: We're not talking about supplemental benefits or about networks, necessarily. And we can all make the assumption that we're talking about the same Part A and B Medicare clinical services.

MR. ROLLINS: Yes. And so again with the illustrative packages that we had in this presentation, you know, those are all built on plans that are still providing

all Part A and B services. It's just if they offer an MA product it has to have one of those three packages. Now they could offer all three, one, two -- that's kind of a policy question.

DR. CASALINO: Three packages of varied cost-sharing by service.

MR. ROLLINS: Right. They could offer the low, the medium, or the high packages. One question that we touched on in the paper is like for a given package, so like the high-generosity package, could they offer an HMO version of it and a PPO version of it? That's a policy question that you all can debate.

DR. CASALINO: And I think you made that point in the chapter that if they offer HMO and PPO and there are three levels of cost-sharing or three different cost-sharing plans, and there are eight plans in the market, that would be 3 times 2 time 8, right? So like 48 plans to choose from.

MR. ROLLINS: I think as an upper bound, yes. My one caveat I'll put out there is it kind of depends on sort of how generous the different benefit package would be. There might be some instances where a PPO product might not

be offered for the high generosity. They tend to bid higher now and get fewer rebates. So you might see more HMOs there than PPOs.

DR. CASALINO: Maximum of 48, but still quite a few, quite likely, right?

MR. ROLLINS: It could be.

DR. CASALINO: Last comment. It may just be me, and I don't know what a better terminology would be. But when I hear "benefits package" it's hard for me just to think about cost-sharing. I do think about covered services. I know you've been careful to make that distinction, but every time I hear "benefits package" I want to kind of refer back to X services covered by Y isn't kind of thing. And we're not talking about supplemental benefits here but actual clinical benefits.

MR. ROLLINS: Right. So you'll get to weigh in on those issues with our next presentation.

DR. CASALINO: Great chapter, by the way.

MS. KELLEY: Kenny.

MR. KAN: This is awesome work. I'm focused on page 13, that shows the illustrative MA benefit packages. So I understand that the parameters for these benefit

packages are illustrative, but they were informed by current cost-sharing practices for regular MA plans. So I'm really curious, when you actually look at the universe of the MA plans -- so presumably you bucket them into low-generosity, medium-generosity, and high-generosity and then you make some tweaks for the benefit parameters. So a couple of clarifying questions.

I realize this is initial work, but do you see a dominant benefit design in an MSA to be a low-generosity product? So basically that's the dominant in that MSA, is actually what we call the medium-generosity for the MSA, but nationally that's a low-generosity product. I'm trying to figure out how do I reconcile the geographic cost variation. I don't know if I'm making sense.

MR. ROLLINS: I think I understand what you're saying. I don't think the information that's here is going to certainly answer your question. That could be something that we sort of try and look at in future work.

MR. KAN: Okay. And in future work, could we possibly contemplate assigning or like suggesting actuarial values, because in the ACA Marketplace, they use actuarial values as defined by metals as you noted in the

presentation. They use an actuarial value calculator, and then based on what comes out, which is the [unclear] value ratio, then maybe you want part -- to page 13 -- is you could have these global parameters but maybe within those parameters could plans have the ability to vary or tweak some of those parameters, but subject an overall goal of hitting this as an actuarial value.

MR. ROLLINS: That is certainly an option. That is one of the things that I sort of laid out for the discussion is to the extent that you want to do something to standardized plans, do you want to be more high level, which I think the actuarial value approach that you're talking about is kind of more high level. There's still a lot of flexibility that the plans have to develop the specific parameters of what Plan X is going to look like versus Plan Y, or do you want to sort of get down like this level of detail and say sort of like here's going to be what the actual cost-sharing amounts for a lot of the services are going to be. That's an issue that can be part of the discussion.

DR. CHERNEW: I'm not sure that this will resonate but just a little bit semantically. The ACA put -

- and I think the ACA is a very good analogy for this -- the ACA created metal tiers, and, in fact, they based them on actuarial values, ignoring any complaint about the actuarial value calculated, which was developed, in part, with our old friend, John Bertko. There are also de minimis rules around that. Usually on the exchanges, when they talk about standardized benefits, if you look at some of the states, California would be the poster child. Marge and others may want to talk about what they mean by standardized.

And Massachusetts -- and full disclosure, I'm on the board of the Connector in Massachusetts. When we talk about standardized benefits, we don't mean within an actuarial value. We mean much more like what Eric showed, these are the actual numbers, so you know exactly what they are. That doesn't mean that we have to recommend one way or another, but there is actuarial value limits, as Eric pointed out, but then there are also what I would call the standardized work that is done in the more standardized ACA exchanges like California, Massachusetts, where it really is standardized. Your office co-pay is $20. That's what it is.

I'm not advocating. I'm just saying semantically that's sort of the way -- and we can discuss in Round 2 which of those you prefer. But I think of in the ACA context that being true. And as an aside in the ACA context, the federal government is also moving towards standardization. So although they had metal tiers, they are moving from the sort of metal tier approach to a standard approach -- and I believe this is true, Eric; I think you said this in the chapter, but I'm old -- where the benefits actually have to be standardized in like literally what they are. Is that right?

MR. ROLLINS: That's correct, and the federally run exchange, starting next year, the insurers, wherever they offer an ACA product they will also essentially have to offer a standardized version of that product.

DR. CASALINO: And by "standardized" you guys are both meaning cost share per type of service, not actuarial value.

DR. CHERNEW: [Off microphone.] The way that the ACA worked before, with the metal tiers, where you had to be within the same actuarial value, you could trade off cost-sharing for outpatient care, physician care, hospital

care, and they would run it through this actuarial value calculator to try and figure out that these plans are roughly the same overall generosity. But there could be big differences based on what people's use is, in a variety of ways.

And now when they're moving to standardized versions, that means $20 for a physician visit, this much for a hospital. Like very specific benefit packages.

MR. ROLLINS: Right. So Larry, Table 2 in the paper lays out what the cost-sharing designs for these plans are going to have to be. So for example, if I'm an insurer and I'm offering a gold plan in any particular area, I also am going to have to offer a gold plan that has exactly these cost-sharing amounts alongside it.

Kenny, one other final thought maybe on actuarial value that I think we probably want to talk to some experts to get a better sense. So one issue, as you know, in the ACA there is usually some wiggle room on the actuarial value for the metal tiers. And there has been concern that the wiggle room around the metal tiers has been sufficiently large and it gets a little hard to tell where a silver plan stops and kind of a low-grade gold plan

starts. So they have tried to tighten up those bands.

That's easier for me to think about when the differences between them are 10 percentage points. Given the level of rebates that we see in the MA market now, to the extent that you're going to have tiers that are tied to actuarial value, that the range is probably going to be smaller. And so given sort of the uncertainty, and would you allow plans to have some wiggle room, it could still be more difficult to tell, I guess, sort of which plans are more generous than others, given sort of the bands would be closer together, and to the extent that plans have some variation in how they're calculating actuarial value.

MR. KAN: That's an excellent point, Eric. So for future discussion, this is a great paper but could we consider including something on this page that says like a Package 4, assuming we venture down the actuarial value path.

So one thing, as noted in the material, states vary in terms of how they look at standardized plans for state-run exchanges. I realize that federal-run exchanges may be looking more towards standardization, but on state-run exchanges there is a plethora of practices, as you

know. Maryland, on the ACA market, is at the lower level of standardization. California does not allow any standardization.

So could we possibly, for future discussion, maybe we have a discussion and we roll it out, but put a Package 4 in there, put an actuarial value in here, and then, in terms of the benefit parameters as a TBD. You know, in some sense it's a hybrid approach. It's not perfect. But it also somehow gets to the standardization in a different way.

MS. GINSBURG: Excuse me. Could I have a quick question that I think is tied into that?

So, looking at the model, the illustrative model here, do we expect the cost-sharing amounts, then, are going to differ even county by county, depending on what the actual cost of services are?

This particular amount, $335 a day for acute care, may work well in one particular county, depending on what the actual cost of inpatient care is, but would not be the equivalent value in another county where the cost of care is much higher. So do you imagine in the future that these figures, in fact, would need to vary, depending on

what the actual cost of delivering the service is in that particular region?

DR. CHERNEW: Can I answer, Eric? Because I'm giving you a Round 1 answer, and that, by the way, is a very valid Round 1 question, so kudos for that. The Round 1 answer is no. We don't envision them varying by county. There's just going to be a number. It doesn't have to be those numbers, and you might view that as a weakness of doing it this way. But I think the policy discussion on the table is the physician office visit copay is $20, and we're not going to envision a world in which that's different in one county versus another county or a whole bunch of other things. We can continue that discussion. I'm just giving you my view on how we think about that.

MS. GINSBURG: No, but at least my reaction to your view is that's a really important point if that's what the group ends up doing.

DR. CHERNEW: And Medigap – the thing you should have in back of mind is Medigap. Medigap has, you know, A/B kind of set of things, and they're quite standardized across a wide heterogeneity of things. The ACA, because they're often within a state -- Massachusetts is always

standardizing within Massachusetts, so that obviously is different than California. So there's a different version of that, but basically, at least what's on the table -- and, again, Eric, I don't know what you had in your mind, so I'm guessing -- is we would have something much closer to the slides that were up there where CMS would pick -- I'm not sure if three is the right number -- we put three illustratively -- but some set of plans that people would know if they got a Medicare Advantage B plan that's loosely the same across different carriers. And, again, it's not going to obviously be the exact right plans, but if you have four, for example, then maybe they would choose different things.

DR. NAVATHE: But, Mike, just to clarify here, you're not saying that we're picking -- we're -- by standardization, we mean copay only. There could still be coinsurance --

DR. CHERNEW: Oh, yes.

DR. NAVATHE: -- based -- which would have some -- if there's rate variation from market to market, then --

DR. CHERNEW: Yeah.

DR. NAVATHE: -- a physician office visit might

cost 22 bucks somewhere and 33 bucks somewhere else.

DR. CHERNEW: So, if you look at table 2, which Eric referenced a minute ago, I think that's really illustrative, the type of thing we're thinking about there. There are a lot of coinsurance things. If you look at what they've done in Medigap -- and, Marge, you probably know -- they've moved to some plans. They're now copay-only version plans.

One thing I will say that's interesting for this discussion is there's something like 10 to 15 Medigap plans, 90 percent of people are in three, right?

So I am a reasonably free-market guy. I believe in innovation in all the value-based insurance design stuff we've done. I think that there's merit in a lot of that, but understand that most of the time, people don't spread across all of these things, like there's someone who really wants -- there might be someone, but there's typically an amazing amount of C and F. So there's a lot of people that would pick similar things, and that's kind of where -- and if you look at table 2, it gives you an idea of just -- that table would look the same across plans. The way it works now is that table could look very different across

different plans.

DR. CASALINO: Mike and Eric, Marge, is it accurate to say then that if one is concerned about geographic variation in prices that that problem can largely be solved if you use copays rather than coinsurance?

I notice in these examples, there's only one thing where it's a percentage of cost that's being paid. All the others are fixed. So, if the cost to patient is fixed, the cost sharing is fixed, then it doesn't really matter if they're in a high-cost or low-cost county to the patient. It might matter to the health plan.

DR. CHERNEW: It matters to their income. So it might be in some counties, you think you'd rather have --

DR. CASALINO: Yeah.

DR. CHERNEW: -- that it's different.

But I want to keep getting through Round 1 because I want to get to Round 2. So I'll try and talk less. Hopefully, the answer to Marge's question is clear. What's on the table now is a standardization of benefit packages that will be sort of like Medigap. This is A, B, C, D, and we would be tailoring to A in California is

different than A in Massachusetts. Think of Medigap. It's just A.

MR. ROLLINS: So I know the discussion is going to continue, but, Larry, one other thing to consider about the use of coinsurance versus copays, there's the geographic issue that you raised. But another thing is, for a given service category, how much heterogeneity do we have in the types of services that are in that category? And copays, I think, in a lot of people's minds work better where there's not as much spread, but when you have a category like durable medical equipment, where it could be a walker that's fairly inexpensive or an oxygen concentrator that's actually pretty pricy or Part B drugs, where some drugs are very expensive but others are not, that might be -- you know, one of the tradeoffs there is coinsurance allows some of that variation in what services are in that category. It's kind of a, you know, who do you want to have pay more or less if you're using copays versus coinsurance.

DR. CHERNEW: And where -- just last clarifying answer is wherever we get to on this -- and I don't know where that's going to be -- we're not going to come down

and pick what the benefit packages are, like we're going to end up saying someone has to think through in what areas do we want coinsurance and why and what areas do we want copays and why, what should they be, that kind of thing. We're not going to do a very specific dive into what this should look like, but the notion would be there would be both standardized categories, like you see in table 2, and then standardized values in those categories. It would look a lot like what you see in table 2.

I think we have Cheryl next. Is that right? And I think Cheryl is the end of Round 1. No?

DR. DAMBERG: Okay. First, thanks so much for this chapter. It was really informative.

Looking at Plan Finder and thinking about this market, it's enormously complicated for anybody, even the people sitting around this table, to make a plan choice, and we understand in great detail how these benefit packages work. So I am very supportive of moving in this direction.

One thing that I was trying to get some sense of, as we kind of look at the world as it currently exists and why there are so many benefit packages out on the street

today, is it strikes me that the health plans are somehow or other trying to slice and dice this market and engage in some kind of selection activity. And I don't feel like I saw enough discussion of that in this draft, and I'm wondering whether, you know, if we're trying to think about sort of why we need to make this change, whether we need to be talking about selection issues and sort of their downsides as well as maybe the potential benefits, because I would assume the plans would assert that they're giving people more choices and that they can tailor their choice to a specific set of health care needs, so that's something that I think it would be helpful to have more discussion about.

MS. KELLEY: Dana.

MS. SAFRAN: Thanks. This is great, a great chapter and great discussion so far, even though it's only Round 1.

[Laughter.]

MS. SAFRAN: Three questions, two of them about supplemental benefits. I think my understanding of the biggest challenge that beneficiaries have with respect to choosing Medicare Advantage plans is the relative

complexity and opacity of the supplemental benefits. So I'm just wanting to understand why we're choosing to keep that out of scope for this work as we begin it.

MR. ROLLINS: It is not out of scope. The topic is simply too big to give two in one presentation.

DR. CHERNEW: We wanted to start with the easier one.

MS. SAFRAN: Oh, okay.

DR. CHERNEW: So we're going to have a whole -- I don't know whether it's October, November, or actually September.

MS. SAFRAN: Oh, okay.

MR. ROLLINS: November.

DR. CHERNEW: So, in November, we're going to have a version of this, where now you're going to be primed with all of this stuff, but we're just going to focus on the supp benefit side.

MS. SAFRAN: Okay.

DR. CHERNEW: It's just doing it all together was too much.

MS. SAFRAN: Gotcha. Thank you.

DR. CHERNEW: And starting with the simplest one

seemed the right way to go.

MS. SAFRAN: Thank you. Okay.

Second question. I think I know the answer, but I'm just making sure. When we talk about the actuarial value of the MA plans, it does include the value of those supplemental benefits, right?

MR. ROLLINS: I mean, it depends on what purposes you're doing, but yes. That's one of the appealing factors that an MA plan is going to offer.

MS. SAFRAN: Okay.

MR. ROLLINS: We cover additional things that you can't get, so that's part of their value.

MS. SAFRAN: I didn't hear you on that last part.

MR. ROLLINS: Yes. We would -- and that's part of the broader discussion about sort of, you know, what MA plans offer that fee-for-service does not.

MS. SAFRAN: Yeah. But I just meant, like, when we are computing A/B for a Medicare Advantage plan, we are considering not just the clinical benefits but the supplemental benefits being offered. Is that correct?

MR. ROLLINS: I think that's maybe. So you could envision -- again, this is very early stages.

MS. SAFRAN: Mm-hmm.

MR. ROLLINS: You could envision a somewhat different set of policies for A/B services where all plans are covering the same thing.

MS. SAFRAN: Mm-hmm.

MR. ROLLINS: And maybe, to Kenny's point, maybe there's some actuarial values tied to that, but they might be more specific to just like what do we see plans do now to buy down Part A and B cost sharing. You could envision, again, very early stages, some sort of separate set of requirements for the supplemental benefits where plans aren't required to cover dental. Plans kind of pick and choose what they want to offer.

So that's why I kind of hesitate a little bit because I think you might want to think about these two sort of broad categories differently.

DR. CHERNEW: Operationally, coming up with actuarial values that include some of the supp items like needles, I just don't think we have an actuarial value calculator designed in a way that would give us a really good sense of that.

MS. SAFRAN: Mm-hmm. Yeah.

DR. CHERNEW: So I think the right way -- we are going to have a complicated meeting in November.

MS. SAFRAN: Mm-hmm.

DR. CHERNEW: Let's schedule four hours for this session.

[Laughter.]

DR. CHERNEW: But at least even -- right now, just so you understand, even for our gauge here, you can tell this is the simple -- this is the sort of most accessible version of this, and even that raises a whole slew of questions.

So I think when we add in supp coverage, there's a question of would you have very specific plans for what they are and what units would there be, but I'm not going to belabor that because that's a November belaboring point.

MS. SAFRAN: Okay. Final question. So -- and this is really prompted by a point that Kenny made that was something I personally hadn't previously known, which is the differences across states in the way that standardization is done. So I'm curious -- maybe you know, or maybe, Kenny, you know -- whether there's been any leveraging of that natural experiment to learn how much it

does or doesn't -- how much different ways of standardizing do or don't help consumers with making rational choices that are in their best financial interest.

MR. ROLLINS: In some states, you cannot do the natural experiment because they have always had -- so like California has always had standardized plans. They never switched from one regime to another.

The one paper that I touched on in the mailing materials -- and Mike knows this well, I'm sure -- is sort of when Massachusetts switched from kind of a -- more of a -- forgive me, Mike -- everything-goes approach to more of a standardized approach, sort of what the impact of that was. And I think the paper found that the share of people who chose more generous plans went up. Enrollment in the bronze plans went down, and the market shares for the insurers kind of moved around a bit. And it was a combination of, you know, it was easier for beneficiaries to understand how plans differed, and so that seems to have led them to say, "I would actually like more generous coverage than I had before."

And, also, with the standardization requirements, which I think we're a little bit -- I think in

Massachusetts, Mike, you were required to offer all of the particular packages. You had insurers who offered plans that weren't on the market before, and so that helped contribute to some of the shifts in the market shares.

DR. CHERNEW: The anecdotal -- I think you can go to Amanda Starc's paper, but the anecdotal view, at least from the staff at the Connector, the standardization was really central. And if you were to talk to John Bertko or to Peter Lee in California -- Cheryl, you probably have talked to them -- they say like the success of the California exchange reflects a number of things but including -- and they would put this high on their list in terms of experience of the navigators, experience of patients to know the extent to which the plans -- one thing I didn't mention and what problems to solve, the ability of plans to use benefits to drive a selection can diminish if you deal with some of these things.

So that's sort of the anecdote, and I think there's still a lot of other issues; networks, for example. What is a standardized needle thing? But for the most part, I think the gestalt is reasonably posited in places that have gone to standardization. And I don't know any

places that have gone to standardization and then gone back.

MS. KELLEY: Scott, I think you have the last Round 1 question.

DR. SARRAN: Yeah. A comment leading to a question. So it seems to me the public policy goal overall here is how do we help promote transparent, innovative, competitive marketplaces that enable beneficiaries, even assuming they're aided by a navigator. And I bet everyone around this table has served as an informal navigator, with much attending frustration. So how do we enable beneficiaries to make good choices?

And if we went to something like what you've got on slide 13, we've already left four variables on the table, right, in terms of choice, quality, service, presumably stars is reasonable, and potentially improving proxy for that. Network and plan type, who's in the network, HMO, PPO, that's second. Third is supplemental benefits pending our later-in-the-year discussion, and fourth is the tradeoff of premium up front versus out of pocket. That's four variables. Nobody can keep track of five.

MR. ROLLINS: So I can't mention Part D formulary?

DR. SARRAN: Thanks. Oh, thank you. You're right. Part D formulary.

[Laughter.]

DR. SARRAN: So you've already got five.

So my question is why wouldn't we push the lever? If we said, look, leave those five, why wouldn't we push the lever maximally towards standardization? How could you argue for a sixth set of variables, which is what currently exists?

DR. CHERNEW: Okay. I apologize. I'm going to in the future let Eric answer more.

MR. ROLLINS: No, I was just going to say that feels very Round 2 to me.

[Laughter.]

DR. CHERNEW: Many of the variables you mentioned, like Part D formularies, is an infinite -- well, not infinite, but there's a ton of drugs. So we're never going to get this right.

I think the argument against standardization -- and I think I'm dying to hear where Kenny is in the queue

here. I think he's second in Round 2. So I'll just say there's real benefit in innovation, and if the government gets it wrong, you end up saying something like, "I want a plan that looks like blank, and you won't let me buy it." And there's just something viscerally problematic about constraining people's ability to work in the market to get things and to tell a plan -- I've done a lot of work on value-based insurances. Say the standardized plan says you have to pay $35 for your insulin, and some plans say, "I want to come in at least just for insulin, make insulin $10," right? Do you say, "No. I'm sorry. You have to charge $35?" And so I think there's this tension of -- that whatever plans you standardize to, someone is going to come up with a plan that they think is better, and then you're in a situation where you're telling them they can't have it. That's the discussion.

And so the tradeoff that you made is one anchor of the Round 2 version of that discussion, and I hope I outlined the other anchor that now we'll hear from all of the people. And I think we're going to start with Stacie, and then we're going to hear form Kenny. And I've been waiting for two weeks to hear from everybody on this, so go

on.

Stacie.

DR. DUSETZINA: Thank you.

I am super supportive and enthusiastic to pursue this over the next decade from what I'm hearing.

So I will just echo maybe what Cheryl had mentioned about how hard of a problem this is when you're shopping. I tend to come at this like looking through the Medicare Part D Plan Finder, and I'm concerned even when you start there. You don't really know about all the other benefits.

So I love this set of kind of example, cost sharing for standardized benefit package, but the thing that just kind of sticks out to me and the thing that I'm like -- I would have to know about the network adequacy at the same time because I feel like if that's missing, it's like, yeah, you know, if you said you can get a specialist office visit for $20, but P.S., there are no specialists in your network or in your area or something, you know, like that is something that I feel like is really difficult for plan shopping. I get that there's, you know, a lot of moving parts, but to me, when I think about advising

somebody about MA versus fee-for-service, that's what I'm thinking about is like what does the network look like for cancer care, what does the network look like for other specialty care, and if that's not visible, it makes it really hard to make the right plan decision for you. And this is kind of a hard decision to change over time.

So I would really love to see more of that information brought in as we think about standardizing.

MS. BARR: Isn't the point to give them a couple things to look at and then dig into, to give them a starting point as opposed -- you know, so I'm not assuming that this is like this is all they get and they don't know anything else, but it's like, okay, well, this plan looks good. Let me look at the network. Okay. Well, I'm --

DR. CHERNEW: Now we're getting into Round 3, which I'm going to prevent.

So I think you made your point. I don't know if Eric wants to respond. We have roughly 25-ish more minutes. We have a lot of people in the queue. I know this is the first meeting of the year. We're going to go through the model of say your piece, take two, three minutes. Hopefully, we'll get through to where we can have

that kind of exchange and discussion.

MS. KELLEY: Kenny.

MR. KAN: Okay. This is great work. It's on a very, very complicated topic. I have three initial impressions that probably are best summarized by the three C's: CMS, contextual differences, and competition.

So CMS. What is the problem we're trying to solve here? Is it one of simplification? Because it appears that CMS is trying to increase competition and have more innovation, and that's why, like what Stacie mentioned, they did away with meaningful difference, effective in 2019, which basically, I suspect, contributed to the big jump in the number of choice of plans.

Second, contextual differences. I realize that standardization may have worked in ACA and Medigap, but there are two key things to be mindful of in both markets. In the ACA, you have a bronze metal level that's 60 percent actuarial value, which means then the member pays 40 percent cost-sharing. Bear in mind that many seniors are on a fixed income so they cannot have unexpectedly high cost-sharing because they have a limited pathway to make up for any financial catastrophes from very, very high medical

costs. So something that we want to be mindful off. It may be very hard to implement ACA-like cost-sharing in MA.

And then on Medigap, one thing to be mindful of is that Medigap basically pays what fee-for-service does not pay. It's roughly 20 percent. So when you look at MA, you're looking at 100 percent. So we have to be mindful of unintended consequences because you could have five times the ripple effects.

So in terms of the potential ripple effects, something that could be an unintended consequence if we do not implement this correctly is that I actually believe that standardization could actually reduce competition. Three observations on that. Why? Well, one, like what Marge pointed out, and Amol has pointed out, there is huge geographic cost variation. So any national standard plan will create winners and losers in geo-regions because of the huge, enormous cost variation. So in a lot of geo-regions, I suspect that the small plans would drop out. The big plans win.

Second, I know that we're trying to simplify choice for the 2 million MA members that pick MA every year, but don't forget about the 25 million existing MA

members. So if the plans that they're currently in don't match one of the three plans that's on here, does that mean then the health plan actually has to basically have duplicate systems to track two different plans, two different frameworks? I mean, this is what has actually happened in Medigap. So this increased costs in the overall system, so something to be mindful of.

And third, if we actually standardize some Parts A and B, and I'll reserve judgment on what happens to supplemental benefits when we have the four-hour discussion in November, it makes it much harder for the smaller plans to differentiate themselves. I mean, because you now have very limited risk selection, price, you know, it's a function of scale, or brand equity, like the AARP. So if small plans have a much more difficult time to differentiate themselves, they cannot grow, and if they drop out then possibly the big plans win and gain more share.

So just points for consideration.

MS. KELLEY: Lynn.

MS. BARR: Great chapter. Thank you so much. I think I'm very, very excited about this and fully endorse

this for the sake of the beneficiary, and I think that's really the thing we need to think about the most. It is impossible for them to evaluate the options today.

I feel like we should move towards not a mandatory program but a voluntary program. The current broker system is broken. It is so old. And that's how people that don't have the benefit of the navigators are being sold, and they are not being told the truth, and we see it all the time.

And so if we had any opportunity to funnel people into a simple system, again, they can have all the other plans they want on their own and use all the brokers they want. But allow them to have one place they could go. I think the plans would do it because they would save the broker fees, and there's a huge financial incentive for them. I mean, when I was looking at broker fees it was like $600 a patient. And if I could actually get patients in my plan, just by joining this, I would definitely put my plan into this and I would find a way to make it work.

So I think there's a way that we have help the plans and we can help the patients, and I really encourage us to pursue this work. Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. Eric, thank you for the clean presentation. I think this is directionally correct. If you have a dizzying array of choices regarding plans it's like having no choice at all because it's very difficult to really land the plane. Your report had mentioned probably in the order of 5 to 10 choices, which are certainly more reasonable than 36 different choices.

I will say, though, that it does feel very transactional, though, because at the end of the day, very similar to Stacie's comments earlier, you want to make sure that you can access the plan that you signed up for. And I don't think there is really, that I could see within the report, anything that speaks to access to care for whatever plan that a beneficiary chooses, and I think that's critically important.

And not to boil the ocean but you could start with primary care, for example, because primary care is really critical for the referrals, coordination with specialists, how the preauthorizations go. Because if you don't have access to your primary care physician then it's going to be very difficult to go to the next steps

regarding specialty care and other diagnostics and treatments as well. So I think that's important.

The other thing is if we're going to consider access to care what are the best models and standardized plans that would leverage that, and should there be standards for these plans to meet with regard to access to primary care, and if they are not meeting those standards should the beneficiary know that they're not meeting those standards so they can make a more informed choice?

I think there is an opportunity here to actually have discussions around this particular issue of standardizing plans to meet a larger strategy regarding access.

MS. KELLEY: David?

DR. GRABOWSKI: Thanks, Eric. This is great work, and I'll also add my name to the list of folks here who are very positive and enthusiastic about the use of standardized benefits.

I do think the illustrative examples are a great start. I prefer matching cost-sharing amounts versus matching metal tiers of similar actuarial value, if that makes sense. I do kind of like the way it was set up in

the chart. Obviously, that's just an example.

In terms of how to treat existing plans and enrollees, I do think ultimately you don't want to create this two-tiered system by grandfathering individuals or plans into existing arrangements. I think you'd have to have an onramp, maybe setting up standardized benefits to kind of match what's out there in the world and then gradually transitioning individuals into it. But I don't think you want this sort of two-tiered system of new enrollees and existing enrollees. I don't like the idea of having kind of non-standardized benefits in the markets. I guess I'm pretty far along this continuum.

Two final comments. One is on special needs plans. Eric, as you noted well, cost-sharing makes a lot less sense here given the role of Medicaid covering this for the duals. That's going to make this second conversation we have really important about supplemental benefits for the duals, because that's really what's driving a lot of the choice across plans. And so I think that's going to be a really important dynamic there, and that's even made more complicated for the SNPs.

Final comment, and several have touched on this,

we've done research on Plan Finder, especially related to Part B, but it's a mess. I still think there's been some improvements, but in addition to putting folks into standardized benefits are there ways to better direct beneficiaries to the plan that best meets their needs? We can make this simpler but we can also improve the overall tool.

Thanks again, Eric, for a great chapter.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks. Eric, this is really tremendously great work. I'm very enthusiastic in general, and I also want to articulate broad support for pursuing this work.

I agree with much of what my fellow Commissioners have said and I think probably have some tweaks or nuances in terms of how I think about this. I think we are relatively fortunate that there is an evidence base for us to be building off of, and you've done a shop of citing some of that evidence, and I think that should be the scaffolding from which we sort of launch into this work, and I think that's really fundamentally important.

A couple of the elements to highlight there, I

think, generally, as you pointed out, there are benefits to consumer choice, better choices in the context of some kind of standardization. So I think we should definitely be building off of that. I think there is general evidence that suggests that competition is better with some degree of standardization. I think it's important to note that. Selection effects are another reason to think well at this.

That doesn't mean that we need to throw out the concepts of innovation and flexibility. My sense is this is not a binary choice between you have to have extremely standardized plans and that's the only thing that we can have, versus not. And I think that's important to recognize in the context of the transition points and in the context of some of Kenny's points as well, in terms of heterogeneity across markets.

And I think one thing for us to be really mindful of here is relative to Medigap, for example, if you look at -- and I think we could probably do this, empirically -- look at the panoply of different benefit designs that do exist for MA, particularly once you start to blend in the supplemental benefits, it's just going to be much, much broader and wider than you're going to likely see in

something like Medigap.

And so I think we should be careful. I think we should be standing from the scaffolding of evidence that we have, based on these other markets, but we should be careful from obscuring the differences or conflating the differences that might exist between what is a supplemental plan and what is a basic primary plan that also comes with other benefits in terms of premium rebates and other things like that. So I think it's just important for us to keep that in mind.

According to that -- so a second point -- I think as we talked about in Round 1, it would be helpful to have some additional analyses to look at what is intra-market or intra-region variation versus not. I would put in a big plug for that.

Third point, so along this point about standardization doesn't necessarily need to be binary, I think, again, I want to articulate broad support for this approach but I think we should be exploring what standardization could mean and, in fact, the degrees of freedom that we have here. So just to paint a different picture in some sense, you could imagine that there are

five different archetypes of Medicare beneficiaries in terms of how they tend to utilize care, and instead of using something like actuarial value, which is probably Greek to most beneficiaries, if we actually look at those archetypes and say, "This is how much you're spending. It looks like this. This is how much you would spend under this plan." I'm just using this as an illustrative point.

There are ways to support consumer choice without mandating three specific benefit designs in terms of the cost-sharing amounts. And so I think we should explore some of these degrees of freedom. And I'm not trying to broaden the work too much, but I think that's an important area for us to be thinking about is what does standardization mean and how can we retain some flexibility there for plans to develop some choice, innovation, et cetera, et cetera.

And the last point, I think that also touches on this point of the transition, say, from the existing system and the potential for non-standardized benefit designs, for example, that would allow us some flexibility to either offer a transition point or even offer the ability for individuals to keep plans. And I think there's a data-

driven approach -- I think David mentioned this to some extent -- which is we could look at where the preponderance of beneficiaries are in terms of the plan designs that they are selecting, and we could start from there, as a launching point. So I think there are some data-driven ways that we could do this that would borrow from approaches that Mike mentioned in Medigap as well.

So thank you. That being said, I'm very excited about this work. I think it's fundamentally important to protect the beneficiary, particularly as we enter the November conversation on supplemental benefits as well.

MS. KELLEY: Greg.

MR. POULSEN: Thanks much. You know, I guess I'd begin by saying that many innovations that we've seen in the past have resulted in the improvement of the program, and I guess would argue that if we had had this discussion a decade ago and frozen things at what we thought was the best program at the time, it would be very different than what we would likely do today. I think that we need to be mindful that we don't freeze out potential future innovation that we would find very beneficial.

I think it's very difficult to get innovation

through consensus, and even worse, consensus that has to go through a bureaucratic process. And I think we would likely find that to be the case, whether we're talking about payment mechanisms or whether we're talking about benefits.

We lose the ability to have laboratories for innovation, which is something that I think we found tremendous valuable. I suspect we have a great deal of information that gets exchanged about what works, what doesn't work, and that happens because things are tried, some are found to be wanting, some are found to be very successful and useful. And so I think that's obviously true for supplemental benefits, but I think it's also true for payment.

Innovative payments supplement, after all, the way that benefits are provided. There are some of the supplemental benefits that really only work in various payment mechanisms and would be hamstrung, to a significant degree, if payment changes weren't part of the alternative.

Payments for innovations like telehealth, hospital at home, automated care innovations, and we could go on and on, that are all sort of part of the current

program -- I'm not talking about real changes in benefits but notifications to the way they're provided -- often very much depend upon the payment mechanisms that encourage or discourage their use.

I think that various payment mechanisms encouraging healthy practices and behaviors can be incredibly important in the way that care value is achieved, and I think that different organizations find that different mechanisms are effective. I think a lot of folks would consider my organization and Jaewon's to be similar in many ways, but I suspect if we identified what we thought was the most effective mechanism for payment we wouldn't necessarily agree 100 percent, and we would find that the organization yields a different performance mechanism based on the payment mechanisms, and vice versa.

Let's see. I think that some of the things that might be worth considering, for instance, are the big differences that would be a difference. We find enormous differences in rural and urban communities, and the payment mechanisms that are most effective in one are not nearly as effective in the other. And that's within a single organization within a single, what I think a lot of people

would consider to be a common geography. And so I think we'd lose potentially some of those capabilities.

I strongly believe that broad standardization, especially if the only plans that are offered would do real harm to the beneficiaries and would stifle beneficial innovation, if we're not extremely careful about how we do that.

I have a number of questions from folks around the country. When we do something innovative, including places -- I can speak with certainty that we get questions from California asking, you know, how did this work? We haven't done that. Is it something that we should be considering? I may have gotten them from Massachusetts. I can't say for certain.

But I think that the ability to try something that's a little out of the box and find out whether it works or not is great as opposed to having an academic discussion and then innovating it for lots and lots of people, which I think is a high-risk kind of an approach.

Let's see. We'll get going on supplemental benefits later, but I guess I think that it's incredibly important that innovation not be stifled because I think

we've learned a lot.

And again, I'd close with what I started with. Were we to define what we think is the ideal benefit package today it would be very different than what I think we would have defined as the ideal benefit package a decade ago, and it's the change in innovation that has been explored by individual organizations that would've led to that change.

So thanks very much. And by the way, I wanted to reiterate. I think that the chapter was incredibly well done, so thanks to the team.

DR. CHERNEW: Just a time check. We have five minutes. We'll go a little bit long. We have, if I got this right -- one, two, three, four people left in the -- five people left in the queue. So I'm not going to cut you off, but just saying. I think --

MS. KELLEY: Jaewon is next.

DR. RYU: Yeah. So just a few thoughts. I think a lot of good points made already.

I like the concept as well. I think simplification, it seems a little bit like there's just a morass and it's very difficult to manage for consumers and

beneficiaries. So I think there is a strong case to be made for simplification.

But there's a balance to strike, and I think it's a tricky balance, to be honest, for a lot of the same reasons that Greg was hitting at. But one of the items that comes to my mind is because these dimensions play off of each other, they interact, and some of these dimensions are not standardizable.

And I think Stacie raised what I would say is one of the best examples, which is network. There are a lot of places in the country or pockets, markets, organizations, that come from a world where you can drive a lot of value-based care models with very closely managed networks. Some people may even call them "narrow networks," and in those networks, you could even get to benefit structures, where you'd have zero-dollar copays not just for primary care but even specialty care. That's an example of the kind of benefit set that would only be able to be pull off-able, if you will, in those settings, that if that wasn't part of the metallic tier, those organizations would not be able to drive those care models.

So I think there's still a way to strike the

balance. I don't know what it is, but I think maybe one of the things you hinted at in the reading is, to the extent you have standardized benefits or some part of the market that's standardized -- and maybe that's even mandatory -- preserving the ability for folks to offer plans outside of that standardized world, I think, would maybe come closer to striking that balance.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you.

I also appreciate this chapter, and I think this is essential work for all the reasons that have been mentioned. I think we're all pretty confident that a lot of people have stuck with plans that are not the best one for them because it's just too confusing to do something different.

So my initial impression was kind of aligning with the sort of metal-level idea where there's different cost sharing and the companies would have the capacity to stack those differently. I think that gives some opportunity for innovation, preferring that over the very detailed kind of, you know, menu.

Although I was very intrigued by the idea Amol

raised about possibly having these not along metal levels but patterns of usage or something that would make more sense.

So I'm more on the side of having a little bit broader packages that could be put together in different ways, even that creates more -- maybe more confusion.

My initial instinct around the non-standardized is no. However, I'd be reluctant to think about a voluntary system. So, if it's the tradeoff between those two things, then I think a non-standardized would be okay.

I don't know if -- you know, he mentioned -- David mentioned the grandfathering piece, which could be problematic, but is there some way it could be a transition rather than a grandfather?

And then, finally, I will really need a lot of information to better understand the one question. Would insurers be able to offer plans with the same package but different provider networks? I can't even put my brain around the ramifications of that and the positive consequences or the unintended consequences.

I know we have a lot to do. I think this is very exciting, and I'm really pleased we're taking it on.

Thanks.

MS. KELLEY: Dana.

MS. SAFRAN: Thanks.

Just a couple of thoughts and really building on what others have said. I think, you know, to boil it down to its essence what standardizing hopes to achieve for beneficiaries is the ability to choose across plans and have as much as we can do and everything held constant other than price, so they can choose on price, and many of the comments have pointed out the challenges of doing that.

So one thing that I would say -- and it's sort of aligning to something David said -- is I think that standardizing based on cost share and benefits as opposed to actuarial value comes much closer to that ultimate goal of, you know, you can look at these things and know they're all the same, other than price.

Similarly, with respect to cost sharing, coinsurance is such a black box. We know that consumers don't understand it, and also, 20 percent, as I think has been pointed out, doesn't mean the same thing with different contracted network values for the consumer. So I'd say really getting to copay standardization as opposed

to coinsurance standardization gets us close again to that ideal standard.

I think also that many of the other ways that we've talked about that the plans might vary, that make it hard to hit that gold standard of everything is the same except for price, can be captured by sharing patient experience data. To the extent that a plan is very heavy-handed with utilization management or has really limited networks, that should be showing up in what other members are saying about their experience with the plan, so thinking about how we can make sure that patient experience data are very visible in whatever the plan finder tool is going to be, I think, could be very valuable, but also really making it clear to people in that tool that networks will vary and make sure that, you know, your doctors, your preferred hospital are in network for the plan before you choose it, I think, helps to solve for some of the things that have been brought up.

And my final thought, which I think is -- well, actually my second final thought, which I think is probably not feasible, but I'll just throw it out there is whether we as MedPAC might be able to do any kind of consumer focus

groups as we're toying with different ideas just to get some input. It's one idea, but ultimately, I think CMS could do that work.

My last point that I wanted to make was just along the lines of what both Greg and Jaewon said. I do hope we can do this in a way that preserves the opportunity for innovation because, otherwise, I just -- for all the reasons, that makes sense, right? And I don't know whether that's there's parallel offerings that aren't standardized or whether, you know, most things that are standardized in some plans also tack on some innovative ways of doing things or offering additional things. I don't know, but I would hate to see us have the entire country having to move in lock step and not being able to have that innovation in Medicare Advantage.

Thanks.

MS. KELLEY: Marge.

MS. GINSBURG: I'm torn. I was tempted to just say I'll save my comments till next time, but of course, I can't save my comments.

[Laughter.]

MS. GINSBURG: So Stacie brought it up, and so

Dana also mentioned this bit about the provider network. I can only speak to my own experience as a counselor. If somebody is just turning 65, they're a newbie. The first question is always, do you have a regular physician now? Is there a particular network you want to stay with? Great, okay. Now we focus on the plans that have that network.

The second question is all around Plan Finder. As weak as it is, it's pretty good for identifying whether they're going to have any problems getting their drugs covered. So that's sort of issue number two, and then we move on to the plans themselves.

My initial reaction in reading this was not enthusiastic because I just felt the chances were slim that Congress was ever going to do anything we recommend here, but I have warmed to this.

[Laughter.]

MS. GINSBURG: And I actually really do think the public would love this, would love this. I don't even think we need to have a transition period. We'd give them two years' warning, at least a year warning about what's coming, and then if you want to stay in the plan you're in

now, here's what they have to offer. Give people plenty of time to work through and see if this is what they want.

But I wouldn't be enthusiastic about keeping the old with the new. I think we transition to the new with plenty of time for people to learn it and move on. I don't think this is all that radical, actually, in terms of what we're asking the public to do, and I think in terms of it making life potentially easier for people making decisions about what level of cost sharing that they can live with.

So I've turned the corner. I'm enthusiastic. Thanks. Good job, Eric.

MS. KELLEY: I have Larry last.

DR. CASALINO: So I came into this quite enthusiastic about the idea of standardizing, but I have to say listening to Kenny and Greg and Jaewon and Dana makes me think I want to think a lot more about it.

Simplifying choice, as we've been emphasizing, there's a lot of good reasons for that, but Cheryl appropriately brought up selection. And, Eric, one thing I think would be great for the future would be if we could know if there is evidence and if there is, what it is, about the ways that plans use their benefit packages to

drive selection in ways that we wouldn't like. So I think that would be useful to have.

I'm very concerned here -- Kenny made a point, and I don't want it to be lost -- that this could lead to more consolidation on the insurer side if done carelessly. I'd be concerned about that.

As the discussion went on, I think the idea that networks could be standardized -- networks, that's the patient's first question: Is my doctor part of this? Is the hospital part of this? Being able to measure networks nowadays, the network, who's in the network is not very reliable, and that doesn't tell you what access really is, right? Yes, you can see your primary care doctor in three months kind of thing. So I find it hard to see how a network can be standardized. You can't standardize just by size of the network.

And standardizing supplemental benefits, that would be hard even now, but doing it without hurting innovation, I can't see that. So that all has made me rethink my position a little.

And the last thing I'll say is that, as Jaewon was talking, I think he hinted at this, and I think, Eric,

you talked about this in the chapter, but we haven't really discussed it. When you talk about some kind of hybrid, I basically thought that's kind of ridiculous, but now I'm not so sure. You could have a thing where you had three standardized plans. We can talk about whether that means standardized supplemental benefits as well. But, anyway, for people who want to have fairly simple choices, they know they're getting a pretty good plan. It's one of the three standardized plans. They can count on it that they're not making some enormous mistake, and it simplifies their choice. They can do it.

And then you could potentially have -- and I think you suggested this as a possibility, Eric -- non-standardized plans, that people who really want to dig into this and deal with the complexity of choice could try it. The only thing -- well, I haven't thought this through. There's probably lots of arguments against this, and particularly if non-standardized plans would even more in this kind of situation foster selection in ways that we wouldn't like, that could be a problem.

But, otherwise, that option, that kind of hybrid option, which I thought had no value, maybe it is worth

some consideration. Particularly, Greg and Jaewon's comments were making me think that.

MS. KELLEY: Cheryl?

DR. DAMBERG: Thanks.

So I really appreciate the comments about innovation, and I do think as we proceed with this work, we need to fully consider not only benefits but potentially some of the downsides of moving in this direction. So that was really a helpful set of comments.

I think what I was trying to sort -- and, Michael, you had mentioned that -- I don't know. What was it? -- 60, 80 percent of people, and I think you were talking about supplemental plans are in like two plans. Is that right?

DR. CHERNEW: Medigap.

DR. DAMBERG: In Medigap. But, like, do we have any comparable figures on the MA side? Like, are people clustered in -- I don't know -- two or three kind of general plan types today?

DR. CASALINO: I think Amol's point that supplemental benefits are different than what Medigap offers, though, is more complex.

DR. DAMBERG: Right. No, I guess what I'm trying to figure out per slide 13, I know these are sort of hypothetical, but, like, if we were to look at where people have sorted today, do they fall into a couple of buckets, or do -- does 80 percent of the market fall into, like, sort of two broad categories?

And just to sort of understand where people are today, part of me is concerned about that because I think we're recognized -- and the literature demonstrates this -- that people aren't making the best choices for themselves right now, and I still think we need to move in this direction, and I support moving this direction to help people make better choices, given their set of circumstances.

DR. CHERNEW: So we are now over. Kenny, you are going to get the last word, but you're only going to get 60 seconds for the last word. So you have a very limited timeline. Then we're going to take a very quick break, and then we're going to go on to talk about MA.

MR. KAN: I just want to echo what Larry just said, which is basically what I hear everyone saying. You want to strike for some balance to maintain the innovation,

and that's why, back to my earlier Round 1 comment, page 13 for future discussion, could we possible include a package for where you put some parameter around it because, to Larry's point, if you have too much non-standardized, then you end up with the same conundrum that you have right now. But maybe you have a parameter like an actual value, suggested actual value on that. That would be the guardrail.

DR. CHERNEW: Okay. I'm going to, in the interest of time, spare you any wrap-up. We will certainly take all these comments back. This is the exact type of conversation you want for the first session, introducing a new topic. So, Eric, that's a terrific job.

Actually, we're scheduled for a five-minute break. What I think I want to do is not have sort of a formal five-minute break. I want to do this what used to be old-school style, Hackbarth era, for those of you that remember that, which is if you need to take a break outside for a minute, take a break outside and then come back. But I think we're going to wait maybe just -- let's just wait like two minutes, and then -- is Eric next? Luis. So Luis is going to just start talking.

I'm going to go away for about a minute and 20 seconds, and then I'm going to come back, and Luis is going to start talking.

[Pause.]

DR. CHERNEW: Okay. Now I see people coming back, and, Luis, time to start talking.

MR. SERNA: Good afternoon.

Today's final presentation will be on Medicare Advantage encounter data, which follows up our published work in 2019 and 2020.

This material is informational and will not be published in our March or June reports this cycle, but we do seek your feedback on future work.

We'll begin with background on how the encounter data came to be collected and the impetus for our 2019 recommendation.

We'll walk through an update on some of our analyses to validate the data, and finally, we'll summarize the current state of encounter data and potential future work.

MA encounter data began with the BBA of 1997,

which required the collection of encounter data for inpatient hospital services and permitted the Secretary to collect encounter data for other services. However, those efforts were abandoned after plans responded that submission of the data would be an excessive administrative burden.

In 2008, CMS amended the MA rule to resume collection of detailed encounter data for all Medicare services for risk adjustment and other purposes.

In 2012, CMS began collecting such data from plans to start incorporating as a source for MA enrollee risk scores in future years.

Beginning in 2022, 100 percent of diagnoses for MA risk scores come from MA encounter data. However, encounter data continues to be an incomplete reflection of the services used by MA enrollees.

Detailed encounter data are essential for program oversight of the care provided to the nearly one-half of Medicare beneficiaries that are enrolled in MA. Without valid and reliable data, there is limited understanding of how MA payments to plans correspond with service use, quality of care, and the provision of extra benefits that

plans use with their rebates.

In addition, administering the MA program requires the use of disparate data sources, including many siloed single-purpose data submissions from plans and providers. Complete encounter data could assist or even replace various data collection efforts and would ensure that the program relies on data that are internally consistent and conform to program rules.

Finally, plans have the flexibility to implement practices that could allow them to provide care more efficiently than traditional fee-for-service, such as utilization management, value-based insurance design, and beneficiary incentives. Encounter data could potentially inform how these techniques are employed and help Medicare policies more broadly.

Despite the importance of encounter data, the data have been incomplete, and current incentives have only resulted in some incremental improvement.

The feedback CMS provides to plans regarding their encounter submissions only contains information on total record submissions per beneficiary. Plans are given report cards that compare their total submissions to

regional and national averages. These report cards do not contain comparisons with external data sources. In addition, CMS does not assess or require any consistency between plans' encounter data and other data that plans submit, such as HEDIS quality data, bid data, and medical loss ratio data.

Encounter data are used to identify diagnoses when CMS calculates MA risk scores, but this only provides an incentive to submit some inpatient, outpatient, hospital, and physician records. In addition, there is less incentive to submit records for other settings that are not used for risk adjustment.

The Commission previously found that encounter data from 2014 to 2017 were incomplete and were only incrementally improving. To accelerate the pace of that improvement, in 2019, the Commission recommended additional steps to increase encounter data completeness and accuracy.

The recommendation directed the Secretary to establish thresholds for the completeness and accuracy of MA encounter data, rigorously evaluate MA organizations' submitted data, and provide robust feedback. In addition, a payment withhold would be applied and CMS would provide

refunds to MA organizations that meet thresholds.

Finally, the recommendation included establishing a mechanism for direct submission of provider claims to Medicare Administrative Contractors, or MACs. One provision was that if program-wide thresholds were not met, the recommendation would require all MA organizations to submit claims via the MACs.

We've now updated some of our evaluations of the completeness of MA encounter data through 2019, which previously informed our recommendation.

While adequate program oversight and administration of the program require data for individual services that beneficiaries receive, external validation of the encounter data at this level is typically unavailable. Instead, we are often limited to more broadly verifying whether the same enrollees are identified in both the encounter data and the external comparison dataset during the same year.

The three comparisons shown here use external data that are derived from information reported by home health agencies, dialysis facilities, and hospitals. These comparisons only assess whether an MA enrollee identified

in these external data sources has any encounter data for that service during the calendar year.

The blue dotted line indicates the share of matching home health users. The matching home health users has shown clear improvement, but as of 2019, 12 percent of home health users in OASIS data still do not have an encounter record.

The green dashed line shows that 95 percent of MA enrollees identified as dialysis patients in risk adjustment data had a dialysis encounter record. This number has shown incremental improvement over time.

Finally, the share of hospital users, the white line, has increased to 97 percent in 2019. However, the match rate drops significantly when we include dates of service in the comparison, a much more useful measure.

Hospital-reported data in MedPAR allows for a rare opportunity to validate service-level data for MA enrollees. When we compare MA inpatient stays matching on beneficiary and dates of service, the match rate of encounter records has hovered around 80 percent since 2015. These results show that potentially 20 percent of MA inpatient stays in MedPAR are either inaccurate in the

encounter data or missing from those records. However, we also find that MedPAR and other external sources of MA utilization information are also incomplete.

It is increasingly clear that using a single data source does not give a clear understanding of MA service use. Combining data sources helps to understand how much data could be missing but still may not be definitive.

For example, the use of MedPAR alone to assess inpatient admissions could potentially omit 24 percent of MA enrollee admissions. Likewise, using only encounter data could potentially omit 16 percent of MA enrollee admissions.

Even simply knowing whether a beneficiary had any service in a particular care setting during the year is problematic using only one data source. Only using external data sources would potentially omit 0 percent of beneficiaries in the inpatient setting, 9 percent of beneficiaries undergoing dialysis, and 25 percent of beneficiaries who received home health services. The limitations of current data sources underscore the importance of having complete and reliable encounter data.

Overall, encounter data are incomplete but

generally incrementally improving. Consistent with our 2019 recommendation, CMS could do more to more to validate the data and hold plans accountable for incomplete encounter submissions. In addition, CMS could assess the consistency between encounter data and other plan-generated data such as HEDIS and bid data.

For Part B encounters, we have determined that independent data sources are limited for data validation. Going forward, to develop metrics for these services, it may be necessary to identify physician encounters through subsets of these services, such as using Part D event data and inpatient data.

Even at its current state, it may be possible to leverage the encounter data when examining patterns of service use or combining the encounter data with other external data sources. Over the next cycle, we plan on examining whether the data can be used to analyze utilization patterns of inpatient psychiatric facilities, home health, and some Part B drugs.

For Commissioner discussion, we welcome your thoughts on the current state of the encounter data, potential uses of the data, and other feedback you may

have.

With that, I turn it over to Mike.

DR. CHERNEW: Thank you for both the presentation and wading into what must be an incredibly complex and sometimes frustrating data exercise. So that's just a broad thank-you.

I think what we're going to do here is we're just going to have one round. I will say I don't see an outpouring of folks in the queue. So we're going to see how that goes, but I think we're going to start here with Larry. Is that right? Again, we're going to do one round, and what's most useful is your general impressions about where to go with this. So you can lump your clarifying question in with your Round 2 question.

DR. CASALINO: Okay. Gosh, I didn't expect to be first. I'll have to change my whole perspective.

[Laughter.]

DR. CASALINO: Well, first of all, I mean, it's outrageous that we don't have better encounter data. It would be good to have some discussion going forward and more ideas about what it would take to actually get it.

With that said, I have really just clarifying

questions as I was preparing for Round 1. Luis, I had trouble with the difference between encounter data and claims data. Do you mean to make a distinction, or do you mean those two phrases to be equivalent? I'm not sure you used claims data at all, but in my mind, claims data has always been encounter data. And I realize like for physician services and some other services, it's not a per-service. It is like a capitated way of paying physicians, for example, and that would be a problem with getting encounter data because there would be no claims. But back to the original question, do you distinguish encounter data and claims data, or are they the same thing?

MR. SERNA: I think the intention of the encounter data is for it to have equivalent information to what you would see on --

DR. CASALINO: I'm sorry. Say it again?

MR. SERNA: The intention is for the encounter data that's submitted to have information that's equivalent to what you would see on a fee-for-service claim.

DR. CHERNEW: Is it true to say that claims data is an encounter data, but encounter data may include things that happen but weren't paid? So claims data is when you

pay, and if you just record it, you don't pay, it's an encounter. But all the claims should -- if everyone paid fee-for-service rates -- and not all plans pay fee-for-service rates, but if everyone paid fee-for-service rates, those claims would be part of the encounter data. But, as you pointed out, there's no necessity to keep it all consistent. Is that basically the right way to --

MR. SERNA: Yeah, that's right.

DR. CASALINO: So would it be fair to say then that the only difference between claims and encounter data is that claims data sometimes would be if I'm getting paid fee-for-service, otherwise I don't get paid? Encounter data could be I'm a capitated physician or whatever, and I'm submitting the fact that I had an encounter, even though it's not a claim to get paid for that encounter. Is that correct?

MR. SERNA: It definitely gets to that level.

DR. CASALINO: Okay. I don't have much more. Along these lines, you said that plans will sometimes only submit encounter data that they need to submit to get risk scores. What would be an example of encounter data that wouldn't potentially contribute to risk scores? I mean,

you wouldn't be saying I'm going to submit a claim for diabetes care because that will improve our risk score or make it higher, but I'm not going to do it for someone who comes in with an URI because I'm capitated and that's not going to change my risk score. How does that work? What wouldn't get submitted?

MR. SERNA: So for risk score purposes for the diagnoses to count, it only needs to be submitted one time. So, if it's diabetes, it only needs to be there on one of the claims, not if you had two or three diabetes treated --

DR. CASALINO: Is there anybody who actually tracks that and takes the trouble to say, "Oh, it's the second time. I'm not going to bother"?

MR. SERNA: I don't know. I don't know.

DR. CASALINO: It seems like that would be more trouble than it would be worth, really --

MR. SERNA: Yep.

DR. CASALINO: -- for whoever. So I wonder if that's a real phenomenon.

MR. SERNA: I agree.

DR. MATHEWS: Luis, could I jump in here? I believe this is correct. Most of the qualifying diagnoses

that are used to calculate a beneficiary's risk score comes from hospital and physician claims, and therefore, there is minimal, if any, incentive for a plan to submit encounter records, say, for home health, post-acute care. So that would be one example where there's just no benefit to the plan to submit that information.

MR. SERNA: And I think there's also a constrained set of diagnoses that fall under ACCs. So, for example, BPH is not in the ACC system. It won't increment your ACC score.

DR. CASALINO: Got it. But how much of the problem do we know is providers of services not submitting encounter data to the plans versus the plans not bothering to submit it to CMS?

MR. KAN: Speaking from a health plan perspective, we basically will submit all encounter data that all the physicians and hospitals pass us like 95-plus percent of the time. So it's the real -- so, to your point, Larry, it's really the source, you know. So the physicians and the hospital systems have to be motivated to submit the encounter data.

DR. CASALINO: So you're saying it's not the

plan's fault. It's the provider's fault is what you're saying?

MR. KAN: For the plans that worked in --

DR. CASALINO: Okay.

MR. KAN: -- typically, we basically pass it on.

DR. CASALINO: All right. And then --

MR. SERNA: And I think that's why our metrics tend to focus on things that a plan would know. They would know if someone was admitted to the hospital. They would know if someone was admitted to a SNF, which is why you have very basic kinds of metrics at that level.

DR. CASALINO: Okay. And then just two more very quick points. Can we take a look at slide 5? Slide 5. Okay. Already made that point.

So then last two points. Just slide 9, please. This is just a presentation point. It may just be me, but I -- no, 9. Yeah, I'm sorry you have to go through all that. So I read this wrong, and maybe I'm not the only one, but at least it wasn't clear to me. So, probably, there are some other people in the world it wouldn't be clear to.

I thought that like the yellow part of the bar

that said 24 percent meant that 24 percent of the data that was completed, submitted was -- or 24 percent could be identified only from that source, but it's the opposite is what this graph means. Is that right?

MR. SERNA: No. In the example that you're talking about, 24 percent of admissions were only identifiable through the encounter data.

DR. CASALINO: Okay. That is the way I thought. Okay.

And last point is I don't think everybody understands how MACs work and how those relate to claims or encounter data. So you don't have to do it now -- or if you can if a lot of people don't understand, but in the written chapter, anyway, it would probably be good to explain that.

MR. SERNA: Yeah.

DR. CASALINO: I think to a lot of people, they're fairly obscure, actually.

MR. SERNA: And we also explained that in our June 2019 chapter where we have the encounter data recommendation, so a lot of detail on that.

DR. CASALINO: That's it.

MS. KELLEY: Stacie.

DR. DUSETZINA: Would you mind going to the next slide back? This one. I just want to make sure that I understand.

So this is great. I am very enthusiastic about getting improved MA encounter data, partly for selfish reasons that I would like to use it, in addition to having you all use it, and being able to ask some questions that we haven't had much insight into before. So I'm glad we're going down this path.

I wanted to clarify whether you're -- you said, I think, that these are the bullet points here on this slide are things you already plan to do. So you don't need me to add to the list, service patterns or some Part B drugs, if I was going to suggest that. You are already going down that path?

MR. SERNA: So that's work that Kim and Nancy are looking into.

DR. DUSETZINA: Okay. Highly endorse the Part B drug space.

I also was just thinking -- if you don't mind going to the end, the set of questions again -- you know,

one of the other things that I think could be really a potential use, just thinking about comparisons across fee-for-service and MA, especially if we think that some of the Part B drug data is more valid and less missing -- and I think that other research has kind of shown that seems to be a reasonably solid set of services to track -- is differences in the intensity of service use, so maybe differences in the dose of treatments rather than just like which drugs are being used but doses as well.

But, in any case, I am very excited that we're at least going into this. I think it is important to improve this over time. We've waited for a long time for it to be of reasonable quality, and it still seems like there's a ways to go.

MS. KELLEY: David.

DR. GRABOWSKI: Great. First, thanks, Luis. This is great work. I'm glad we're taking another look at it. I share Larry's outrage. We should have complete and accurate encounter data. It would benefit our work in so many dimensions.

I think if I had to sum this up at a high level from when we looked at it last, I think the data are better

but still not well, and I think we need to keep pushing here.

I have a couple of questions. So one Round 1 and then I'll make some comments. On Round 1, you did the match with the OASIS for home health. Did you do a similar match for the MDS, or did I miss that?

MR. SERNA: So our 2020 March MA report has an analysis on that. That's data as of 2017. We are looking into the total number of records in the MDS, which is why we didn't present that data here.

DR. GRABOWSKI: Okay. But I assume it's getting better but sort of along the same path. So that was Round 1, and then a Round 2, a couple of thoughts. The first thought, at the Health Economics meetings this summer lots of researchers are getting access now to the encounter data. Lots of them are now using it. I wonder what we could learn from them. There's obviously an old joke: there's no dataset so bad that health economists or economists generally won't use it. So I don't know if that's the right threshold but I do think --

DR. CHERNEW: That's not a joke.

[Laughter.]

DR. GRABOWSKI: That's the truth. Where's the punchline? That's the truth, actually. Thank you, Mike. That is a fact, truth.

Maybe we don't want to go too far down that path but I do think there are probably some lessons, and non-economists are using them as well. So I don't want to just put this on the economics profession. There are potentially some lessons.

The second point, as we continue to push on these data, I remember when Andy looked at this, the encounter data was missing in a non-random fashion. And how do we think about sort of by plan, by area, like trying to really dive into some of the kind of -- like what can we do with these data? Where are they missing? It would be great if it was just kind of a 1 percent or 3 percent across all plans. That's not the way it's going to be, obviously.

So that next dive, it would really be interesting to look at some of that. In what ways is this missing at a system level? Thanks. What's that?

DR. DUSETZINA: [Off microphone.]

DR. GRABOWSKI: And at a service level. Thank you. Good amendment by Stacie.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks for the presentation. I wholeheartedly support efforts to improve the completeness of the data as well as the granularity. And I think, if anything, MedPAC should double down on some of its prior recommendations in terms of whether it's providing plans feedback -- I think that would be an important step -- but also considering a payment withhold.

One of the observations from California, at least on the commercial side, in the HMO space, is that the payers or the purchasers definitely wanted the encounter data, and they put a lot of pressure on the health plans. And the health plans, in turn, put a bounty out with their provider groups. It was part of the incentive program and it became like a threshold for being eligible for any kind of value-based payments. And I don't know to what extent the Medicare Advantage plans are using that type of leverage with their contract providers to try to get more complete data, but definitely something to consider.

And then in terms of other potential uses of the data, I do think that if the data were more complete and that we have more confidence in the data, definitely are

ample opportunities to code up quality of care measures, and potentially either expand or replace some of the ones that providers and plans have to submit that could be calculable through the encounter data.

MS. KELLEY: Lynn.

MS. BARR: Thank you. I wholeheartedly support this for a variety of reasons. We've all talked about how the economists and MedPAC want this data. The providers desperately need this data. I would like to officially announce that Health Information Exchange is dead. It died 10 years ago. Nobody can exchange data. So all we have in our EMRs is all we have in our EMRs.

And the way we move the needle on value-based care is we use data to identify patients who need help, and we can't rely on EMR data. The EMR data is a mess. And so the providers need this data as much as everyone else, and I would take it a step further and say, well, if United is giving us all the MA data, could I have their commercial data too because these patients are going to end up in MA or in Medicare, and to be able to know whether or not they had their colonoscopy and where they had it would be tremendously helpful to whatever provider is seen.

So I think like, well, that would be cool for MedPAC, but the providers are the ones that need this data. And if the goal for CMS is that 100 percent of patients are going to be in value-based care, today MA might be value-based care. I don't know. You know, I mean, nobody can really tell because we don't have the data.

And so we can't actively help these patients, particularly in the small-ball world I live in, unless we have that information. So I'm strongly, strongly supportive of this. I love the idea of using the MACs. I worked at a critical access hospital. We had 25 beds, and we had 50 billers and coders because we all had to submit our data to all these different places.

So it is incredibly important that we offer a standardized path. I don't think people have to use the MACs, but wouldn't it be great if we offered that as an option? Because many provider groups are out there like, oh God, I've got to pay claims. I'm in direct contracting. I've got to pay claims. Thank God it went through the MACs. Because, in direct contracting, the claims went through the MACs, I reduced my claims costs from 3 percent to less than half a percent.

So it's really important from the delivery system point of view that we get this data out of the payers and into some sort of system that we can all draw on so we can help our patients. Thank you.

DR. CHERNEW: I'm going to go back to a Larry question, given that comment. You want to take three seconds and talk about the MACs? There are a lot of MACs in Lynn's comments, which is about six comments after Larry said most people might not know exactly what the MACs are. It says they're Medicare Administrative Contractors, but you might want to say a little more about their role and how they run fee-for-service.

MR. SERNA: So basically, it's a way for providers to submit claims, when they submit claims to the MAC and it's processed for payment. And the MACs will make edits based on what's submitted. The concept of the recommendation is basically similar. So in order for the payment to go through it has to go through the MACs.

DR. CHERNEW: So the MACs are working in fee-for-service. There's, I don't know how many, are there six or seven of them, and they're regionally based?

MR. SERNA: Right.

DR. CHERNEW: They have some discretion to do certain things. So they do some what I would consider rudimentary, relative to what MA does anyway, utilization review, and they can make some other -- they don't have a lot of authority. They are largely doing claims processing. They have some administrative authority and I think they have some role -- I'm not sure if what I'm about to say is true. I wish I weren't talking to a whole bunch of people online. But nevertheless, I think that local coverage determinations and stuff like that would also work through the MACs, when they do those types of things.

So they're essentially the administrative TPA, almost, if you will, on the fee-for-service side, and they're not really applicable on the MA side, and that's what this whole discussion is about.

Larry is my boss. How was that?

DR. CASALINO: I'm sorry. That was helpful. I guess I could use more explanation of how the third bullet on this recommendation slide would work and why it would be an improvement on the bad situation we have now. And keep me in the queue, please.

Luis, can you explain how this might work and how

it would improve the percentage of encounter data that we have?

MR. SERNA: It's a way of helping ensure that all the encounters from the providers get to the encounter data without having to go first through the plans and then submitted from the plans to a contractor.

DR. CASALINO: I see. So the assumption is that it's not just the providers who are the problem. Contrary to what Kenny was saying, at least with this plan, it's not just the providers who are the problem. The plan might be the problem. So, therefore, if you go through the MAC you could improve the situation. That's the point?

MR. SERNA: That's the point, and it would be easier to discern where the problem was.

DR. CASALINO: It's what?

MR. SERNA: It would be easier to discern where the problem actually lies.

DR. CASALINO: Oh yeah. Okay.

MS. BARR: [Off microphone.] -- on standardized dataset, which is incredibly important. I mean, when I try to work with a plan and get their data it's a mess. Even if you got 100 percent of that data, I don't know how you

would be able to standardize it. We have to build a ton of interfaces and things to try to translate it. It's a disaster.

DR. CASALINO: [Simultaneous discussion.] Gosh, I thought the [unclear] systems were why we pay them so much.

DR. CHERNEW: But the thing about the fee-for-service system is there's a very specific set of fee schedules and rules and you know what's happening. When you move outside of the fee-for-service system the actual flow of money doesn't necessarily follow the Medicare fee schedules. The codes could be different. They could have various types of sub-caps and other things going on. It's not like they're running a shadow fee-for-service system and then they could just send it to the MACs. So there would be a lot of discussion about whether the MACs could digest it, what it would mean, what do you have to do.

Let me just, again, to set the -- I'm afraid I'm waving my hands in front of the camera. I apologize to all of you watching. This is an informational session. It's just to give us an understanding of where the state of the encounter data is. And I'll something about that when we wrap up.

We are not pushing this forward to a series of recommendations right now beyond the recommendations that we've had. What is pretty clear, and I think Robert is going to be next, but what is pretty clear there is widespread agreement that we would like better data. Right now I think we're not at the stage where we're going to try and figure out the processes about how to do that and all the unintended consequences that might occur when you do that, and how the transparency should align.

But just to be clear, I think I speak for Jim and Luis. I think we hear you very clearly that if we could get better encounter data, that would be better. And more to the point, and I think what might be most important is in general discussions over the course of the year, when you're thinking, well, let's just get that from the MA encounter data, to at least understand the weaknesses associated with doing that. It is not as simple as saying, well, we'll just get the encounter data and then we can do blah-blah-blah.

Luis, do you want to add anything?

MR. SERNA: No.

DR. CHERNEW: Jim?

DR. MATHEWS: Just to amplify a couple of things with respect to the respective roles of the provider and the plan. I believe this is correct but it's been a couple of years. In the run-up to our 2019 recommendations we did talk to providers about their experience submitting encounter data, and some of the things that we heard have been mentioned, at least in passing, in this conversation, that any given provider might be working with eight or nine different plans in their market, each of whom has a somewhat unique or idiosyncratic manner of submitting encounter data -- different fields, different protocols, that sort of thing.

And we also heard that providers would have the experience of submitting an encounter record a plan and it being bounced back as unsubmittable with little, if any, explanation as to why it was bounced back. So there was never any guarantee that even if corrected in some way and resubmitted, it would be accrued to the encounter record. Whereas providers have a fair amount of experience dealing with the MACs with respect to no-pay claims that are submitted for different types of services, different types of patients. There is a standardized format that they can

use. There is a single format that they use. And from an administrative burden perspective, again we heard this from some providers, some appetite for being able to bypass the plans and use a more streamlined and consistent method of submission of encounter data.

Does that help?

DR. CHERNEW: This isn't the 2019 recommendations. We're not revisiting the 2019 recommendations. This is information -- and I wasn't on the Commission in 2019, so it is news to me too -- just to give some sense of where we've been on this point.

DR. DAMBERG: Can I just follow on something that Jim just said? California has been trying to do this for the past 20 years, and everything you said is exactly what's been going down in California in terms of the providers submit it, there's not this neat handoff with the plans, the plans reject it. They throw this back and forth and it creates a huge amount of burden.

MS. KELLEY: Lynn, did you say that wanted in on this issue? And Kenny, did you have something to say on this issue?

MR. KAN: Yeah. I wasn't on the Commission in

2019, so I have not read the report. But I'm just thinking out loud here. I understand why it's important to get this data, and I fully support the effort to make the data as accurate as possible. But why couldn't we actually have the provider -- and this may sound crazy -- submit both to the MAC and to the health plan?

Because you have a standardized format, you can submit to the MAC, but then I think the health plan has a certain way of using it for their own back-office processes. And maybe this is the transition period work-through. And then maybe as part of that, the MAC may have some learnings, and somehow the learnings can then be applied to improve the process.

DR. CHERNEW: So if that was a question, I don't have an answer. But I will say, we have a set of recommendations, CMS should sort out some of this. And so they can go with whatever they're going to do to try and get this data better in a bunch of ways.

So at least the status quo now is we have the data that we have. We can think through when we want to figure out what else you might want to do and how we would balance, for example, the administrative costs and how much

you want to standardize the forms for the way the MA plans -- Greg, you may want to talk about how you do it compared to how a more fee-for-service-oriented MA plan might do it versus how Kaiser might. There is a lot of different heterogeneity in the plans.

So we could have that discussion. It's just for this meeting we're not really going to delve in. But that's a whole other set of processes and standardization. So right now we've been on the record, and this conversation is very clear that the current Commissioners are on the record as much as the other ones to be supportive of trying to get better data. But there usually are unintended consequences and a range of ways of doing that, and we're not going to explore that, at least at this phase.

Are we at Robert?

DR. CHERRY: Thank you. I definitely understand the whole challenge with incomplete or missing data within health care. I guess I'm a little challenged by this particular problem and what the root causes are, and I know there is some attempt to explain it.

I think the reason why -- I'm just kind of

putting my provider hat on and the way I think about encounter data versus claims data -- to me, encounter data is all clinical and administrative data that's part of the legal-medical record, at least within our electronic medical records, and that information is then used to generate a claim.

So I think the issue that I have is the information that's incomplete on Slide 9, at the most basic of levels, because providers can't be reimbursed unless you know the dates of an inpatient encounter and service. You know when they're admitted. You know when they're discharged. It's in the electronic medical record. But for some reason we're not getting that data, and I don't understand why.

The same is true regarding whether they're inpatient or not, because we're under very heavy CMS scrutiny to make sure that we record the level of care accurately -- inpatient, outpatient, observation status. So all that information is sitting someplace. It just not getting turned over or rolled into other systems.

This requires, I think, a little bit of discovery to understand what it is about our disparate electronic

systems that doesn't allow this information to be pulled, because I would argue it's all there but we're just not accessing it, for some reason.

DR. CHERNEW: So I think that was the end of our round. Okay. So we're going to have Larry, Scott, Lynn, and then Kenny. I think that's what I see.

But one thing I think is important to understand in this is there is huge heterogeneity in plans and providers, so I think a lot of people bring to this how it works in their system, and we have all of this so we can do this in a whole range of ways. But then it turns out when we do things nationally there are a whole bunch of people that aren't in the same institutional settings or the same resources, doing a bunch of things. I've seen people in health care using faxes, for example. So there's a whole bunch of stuff across the country that is where this is.

So I do think there's some that can do this, but I think it's important to keep in mind the heterogeneity across the country in the different types of organizations in terms of both plans and providers, and how they're managing electronic medical records or any one of a number of things, and how they're getting paid.

DR. CHERRY: Yeah. I would agree with that. However, if you look at the major EMR companies there are two to three of them that have a monopoly on that basically. And providers of various kinds, whether you're a critical care access hospital or an academic medical center, are using these EMRs for billing purposes.

So I agree. There may be some heterogeneity but there is a lot more that's common than not when it concerns this particular issue.

MS. BARR: [Off microphone] -- and I think that's what we have to get rid of. Because, I mean, if you're talking about inflation and provider margins and things like that, this would be a huge impact on provider margins if we can simplify this ridiculous administrative burden they have of dealing with all these plans.

MR. POULSEN: If I could just make a quick point. I think that by and large we're right, but not 100 percent right, because there are some organizations, for instance mine, that accept from a payer the entire capitation, 100 percent, and they don't get anything back from us in terms of detail. They gave us the money, we take care of the patient, and that's the end of the story.

So if you wanted to look at it as claims information, that's within our own organization. It's not necessarily back to who we would consider the carrier. So it's a little complicated.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. I'm probably going to sound a little frustrated. MedPAC has come out in the last few years and said very explicitly we can't measure quality in the Medicare Advantage program, period, because we don't have good enough data. This is a program that almost half of Medicare beneficiaries, for 30 years now, we've been overpaying, and in not one of those years has the program saved money for Medicare, according to MedPAC's analyses.

The health plans, one of the main claims to fame is that they have such good IT systems. Frankly, a lot of the consolidated provider organizations make the same claim. And yet, we are 30 years later and we're still where we are. And I really see it as unacceptable. Now we will have, now that the data is available, as David said, we'll have a health economist publish an article, which is probably better than nothing.

[Laughter.]

DR. CASALINO: I didn't mean it. I didn't mean it that way, David.

DR. CHERNEW: We're better than nothing. That's what it says outside of our door.

DR. CASALINO: But you understand my point.

I'm kind of tired of the excuses, the heterogeneity and all our systems don't fit together. I mean, full capitation, Greg, is the point where everybody is supposed to be trying to get to with capitated care, right? Remember the old Commonwealth Fund slide with the three axes, and we're all trying to get to full capitation? Oh, by the way, then we won't have any data to measure quality.

MR. POULSEN: Unless you get it from that data source, which was sort of the key point that I was trying to make, which is going to the carriers may not be sufficient. You may need to get it from the providers as well.

DR. CASALINO: Right. But obviously the point I'm trying to make is it's been long enough. And even now, with the Commission here, I don't actually see where we stand or what's going to happen next. I mean, we have

these 2019 recommendations. This has been an interesting session. But is there an idea for what's going to go on next on our roadmap?

DR. CHERNEW: I think I'm going to take a stab at this and then get corrected. We don't have a roadmap explicitly about Medicare Advantage encounter data. We, of course, do have a roadmap on Medicare Advantage, and we have a roadmap on quality, and we have a roadmap on a range of different things. This is foundational to fitting into other roadmaps, but we are not envisioning a set of recommendations analogous to the 2019 recommendations.

I think we can ponder that as time goes on, but at least in my sense of our sort of work on the cycle we have not yet said on the agenda the type of work it would take for us to get to a whole set of recommendations. We would have to go through and do more analytic work to sort out some of the things you guys have asked.

So it's not that I disagree with any of the statements, and just to be clear on record I think the staff, me, I will speak for Amol, believe having better encounter data would be useful. And what I was going to say in my wrap-up, I'll say it now, is my guess is the risk

score stuff is actually probably reasonable because now they have strong incentive to get the risk score stuff. So I'm not worried that when we use the encounter data for risk score type of stuff, understanding that we're way off if the encounter data is not sufficient to support that. I believe that's probably reasonable.

Quality measurement, that's a whole separate issue, and that gets to stuff that will be in a different part of our roadmap, the MA star program, the status fee MA, where we're getting that data, how we're measuring quality in MA. I think that's a real issue.

Some of the -- I'll call it, for lack of a better word -- cost margin, you wanted to know sort of what an MA margin profitability is and you wanted to build the data into that. I don't think this is well set to do that, and frankly, I think if you had all this data it still wouldn't be that great for this because a ton of payments are happening increasingly outside of the claims system. So you can have perfect encounter data and you could be missing a lot of the expenses that the MA plans have because they're paying bonuses for a whole bunch of other things for which there's not actually an encounter in

place.

So I think there is a series of things that we do over the course of our business that could be informed by MA encounter data, and the purpose of this session was to give you some sense of the status of where it is. And again, for certain things, risk adjustment, I think it's great. For understanding the profitability of MA plans I actually don't think it's very good and I don't think it would be very good even if we made it better for that purpose. Quality stuff, I actually think that's probably a really useful -- probably the strongest case for better data would involve some of the things that you said, Larry, that we have a very hard time assessing aspects of quality if you don't have good encounter data.

But anyway, Jim, Luis, you was asked a very agenda-specific question and I jumped in.

MS. KELLEY: Stacie, did you have something on this point?

DR. DUSETZINA: You know, I think that maybe going back to the frustration with this, I think that David made a nice point about getting more information about the completeness and the quality, and I think by service

category, just to know these sorts of snapshot levels of what can we trust and what can't we trust right now from what it is, and also are there incentives that are banked in that are making one part of services really reliable and really showing up where we could think about incentives to get better quality information.

But I think otherwise, you know, we're all going to be tempted to be comparing fee-for-service and the encounter data over time, and knowing whether we should trust those studies or where there are huge gaps in what's being collected, I think would be a huge service to the field.

So even if that's where we stopped, I think that would be a huge, huge benefit for this field. And all the economists who are using it, no matter what.

DR. CHERNEW: Also stakeholders.

So I think just to give a check, we have 15 minutes, and if I'm right we have Scott and then we have Lynn. I'm just looking at the names. I'm not reading all those things. I'm just going to be quiet. We have Scott.

DR. SARRAN: I'm just taking off from what Robert said. I'm not sure we know what we don't know. Looking at

Slide 9, for example, the amount of inpatient data that's missing. There aren't that many hospitals that are fully capitated where they don't need to submit a claim to their MA plan to get payment, and the MA plays are incented by virtue of the HCC system to get those claims submitted through for encounters.

I mean, I'd love to see a couple of studies where people dig into a couple of different MA plans and actually look at what's going on. I'm just not sure we understand all the process flow stuff that's going wrong here, and it's fairly high volume, which just doesn't fit.

DR. CHERNEW: I'm going to say something about that, but does anyone want to say something that's actually correct first? You're up.

MR. POULSEN: I'm not sure this is actually correct, but having played with the MedPAR data a lot, a long time ago, I don't know if it's changed, but we often found things like dates that were slightly off compared to the records that we had in our own institution and things like that. And it may be that the data is really there but it's not tying up because of some modest inconsistency. I don't know that that's it, but I just toss that out as a

possibility. I think you mentioned the dates were an important way of making that connection.

We found those kinds of things, and I'm not sure what the source of the error was, but we found them on a moderately consistent basis.

DR. CHERNEW: So what I was going to say, and again, having not looked into the specific things and certainly not having done these data diagnoses, but as someone who does work with data, it is never as good as you think it's going to be, no matter how good someone tells you it's going to be. If you just start with fee-for-service for a moment and you look at risk adjustment in fee-for-service, you will see a large number of people that have chronic conditions in one year not having it the next year, which brings us back to our issue about, well sure, that's why we want to deal with risk adjustment for, say, two years, or other types of things that are talked about in risk adjustment.

The MA plan can do a better job, at least a more accurate job, of making sure that those claims don't fall off. They are incented to do so. That leads to a gap between measurement in MA and fee-for-service, which is

another topic of great MedPAC interest. But even though the MA plans might do a better job of being complete relative to fee-for-service, that's not the world's highest bar, and they spend a lot of time trying to make sure that they are somehow collecting data.

I'll just give you an example. I have no idea. Someone gets admitted to a hospital out of area because they were traveling and the MA plan didn't have a contract with that hospital, and how did that data get submitted into that plan, and now you've lost it. Or someone was admitted and there was just a typo in the admission. They had the wrong enrollee record, for example. They didn't know, at the time of the admission, who the actual carrier was and so they billed separately to the MA program and they didn't sort all of that out. There just tends to be a lot of core data collection problems that you see any time you look at data. And it is obviously frustrating, which is why we spend a lot of time learning about how good the data is.

But I can think of a lot of reasons why, although you would expect that organizations can do a lot of things, there turns out to be a lot of exceptions, and then a lot

of people just aren't executing on things that they have incentive to execute on. You know, the MA risk scores are higher than the fee-for-service risk scores. They may be higher. We could debate whether they are higher than they should be. But they rise every year and they have been rising. So that means that at any given point in time, there are some next year, and they will figure out that they were missing certain things and miss less of those things going forward.

So I just think there are a lot of challenges with collecting data in ways that if you looked at almost all the databases, doing things you think you could match up the facility and the professional payment for an ASC stay. That turns out to be a lot harder than you would expect. And I've actually never done it. I've just looked at parts of the data.

MS. BARR: I wonder, Luis, could you do a comparison between fee-for-service and that slide that you have, and say, okay, is there an apples-to-apples where you can say, well, this is what it looks like coming through a MAC and this is what it looks like coming through there? So you can sort of answer those questions -- is it the

MedPAR data or is it something else?

I'd just like to reiterate one more time that you have providers all over the country that are trying to get clean data out of MA plans with almost no success, and MedPAC would be doing a huge public good by solving that problem so that every provider group -- because you can't imagine the amount of effort, time, and money people are putting into this with no success.

The capitation problem is a problem, you know, and I don't know really how to work around that. I don't know how many lives are capitated? Does anybody know what percentage of lives are capitated? Kenny, do you know? It seems pretty small.

DR. CHERNEW: [Off microphone.]

MS. BARR: Right.

DR. CHERNEW: [Off microphone.]

Primary care capitation is pretty common, I think, in the MA world. Hospital capitation obviously less so. But there's other complicated bundling programs. I don't know how Horizon is dealing with the data but they had one of the leading episode-based payment models in the country. For a long time Horizon was known -- and I'm not

sure how they collected all of those claims in that process. But they may well have done it in a very fee-for-service way because a lot of those models are built off of fee-for-service. But sometimes they could just do a sort of episode-capped type model for a particular group. So there is a lot of heterogeneity.

We could look into it more. We will have a discussion about that. But right now we are planning to move forward to a series of recommendations. I'm actually in the process of wrapping up, if that wasn't clear. Dana, is that okay?

We are in the process of thinking through how this data is and then the implications of it for the other things that we do. The points that have been made here, which I agree with completely, is a lot of people would be able to do things better if they had better data. And there has been a long history of health policy around meaningful use incentives and different types of quality organizations, regional information exchange. There has been a whole lot, I think, of efforts of people trying to bring information together to make it more manageable, and I think, in general, the position of MedPAC has been

positive about those things. But that's not an agenda item that we're really going to delve into more deeply in this cycle.

Jim?

[No response.]

DR. CHERNEW: Okay. That was the on/off transition.

So 30 seconds for other comments.

For those of you at home that want to make comments about any of these things that we have not gotten right, and you want to correct, in particular, correct me, please send your comments to meetingcomments@medpac.gov or go onto the website and send comments about substance or my style, and we will review those.

I think the takeaway, both for us all from today and for those listening is the Medicare Advantage program has been important for a long time. It is of growing importance. We have spent a lot of time on it, and you will see this cycle a lot more time will be spent on it, both in terms of the standard work that we do -- we have a Medicare Advantage status chapter that will show up in March -- and then the issue about how we might be able to

do other things around benefits and where that might lead in terms of Medicare Advantage policy. It's becoming increasingly a big part of the Medicare program, and the MA program itself was not designed to be as big as it seems to be growing, and that is going to take a lot of attention. This sort of data discussion is a part of understanding that context.

So, really, thank you all for the day. I know the Thursday meetings are long days. We will show up tomorrow morning, and I would normally ask Jim when but now I'm not going to. But 9 a.m. tomorrow. We are going to talk about two other topics of great interest, hospital wage indices and Medicare Part B, which are areas also of great Commission interest.

So again, thank you, those at home, for listening, and thanks to all the Commissioners, and we'll see you tomorrow at 9.

[Whereas, at 4:55 p.m. the meeting was adjourned, to reconvene at 9:00 a.m. on Friday, September 2, 2022.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

And

Via GoToWebinar

Friday, September 2, 2022
9:01 a.m.

COMMISSIONERS PRESENT:

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AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
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P R O C E E D I N G S

[9:01 a.m.]

DR. CHERNEW: Hello, everybody. Thank you for coming to our Friday morning MedPAC session. We are going to talk about two important topics today. The first is going to be wage indices, and the second will be Part B drugs.

I think there's been a lot of discussion in the popular press about Part B drugs, but I will just emphasize wage indices also are unbelievably important for how the health care system works. And I think the work we're about to see is really important.

Our plan is now just to give you a sense of what's going on and to bring you up to speed about where we are, and then we're going to move further along. And, hopefully, we'll get to a -- we're going to go to a recommendation?

UNIDENTIFIED: Maybe.

DR. CHERNEW: And depending on how it goes, we may get to a recommendation by the end of this cycle.

But, in any case, I'm going to turn it over to Alison and Jeff to talk about wage indices.

MS. BINKOWSKI: Thanks, Mike.

Good morning. I'm excited to present today on reforming Medicare's wage index systems. This presentation updates work from MedPAC's June 2007 report and information presented in October 2021.

The audience can find a version of these slides in the control panel on the right-hand side of the screen.

In this presentation, I'll provide a brief overview of current Medicare wage index systems, describe key concerns with current wage index systems, present potential goals and principles of an alternative wage index method that would address these concerns, outline an illustrative alternative wage index method consistent with these principles and summarize its benefits and effects first for acute care hospitals and then for other sectors, and finally conclude with a list of discussion questions.

Medicare's various prospective payment systems use wage indexes to adjust Medicare base payment rates for geographic differences in labor costs. As illustrated in the figure, this is generally done by multiplying the labor share of the PPS national base rate by the relevant wage index value for the area where the provider is located.

The labor share varies across PPSs from 50 percent for ambulatory surgical centers to 77 percent for inpatient psychiatric facilities.

For most provider types, such as post-acute care facilities, CMS uses one wage index based on acute care hospitals' cost reports. In this presentation, I'll refer to that as the "initial wage index."

However, for acute care hospitals, CMS applies many modifications to the initial wage index.

To calculate the initial wage index that is used in most Medicare PPSs, CMS first calculates the aggregate average hourly wage for acute care hospitals in each area by taking their aggregate wages for inpatient services divided by aggregate hours as reported on hospital cost reports and, second, divides that area average hourly wage by the national average.

By construction, geographic areas with an average hourly wage less than the national average have wage index values less than 1.0, while those areas with an average hourly wage greater than the national average have wage index values greater than 1.0.

For example, to adjust fiscal year 2022 payments

for most PPSs, CMS calculated an initial wage index based on wages and hours from about 3,200 acute care hospital cost reports that began in 2018.

CMS then aggregated this cost report data to 459 labor market areas, including 411 Metropolitan Statistical Areas and 47 residual rural areas, which include all counties in the state that are not in an MSA.

As shown in the graph, most labor market areas have a wage index value slightly below 1, but a minority have much lower or higher values.

To adjust payments for acute care hospitals, CMS starts with the initial wage index, calculated as described on the prior slides, but then performs several modifications.

CMS starts by calculating an occupational-mix adjusted wage index for each area by using a separate survey of acute care hospitals to recalculate what each area's average hourly wage would have been if hospitals had employed the national nursing mix.

CMS then applies up to four wage index exceptions, shown in light blue. First, CMS calculates a post-reclassification wage index that generally includes

the data of all hospitals that are either located in or were reclassified into each area. Hospitals can reclassify to another area through one or more reclassification pathways. Second, CMS applies the highest of up to three different wage index floors to generate a post-reclassification, post-floor wage index for each area and state combination. Third, to this wage index, CMS applies an out-migration policy which increases the wage index value for hospitals located in counties with a high share of hospital employees who commute a higher wage area; and, fourth, CMS applies a temporary low-wage policy which increases the wage index value for hospitals in the bottom quartile of the wage index distribution.

The Commission has several concerns with the current Medicare wage index systems, the primary of which is that the current wage index values reflect not only geographic differences in labor costs, but also hospitals' market power, hospitals' employment decisions, and various non-empirical wage index exceptions for acute care hospitals. In the following slides I will briefly describe each of these in turn.

One reason why the current wage indexes do not

solely reflect geographic differences in labor costs is that they are based on data from a small number of acute care hospitals. The use of this data can be circular and cause the wage index to reflect hospitals' market power.

For example, as shown in the figure, hospitals that successfully moderate increases in hourly wages relative to the national average increase, perhaps because of low market power, will see a decrease in their wage index over time. These hospitals will then receive lower payments, which can create pressure to keep wages low. The reverse is also true among hospitals with high market power.

CMS, the HHS OIG, and others have recognized this issue with circularity, and in response, CMS added a temporary low-wage index policy in 2020 that increases the wage index value of hospitals in the bottom quartile of the wage index distribution.

However, this policy is only temporary, has no empirical support for the specific magnitude of the increase, and only addresses low-end circularity.

A second reason why the current wage indexes do not solely reflect geographic differences in labor costs is

that they are based on aggregate average hourly wages across all occupations, which can cause the wage index to reflect employment decisions, as providers may employ different mixes of occupations and relative wages can vary across occupations.

To address this concern for acute care hospitals, Congress required that the IPPS wage index include an occupational-mix adjustment. However, CMS has implemented this requirement using a survey of only four different nursing occupations and, therefore, only partially removes hospitals' employment decisions from the IPPS wage index. In addition, no occupational-mix adjustment is applied for other PPSs.

For the acute care hospital wage index, a third reason why the wage index does not solely reflect geographic differences in labor costs is that it has exceptions with no empirical basis.

Collectively, these exceptions erode the integrity of the IPPS by creating large differences between the wage index value for hospitals located in an area and that area's relative labor costs. In particular, the Commission is not aware of an empirical basis for any of

the three wage index floors.

A related concern is that the presence of these non-empirical wage index exceptions for acute care hospitals can create large wage index differences between these hospitals and other providers located in the same area, even when they face similar relative labor cost and, therefore, contributes to variation in payments across settings for the same service.

In the past several years, some attempts have been made to remove some exceptions. However, these have been largely unsuccessful, and more exceptions have been added over time.

A second concern is the numerous exceptions in the current acute care hospital wage index both creates opportunities for wage index manipulation, of which hospitals have been increasingly taking advantage, and adds administrative burden for Medicare to maintain and adjudicate.

In response, CMS has tried to create policies to limit some opportunities for wage index manipulation, but CMS has had limited success, and developing these policies has added administrative burden.

Three examples of increasing wage index manipulation identified by CMS are, first, an increasing numb er of hospitals have been reclassifying to a rural area in order to raise the rural floor of its states. Specifically, certain high-wage hospital are reclassifying to its state's rural area, thereby raising the rural floor and increasing wage index values for urban hospitals in that state as the expense of all other states, as the rural floor is required to be budget neutral.

Second, an increasing number of hospitals have been timing their reclassification cancellations and reapplications in order to maximize their wage index. Specifically, certain low-wage hospitals are cancelling their rural reclassification and then reapplying for reclassification to a rural area, only once it was too late for CMS to include their data in the calculation of the wage index value for that rural area, thereby receiving a higher wage index than they otherwise would have.

Third, an increasing number of large urban hospitals have been dually reclassifying in order to gain non-wage-index benefits. Specifically, certain large urban hospitals are first reclassifying to a rural area and then

reclassifying again, either back to its original area or to a different area. While a second reclassification applies for wage index purposes, the first makes them eligible not only for additional reclassifications but also for certain non-wage-index benefits for rural hospitals, such as lower 340B eligibility or additional residency slots.

A related concern with the number of wage index exceptions is that an increasing number of hospitals have been receiving them. For example, in fiscal year 2022, about 68 percent of acute care hospitals benefitted from at least one wage index exception, up from about 40 percent in 2007. Furthermore, these wage index exceptions, which are generally not mutually exclusive, can result in substantial increases in payments for these hospitals. These higher payments are paid for by a combination of a relatively small decrease in payments to all acute care hospitals for the budget-neutral exceptions, an increase in Medicare program spending and beneficiary cost-sharing for non-budget-neutral exceptions. Thus, acute care hospitals that benefit have strong incentives to fight for their exceptions, while others have smaller incentives to remove exceptions.

A third concern with the current wage index systems stems from defining labor market areas broadly as MSAs and rural balance-of-states, without any county-level smoothing.

This approach can result in both masked variation in labor costs, where there is one wage index value for an area despite significant differences in relative wages within the area, and wage index cliffs, where an adjacent area has a much higher wage index despite competing for similar employees.

Congress has attempted to partially address these labor market area issues through reclassification pathways and other exceptions. However, these can create domino effects and result in even greater masked variation and wage index cliffs. An example of this is in the paper.

A fourth and final key concern with the current wage index systems is the use of the initial wage index for other PPSs. The primary concern is that the current initial wage index may not accurately reflect relative labor costs faced by other providers because relative wages of acute care hospitals may not accurately reflect relative wages of other health care providers, and the mix of

occupations employed by acute care hospitals may not reflect the mix employed by other providers.

The Commission contends that the goal of a wage index is to accurately measure the labor costs of doing business that differ solely because of geography. To meet this goal, the wage index method would ideally have three characteristics. First, it would use cross-industry occupation-level wage data, weighted by sector-specific occupational weights, as all employers of a given occupation participate in the labor market. An area's relative wages can vary across occupations, and the mix of occupations employed varies across sectors. Second, it would ideally account for county-level variation in relative wages and smooth wage indexes across adjacent counties; and third, it would have no exceptions.

To the extent that policymakers do want to increase payments to certain providers, in particular, those that are important for access and vulnerable to closure, these payment increases should be targeted specifically to those providers to achieve defined and relevant policy goals and not made inefficiently through unrelated vectors such as the wage index.

To illustrate how CMS could construct an alternative wage index consistent with the principles in the prior slide, we took the following steps to develop an alternative wage index for acute care hospitals.

First, we calculated an initial area wage index for each MSA and balance-of-state using occupational-level, cross-industry average hourly wages and national occupation weights for acute care hospitals, both calculated from Bureau of Labor Statistics data. The occupation with the highest weight was registered nurses, with a weight of 47 percent, indicating that, nationally, wages for registered nurses accounted for about half of acute care hospitals' institutional wages.

Second, we adjusted this initial area wage index for benefits' share of total compensation in that region, again using BLS data.

Third, we applied a county-level intra-area adjustment, up to plus or minus 5 percent. We developed this adjustment using Census data, as it is collected at the county level.

And, finally, we smoothed the wage index across adjacent counties, such that the maximum difference in wage

index to an adjacent county was 10 percent.

By construction, this alternative wage index for acute care hospitals would have two key benefits relative to the current wage index. Most importantly, it isolates county-level differences in labor costs while limiting wage index cliffs; and second, it minimizes opportunities for wage index manipulation and administrative burden on Medicare by having no exceptions.

As a result, the alternative wage index more closely reflects geographic differences in labor costs at a lower administrative cost than the current system.

Moving to the alternative acute care hospital wage index in a budget-neutral manner would not change aggregate IPPS payments, but we estimated that it would shift payments towards acute care hospitals with no current wage index exceptions, with a relatively low current wage index, in areas where they pay less than the usual premium above other employers' wages for similar employees, and in counties with higher wages relative to its parent area or adjacent to a county with a much higher wage index.

At an individual level, we estimate that moving to the alternative wage index would cause IPPS payments to

change by more than plus or minus 5 percent for a small minority of acute care hospitals once fully phased in. To minimize large changes in a single year, policymakers could take steps such as phasing in the wage index over a short period of time for hospitals that would face a wage index change of more than 5 percent.

To illustrate how this same alternative wage index method could be applied to other sectors, we developed illustrative wage indexes for inpatient psychiatric facilities, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies using the same method as for acute care hospitals but using occupations and weights specific to each sector.

A primary benefit of these separate alternative wage indexes is that they more accurately measure the labor costs faced by different providers, with minimal additional added burden, administrative burden.

At an individual provider level, we estimate that implementing the alternative wage indexes in a budget-neutral manner would shift PPS payments toward certain providers, generally similar to the results for acute care hospitals described on the prior slide. For example,

payments would shift towards providers located in areas with current low wage index values and areas where acute care hospitals pay less than the usual premium above other employers' wages for similar employees.

However, the effect on individual providers would often be larger than on acute care hospitals because these sectors have a higher labor share, which causes the same change in wage index to have a larger effect on payments.

That concludes this presentation. During the discussion section, staff would be interested in Commissioners' responses to the questions on this slide and, in particular, what additional information would Commissioners want to see in the Spring if they're interested in updating MedPAC's 2007 recommendation to improve Medicare's wage index systems.

And, with that, I turn it back to Mike.

DR. CHERNEW: Thanks. That is terrific, and it is really an enormous amount of information here.

So we're going to go through our Round 1 and our Round 2 questions, but remember one of the things we are actually trying to figure out is how much interest there is in moving actually to a recommendation. So while you can

react to the information, however you want to react to the information, there's also some sort of agenda-setting workflow issues that we're trying to gage your enthusiasm for.

So, with that said, Dana, do you want to go through the queue?

MS. KELLEY: I have Kenny first.

MR. KAN: I am very enthusiastic about this chapter, so thank you.

I understand that the Commission also -- MedPAC also analyzed this issue back in 2007, and I wasn't part of MedPAC in 2007. Can you provide some context about why was it not adopted and what are some material differences? Obviously, since 2007, the problem has gotten more significant. Can you just provide some context, like the current methodology and what it was in 2007? What are some key differences, please?

DR. STENSLAND: I'll start with 2007, since I was here. There was a congressional mandate that we look at the wage index that came out in 2006. So in 2007, we did our report and we came up with some recommendations, and the methodology was very similar to what we're presenting

today.

It was fairly well received from a technical standpoint. Like we went around and I would talk to the AHA and the CFOs of the hospitals, and I think from a technical standpoint of does this make sense it was pretty well received. There were other reports by Acumen and the IOM that kind of had somewhat similar conclusions, saying this BLS data is probably better than just using hospital data. And then there was a serious look at it from the American Hospital Association that had their own organization committee look at it.

But in the end probably this is more of a difficult political problem than it is a difficult technical problem, because there are some entities that would have lost a fair amount that had gotten exceptions if they took away these exceptions and kind of smoothed everybody out. And their losses, on an individual basis, tended to be bigger than the gains that the other people would get by removing all this budget neutrality.

So from a political standpoint those that would lose, I think, were shouting larger than those that would win, and that's why I think in the end that didn't happen.

DR. CHERNEW: A few things. We should not worry a ton about whether it will or won't get done if we think it's the right thing to do, and I think one of the other things that's happened, I think increasingly since then on MedPAC, is sort of -- well, I think we've always believed this but now I would say it's even more explicit. There may be other policy goals that policymakers have. We have a whole safety net agenda, for example. And so part of the issue here is if you want to accomplish a goal you shouldn't necessarily bury it in the wage index or through some other mechanism that has a whole bunch of other distortions that are going on. And I think what's clear in this particular case, and you'll see some examples, is there are some real issues about how things that may have been well meaning are playing out in particular ways.

So I'm not sure where Congress will go. The way we're going to do this there's always going to be winners and losers. You can see in the materials what those are. But I think the real question is if we're worried about the losers, we might argue we should figure out what the issues are and if we want to target them think about why they need to be targeted. But creating a complicated set of wage

index floors and other things may not really be the best way to go about accomplishing that goal.

DR. STENSLAND: And just as a quick clarification, I didn't want to imply that the recommendation doesn't do any good, because often if there is a recommendation out there and somebody else says, oh, let's create a new exception or do something else that's going to make it even worse, there are some people that can say, "Well, look. MedPAC had this study. They said there's already too many exceptions. This isn't a good idea."

So even if there's a recommendation out there that doesn't get enacted in law it still can do some good.

MS. KELLEY: Lynn.

MS. BARR: Good morning, everybody, and here's my Round 2. I totally support this, so you don't need to get me in Round 2 again. I do have a couple of questions.

How does an urban hospital reclassify as rural? What is that?

MS. BINKOWSKI: So there are two main ways that it can happen. One is if they are in what's considered a rural county within an urban area, and there are various

ways that that can be defined. But you can imagine MSAs have more central, more outlying counties than some of them can be reclassified as rural that way.

The more common or increasingly common over time approach is they can reclassify to rural through what's called 412.103, reclassifications based on the section in the regulations. And there are several ways that you can fall into that. The one that's becoming most common is you can be reclassified as rural if you would otherwise meet the requirements to be a rural referral center. And there are many ways to become a rural referral center, but one of those is just to be located in a rural area and with more than 275 beds.

So through that way most large urban hospitals could meet that criteria for reclassifying to rural, and an increasing number are.

MS. BARR: That's interesting. But they'd probably convert to a rural referral center anyway, just because of higher payments, right?

MS. BINKOWSKI: So rural referral centers don't get higher payments themselves but they get certain other benefits such as different 340B eligibility requirement for

reclassifying to yet a different area. So there are benefits but it's not directly through payments.

MS. BARR: I see. All right. My last question is have you looked at the impact of the change on rural and safety net hospitals for the hospitals that we've been identifying as underserved versus more served? If you could show us that comparison, I think it would help us better understand who this is targeting.

MS. BINKOWSKI: That's hopefully something that we can come back with in the spring. We have not done that yet.

MS. BARR: Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks Alison and Jeff. I have three hopefully relatively quick questions. One, I was curious. I assume that there are examples where rural hospitals or rural areas have higher wage indices than urban ones, and I was curious, is that extremely uncommon or is that fairly common? Can you give us some sense of how to quantify that?

MS. BINKOWSKI: So I think it depends, when you say higher wage index, is at what step in the process

you're talking about.

DR. NAVATHE: Higher, yeah.

MS. BINKOWSKI: But like, for example, the Frontier floor will include a floor of 1.0 for all Frontier states, and that can raise their wage index. There are also, in some of these instances of certain larger urban hospitals reclassified to a rural area and stay there, they can raise the rural area wage index, and that can actually, up until 2023, be higher than the state's rural floor if that policy then changed again. So there are many ways it can happen, post all exceptions. It can also happen in the initial wage index.

DR. NAVATHE: Sorry. I should've clarified. I was curious about the initial. Post-exception it makes sense, but I mean more in the initial index.

MS. BINKOWSKI: So I don't have an exact number on me. I'd say it is not common but not rare. It can really vary based on individual states. But there are certain states where there are certain urban areas that have lower initial wage indexes than the rural balance of state. I can try to come up with a specific number to get back to you.

DR. NAVATHE: Okay.

MS. BINKOWSKI: Jeff, do you have more to add?

DR. STENSLAND: I would just say that it is rare but it does happen, and the premise of the rural floor is that it would never happen. It doesn't make sense for rural to have higher wages than urban. But we think in some cases it does make sense. In essence, there are high wages on Nantucket. It's a high-expensive place to live. It might be higher wages there than in Springfield, and that's not some sort of thing that we would necessarily want to correct. We'd say, yes, the wages are high in Nantucket.

DR. NAVATHE: Okay. Great. Thank you. My second question, so second of three, is in Figure 2 in the reading materials we had a distribution that was I believe by labor market area. And I was curious again, if we looked at the distribution by hospital would it also look similar to that?

MS. BINKOWSKI: Yes, there would be more data points and there would be even more among the middle. But there are still a small minority of hospitals that would have wage indexes that are really low and really high, both

in the initial wage index and in the final acute care hospital wage index. The one difference for the final acute care hospital wage index is that during this period where there's the temporary low wage index policy that very low tail is brought up a little bit.

DR. NAVATHE: I see. Okay. And here it looks like the wealth of distribution is shifted such that there or more less than 1.0 than higher than 1.0. Is that roughly what we would see also for the hospitals?

MS. BINKOWSKI: I am nodding yes.

DR. NAVATHE: Okay. Great. Thank you.

Last question is about the illustrative scenario. So in the reading materials we talked about, or you discussed a 5 percent intra-geographic area adjustment to I think account for some of the county-level, and then also a 10 percent adjustment. And I realize these are illustrative and not that we're trying to say that these are the right ones, but I was just curious, was there an empirical basis for coming up with those estimates or are they truly purely illustrative?

MS. BINKOWSKI: I would say a bit of both. One of the issues is that especially on the West Coast there

are certain counties that are very large and that border others. So if you start to try and get lower than a 10 percent smoothing that can cause much larger domino effects. So I think it could be somewhat lower than 10 but not much. For the 5 percent intra area, we looked at things between 5 and 10 percent, and ended up choosing 5 percent for this illustrative example, as it modified, I would say, roughly a third of the counties within an area, which seemed reasonable. And we also wanted to avoid trying to do additional data cleaning on the census data and to have it be particularly large. But yes, it could've been plus or minus more than that.

DR. NAVATHE: I see. So just to restate what I'm hearing here is it's empirical in the sense that we are looking at different values and seeing what might make sense, but at the end of the day a lot of it is based on what would be reasonable from a policy perspective, rather than something --

MS. BINKOWSKI: Yes. They did not come a priori.

DR. NAVATHE: Right. Okay. Got it. Thank you. I appreciate it.

MS. KELLEY: David.

DR. GRABOWSKI: I'm actually okay.

MS. KELLEY: Okay. Betty.

DR. RAMBUR: Thank you very much. I think this is really important work and I support us looking at it.

I'm having trouble reconciling in my mind so maybe you can help flesh it out, two things that both seem completely true and yet antithetical to me. So obviously I don't understand it.

One, occupations and weights specific to the sector makes total sense to me. And then another place in the document which I agree that organizations compete across these sectors. And I know on the working surface that kind of creates a hierarchy of value among, for example, nurses, of the best place to work.

So I'm just trying to understand how to reconcile those two things.

MS. BINKOWSKI: I'm not sure if I fully understand your second point, but to take a stab at it, yes, for example, nurses are one of the most common occupations, in general, across sectors. For example, registered nurses are much less common in, say, home health agencies. And so the first premise is all of the employers

of registered nurses are in some sense competing for the same pool of registered nurses.

But I think this is what is getting to your second point. We're not saying that necessarily each sector is going to be paying the same amount for registered nurses. It's more about their relative values. So we're saying that within a given area hospitals may pay more for registered nurses than, say, SNFs, but I'm thinking about if they pay twice as much, as an extreme example, compared to the national average, that it would also be about twice as much for the SNFs.

So we're not saying that the levels are the same across sectors but relative to the national average would be.

Did that answer your question?

DR. RAMBUR: It does, and so that leads into something I'll say in Round 2, so thank you. I appreciate it.

DR. CHERNEW: Yes. I think sort of the issue that arises here is the heterogeneity within occupations. And that is a clarifying answer so I'm going to leave it there. We'll see how Round 2 goes.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. Just a few questions. What is included, what jobs? Is it all jobs that a hospital or an entity has, so even back office, non-patient-facing, let's say, your accountants, your EMR team, your IT. It's all of the above -- is that right?

MS. BINKOWSKI: Yes. So let me answer the question two ways. First, in the current wage index it is all of your occupations that are attributed or through cost reports assigned down to IPPS services. So if you have a separate SNF wing you kind of discount those, the wages and hours in that unit.

But yes, you are correct, it's not just clinical staff. It is maintenance, it is administrative, it is EMRs, and they are allocated to the extent that you have one administrative staff and you have large hospitals with different units, of a psych unit that the administrative staff is allocated the wages and hours across those different units and the parts that are related to the acute inpatient counted.

DR. RYU: And similar lines, does it include employed physicians or advanced practitioners?

MS. BINKOWSKI: The answer would generally be no. Again, I talked about inpatient services. So these are services that are paid under the inpatient prospective payment system. So physician services generally are not, and the physicians would not be counted. Certain exceptions could be certain attending physicians or other types like that.

So that's what we tried to say in the paper, is institutional wages or wages for IPPS services.

DR. RYU: So if it was what's called hospital-based specialty, the anesthesiologist, ER docs, hospitalists, radiologist, pathologists, would those be included?

MS. BINKOWSKI: No. So those would be reimbursed under the physician fee schedule for those services unless they're performing some sort of administrative role.

DR. RYU: Okay. And then lastly, does it include contracted labor?

MS. BINKOWSKI: Yes, and again, it's allocated down across sections.

DR. RYU: Thank you.

MS. KELLEY: Greg.

MR. POULSEN: Thank you. Yeah, I'm very enthusiastic about this excellent work as well, and I think you've done a terrific job on this, but I do want to expand on that in Round 2.

The question I have is, do we have a sense of, compared to 2007 at any rate, how large the group is whose ox would get gored and how deeply it would get gored compared to 2007? Is it similar or has it changed in a meaningful way?

MS. BINKOWSKI: I don't have those direct results. I think broadly the sets of hospitals that would be affected are similar. I think for some of the large changes is some of the additional exceptions that were added since 2007 -- the Frontier floor, the low wage index policy, et cetera, as well as the ability for hospitals to dually reclassify. So I think the broad category that payments would shift towards hospitals that currently don't have any exceptions still holds, but exactly who those are and some caveats have changed.

DR. CHERNEW: There's two parts of your question. One is what's the distribution. I think there's some mailing material parts on that. The second one is how does

that change to what we had in 2007. That's a little bit of a different.

MR. POULSEN: I'm just wondering about the politics.

DR. CHERNEW: Yeah. I understand. 2007 politics seem a long time ago.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. This is a really informative chapter, and I appreciate all the work that went into producing it.

I had two questions, just to make sure I was tracking this right. On page 5 it talks about that the geographic labor market is defined by MSAs, if I have that correct, and that there's this residual called the statewide rural area. And I'm trying to think about that sort of amalgam of the rural areas because I imagine that there are -- I think the example was Martha's Vineyard, you know, high costs but then there's probably low costs. And so does it make sense to sort of combine those? I recognize it's probably trying to deal with small-number issues. So that's the first question, and I'll pause there.

MS. BINKOWSKI: Yeah. So I think broadly we think it does not, or at least not with any recognition of which other counties those individual rural counties are bordering. And so the current wage index systems amalgamize all of them, which can be very disparate areas of the state, geographically distant as well as have different characteristics, as you mentioned.

What we ended up doing in our illustrative alternative wage index is we started with them as just one rural balance of the state, again because you can't necessarily get a large enough sample size if you're looking at individual counties by themselves at step one of the initial area wage index. But then when we had that plus or minus 5 percent that we mentioned, that's where we could let them then vary within that area. And maybe that should be slightly higher or less.

So we think there's no perfect definition of labor market areas, and we're concerned about this amalgam. We think it's a reasonable place to start but not end.

DR. DAMBERG: Thanks for that clarification. The other thing that, again, I just want to make sure I'm tracking this, is at the top of page 13 it's describing

differences in relative labor costs being matched among counties within a single labor area. And I'm just curious. Maybe I missed it. Do you have some sense of the amount of heterogeneity or variation sort of within markets?

MS. BINKOWSKI: Yeah, that's partially where we ended up settling on 5 percent. There definitely were some areas that were higher if we looked at the raw census data, which is based on the American Community Survey. And again, it depends based on MSAs. There are some MSAs that are larger. The distance both in terms of geography and kind of similarity between the central core area and the outlying area can be greater, and there are ones where it is more similar, and also these rural balance of states. I think it was high as 10 percent in a small minority of counties, that we ended up capping it at 5 percent for some of the reasons I discussed earlier.

DR. DAMBERG: And is this largely happening -- so I'm from Los Angeles, and I kind of understand the geography there. So it is happening in these very large regions, and would that suggest maybe the need to kind of split those areas for a little more precision?

MS. BINKOWSKI: Yeah, so it's happening as

described on page 13 in kind of two main types of areas. One is these kind of larger MSAs. And one of the things that CMS already does is it looks at, for some of those, at metropolitan divisions within MSAs, which has its own pros and cons. And other types of areas are in these sprawling rural areas that can be quite different. So the physical fact of the MSAs and their heterogeneity vary. And I want to defer to Mike.

DR. CHERNEW: Yeah. There's no perfect answer for this, and they've tried this through the out-migration and these other sort of things to deal with these sort of border-crossing issues. So I think there's only so good you're going to get.

There is another designation of commuting zones, which again there's also border crossing across commuting zones for a bunch of reasons, but their commuting zones are intended to sort of measure loosely where people might commute for work. But, again, they're not perfect for a bunch of reasons, and in an era of travel nurses, people can be moving all over the place.

I think these are really important issues, and I think it's good to understand what the options are, but I'm

just trying to lower expectations about how we'll also -- any method would solve some of the things.

DR. DAMBERG: Yeah. No, I wasn't necessarily proposing an alternative. I was just trying to understand sort of the underlying landscape.

MS. BINKOWSKI: Yeah. I think you articulated a tension between the size of geographic areas that you start with and how you balance those out.

MS. KELLEY: I think we're in Round 2 now.

DR. CHERNEW: Round 2.

MS. KELLEY: David, you're first.

DR. GRABOWSKI: Great. First, I'm incredibly enthusiastic about this work. This is really super.

We know the current wage index is flawed. I think this use of the cross-industry data by occupation type is really clever, Jeff. I don't know if you came up with that back in 2007, but I think it's really kind of a neat idea.

So some thoughts here, reflections on this. First, this issue came up, the heterogeneity of workers, and I wondered this as I was reading the chapter. RNs in hospitals are very different than RNs in SNFs, for example.

They're paid different. They have a different skill set. Betty could probably talk about this for a long, long time, and I wondered, does that trend by local area in a similar manner?

And I know you're weighting back, but just something to think about there as we're constructing this. I don't think that dooms this, but just an idea there that the key is something when you're using that sort of cross-industry data, do you actually end up weighting it back such that they trend similarly across local areas?

The second point, I thought the smoothing across counties was really important. Currently, you have these big discontinuities. Researchers have even exploited there. So we'll get payment differences in two hospitals sitting on either side. I mean, that makes absolutely no sense. I really liked this idea you had sort of put forward, 10 percent as a potential cutoff. That still seems really big to me. Maybe it's not. I know we hate cliff effects at MedPAC, but is that 10 percent still a cliff effect there? So just thinking about what's the right kind of difference by local county.

I love the idea of no exceptions. I think the

current system is so complicated, and I think part of what makes it so complicated is that we've allowed all these exceptions.

The final point, it's always bothered me that we take a flawed hospital wage index and just apply it to other sectors like SNFs. If this is broken for hospitals, it's even more flawed for skilled nursing facilities. So I really like the idea of kind of re-weighting the jobs based on who works in a nursing home versus who works in a hospital, because it's a very different skill mix in terms of physicians, RNs, LPNs, and nurse aides.

So getting very enthusiastic about this and look forward to following this work. Thanks.

DR. CHERNEW: I'm just checking the audio.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. I'm in favor of the work as well. I think it's very thoughtfully done. Thank you.

I just had one comment, and it has to do with remote work, which I think is becoming a bigger and bigger piece of even the hospital workforce, and some of these areas that I think are becoming a larger share of the hospital workforce.

So, if you take IT, data, informatics, analytics, even the more traditional back-office jobs, I think more and more of them are becoming remote workers. And so I think it raises the question -- and you could probably lump contract workers into this category as well -- what is the market? Is it really geographic or regional or local or what have you, or is it truly a national labor market in those job classes? And so I don't know that the wage index -- even the Version 2.0 improved version, I just don't know if that's the right construct for that component of the labor pool.

So I'm not sure I have any ideas, but that might be something to think through as you proceed with the work.

DR. CASALINO: Jaewon, would you say it is a national market for your organization now?

DR. RYU: Yeah. I mean, if you took a look at -- let's start with the EMR. I'd say most of those folks are working remotely, and they're working from all over the country. And I think you're not competing with the folks inside your MSA. You're competing with anybody across the country.

And I'll take it a step further with data,

analytics, those areas. You're competing even outside the industry, you know, with big 10 companies, tech companies and so forth, and so that, you know, entering your wage index calculation, I think it's misleading.

MS. BINKOWSKI: I think that is a good point for us to think about. I do want to mention that the vast majority of wages that go into the wage index are, if not clinical, you need to be there on-site. So the most common occupation that I'd say is on the potentially remote side of certain types of administration, which is a mix, is maybe 5 percent.

So I think it's true, but I think it's small.

DR. STENSLAND: And if the wages are actually equal across everywhere, then it wouldn't cause a problem because it's just going to show up in the data as being equal in this market and that market.

DR. RYU: But would that dampen your calculation, I guess, to the extent that's --

DR. STENSLAND: It would dampen the differential.

DR. RYU: Yeah.

DR. STENSLAND: But then you can say but it should be dampened because they're paying the same rate for

that particular category of employee. There's kind of this weighted average --

DR. RYU: Yep, yep. I see where you're going.

DR. STENSLAND: -- and that one part of the weighted average is equal across everybody.

DR. RYU: Yeah. Versus if you were to extract them from your calculation from the beginning. Would that be cleaner? I don't know.

DR. STENSLAND: Yeah. I think if you extracted them from the beginning, you would have a bigger differential but maybe too big a differential because you're ignoring the part that's equal. You've kind of had this weighted average --

DR. RYU: Yeah.

DR. STENSLAND: -- of a little bit that's equal and more that's different than --

DR. RYU: Yep, yep.

MS. KELLEY: Robert?

DR. CHERRY: Thank you. I can tell there's a lot of really great work put into this, and even what's being proposed as-is is much better than what we currently have. So I want to thank you for that.

A lot of us are going to give comments and feedbacks, and there is no perfect solution to this. It's just other items to consider as you're still refining the formula for the index.

There are some limitations, some of those things that have been mentioned already. One of those is around sort of purchased or contracted services, and I think that needs to be defined a little bit more in terms of what's in and what's out. You know, is agency in as per diem from a nursing perspective?

Regarding physicians as contracted services, I agree that they're compensated in a different way through Part B, but often hospitals will engage in locum tenens, call pay, employing physicians at a premium in order to provide a coverage model in an integrated service line, and so that does come at a certain cost. There may or may not be a way of problem-solving through it, but I just want to mention it as a limitation.

I also agree that remote work is challenging, and it's a big unknown right now because we don't really understand its entirety, you know, what the final proportion of the health care workforce will be remote and

how many of them will be out of the counties that are in these catchment areas and whether those salaries will be comparable to or maybe at a reduced, you know, cost to the facility in exchange for remote work.

And then the other limitation too that was mentioned is that there are other occupations that hospitals, health systems, provider practices are competing with, you know, HR, financial services, and particularly IT, and because in IT, for example, hospitals and health systems are competing pretty aggressively with large tech companies that can pay much more substantial dollars, it's also increasing the cost. But it's hard to say that all things are sort of equal in certain types of industries and certain types of fields. So I just mention that. Wherever you can thread the needle on these things, that's great.

The one concern that I do have is on the downside risk to providers, which could be up to a negative 5 percent. Right now, I think many physician practices are under considerable stress just trying to pivot towards value-based care, population health. They're already taking on, many of them, downside risk with regards to bundled payments and so on. This could be a stressor that

could be introduced into the system a little bit too quickly. So I just mention this with some degree of caution about introducing a negative 5 percent for providers.

But other than that, I think this is well done, and I look forward to the future iterations.

MS. BINKOWSKI: Thanks, Robert.

The one thing I wanted to add is that while we're talking about this for various sectors, of institutional sectors, there's a separate process of GPCIs and a separate thing for physicians, and we're not addressing this at that time. So I know this was just your example, but --

DR. CHERRY: Great. Thank you for clarifying.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much.

I think my Round 2 comment just became a Round 1 question. I just want to make sure I understand something that you said.

I'm going back to the issue of the occupations and weights, and obviously, in long-term care, there's many more nursing assistants, LPNs, fewer RNs, but very, very needed.

And, in the current situation -- so not as a generalist, as you know, and I as a nurse could work in a nursing home, work hospital, or be a traveler with very different salaries, despite the fact that I am legally able to work in any of those settings. Does this address that or make it worse?

[No response.]

DR. RAMBUR: Or we can think about it, but I think it's really important we don't exacerbate that problem because there is absolutely a hierarchy that spreads to education and student interest. It shapes curricula in terms of where people want to go and where they don't want to go.

MS. BINKOWSKI: Jeff is going to say something more brilliant after I, but I would say it does not exacerbate. But I think it does not completely address either. I think under the current system, part of the issues is, you know, there aren't relative wages of nursing assistants included much at all in the current initial hospital wage index or of certain home health aides or psychiatric technicians, and so just bringing those in, I think, is a large improvement and weighting them highly.

Does it completely address the -- or both of them have issues with just heterogeneity of how occupations are defined of registered nurses? And this doesn't address that, and that's a limitation of the data.

DR. STENSLAND: I don't think it makes it worse. It might make it a little bit better in some markets in that if you are a nursing home and you're competing as to hospitals that got a wage index reclass, so it gets a much higher wage index now than you do because you're going at the pre, reclass wage index, we would eliminate that problem, but we wouldn't eliminate all this differential pay for a hospital versus a nursing home, which might be more fundamentally based on ownership and financial resources and other things.

DR. CHERNEW: I think -- so I know we have a bit more people in Round 2. Let me just try and put a little framing on some of this discussion. There's sort of two underlying issues in my mind. One is there's a lot of issues that have happened and crept into the existing wage index system where there's classes, reclasses, a bunch of exceptions, and so there's one sort of path of thinking which is we're okay with sort of, kind of approach, but the

exception process has gotten out of control. And that current system fundamentally -- I'll just pick the hospital sector -- relies on hospital wages to get -- so what you do then feeds back, and there's that slide that shows you the circularity, right?

What's nice about this is it gets -- so the second pathway is -- so ignoring the exceptions part of the problem, let's fundamentally change the paradigm for how we think about this, where now we're going to put less weight on like what you hire and what your wages are. So what you do and how you reclass doesn't affect things as much, and we sort of work down this occupational path.

There's a lot of merit, exceptions aside. I think there's a lot of merit in thinking through that broader approach, but when you do that, what we're calling the "alternative approach," you run into this challenge that it is occupation basis as opposed to what individuals or hospitals are doing. And so the exceptions aside, the status quo looks at hospitals where hospitals are paying from their cost reports, and it comes up with the variation across hospitals, across areas, and that's how it creates the differences between -- I'll pick Cleveland and

Pittsburgh, being from Pittsburgh. Go Steelers.

In any case, it's based on what the hospitals in Cleveland are paying relative to hospitals in Pittsburgh are paying, and if they change, there's a bunch of issues there. Whereas, the alternative approach is more about what are nurses in Cleveland getting relative to what nurses are getting in Pittsburgh, and the nurses are then not just hospital nurses in Pittsburgh and Cleveland. But they're nurses in SNFs and all the other nurse settings.

So, for Alison and Jeff, did I characterize sort of the two issues?

And so, as we go forward, we could limit what we -- I think -- and I'm just gaging from the Round 1 and some of the Round 2 questions. I believe there's widespread agreement that there are problems with the exception process, and there hasn't been a lot of people that seem concerned with that. And now what I think where most of this discussion is going -- and I know we have a few more people to comment -- we are struggling with the merits of hospital or sector-specific wages would have all these circularities and issues compared to an occupational approach, which has some real advantages, but to your

question, Betty and why I'm talking now is if there's a lot of heterogeneity in those occupations, if a hospital nurse and a SNF nurse are really like completely different, but the occupation is lumped together, than the occupation approach is problematic. And I think as we go forward, we will probably think about those two things separately about sort of where we go.

That was -- sorry. I just burst out my excitement for wage indices.

[Laughter.]

DR. RAMBUR: Can I just say one other thing?

DR. CHERNEW: Yeah.

DR. RAMBUR: I'm not in a hurry to --

DR. CHERNEW: Excuse me?

DR. RAMBUR: Are you done? I don't want to interrupt.

DR. CHERNEW: No. Please. I work best when being interrupted.

DR. RAMBUR: I was just going to say I certainly do support this, and I just want to say there is a big movement to have unique nurse identifiers in which individual nurses' contributions could be more easily

teased out, which doesn't help us in the short term.

But a number of questions have come up about physicians, and really physicians and nurse practitioners in the current funding model are revenue generators, and all of this is labor cost, which is part of the problem because they're the people actually delivering the work.

And even though it's not part of this, I just have to say again I do hope that there's some way we can help policy-wise shape the employment decisions, given that there's so much data on what we certainly know is to be true but lots of data that more registered nurses, more staff, better educated staff makes a big difference in quality and safety.

So I know that's a big thing to hit with this, but to the extent that that's part of our orientation, I think it's an important value.

DR. CHERNEW: And, as I said at the beginning of this, if there are issues like there's specific access problems for rural hospitals or their safety in hospitals, they're just unable to provide the care that we think the beneficiaries need, which is a problem we worry a ton about and will continue to worry about over this cycle, the

solution for that problem may likely be how do we support those hospitals in a bunch of ways as opposed to how do we create a wage index that makes sure they get things.

What is often challenging and sort of my stay-up-at-night problem is we can't get folks to adopt every portion of our recommendations, even within a chapter and across the chapter. So then you end up worrying that you'd like them to target the safety net hospitals in a particular way and you'd like them to get rid of a sort of very cumbersome wage index approach to doing that, but if they just do one and not the other, then you worry.

Now we're into the therapy stage of MedPAC. Okay.

[Laughter.]

DR. CHERNEW: Who's next, Dana?

MS. KELLEY: Greg.

MR. POULSEN: Thanks.

I again really, really appreciate this good work. I think exceptions decrease general senses of fairness and accuracy, and they destroy transparency. And I think that that's clearly the case here.

The exceptions, not surprisingly, lead to gaming,

which consumes resources both on the part of the provider organizations as well as the government. So I'd love to see that.

I absolutely agree with the goal of separating the wage index from other policy goals that Michael just talked about. I think conflating policy goals with what should theoretically be a theoretical and empirical procedure puts both the policy goals and the procedural goals at risk.

Finally, I think that the point that Jaewon brought up is a really good one, and I think even in the clinical world, we're seeing an increasing percentage of the clinical care being delivered remotely. And it could be being delivered from anywhere, and I think that those percentages are significant in many settings, especially rural settings today, and they're going to grow even more in the future. And we just need to keep those in mind.

What it may mean is that whatever the local wage differential is should have some additional national component built in that sort of maybe regresses towards the mean to some degree as that happens more and more, and that's whether you're a high index -- or a high wage area

or a low wage area.

So, anyway, again, just really good work. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks.

I also, Alison and Jeff, wanted to echo the Commissioners' support of this work. It's an excellent chapter. There's a number of different areas that I thought what about this, and I went to the tables, and sure enough, you had already captured some element of it in there. So I think it's absolutely wonderful work, and I'm very enthusiastic and supportive of the direction.

I think Greg actually recapped many of my comments, which is really around the integrity of the program, and I think that this will really push us in the right direction.

I also wanted to say that I think the tele/remote work is an important piece for us to track over time. I agree with you, Jeff, that to the extent that there are common trends across different areas and market areas, labor market areas, et cetera, that they'll essentially net out, and you'll get a more accurate -- but there are

reasons also that we might believe that certain areas, like rural settings, would end up relying more on remote/tele type of care and/or work. And so there may be some discrepancies that emerge over time.

I personally don't think it's something that we need to absolutely address in this recommendation in this cycle, but I think it's an important element for us to keep track of as we move forward and continue to monitor what's happening in the broad health care workforce. And maybe it's something that belongs more in the workforce element rather than the wage index. So I'd put a plug in for just making sure we allocate things in the right bucket.

And my last point is, in part, response to what Betty was saying. I think there's a lot of -- as we've talked about, there's a lot of complexity here, and there's essentially some puts and takes, and any policy change creates some winners and losers.

I think the way I view what we're doing here in this wage index work is much less what I think an economist could consider normative, which is that we're saying this is the way it should be, and it's much more of a descriptive thing of here's what's happening.

So we're not necessarily trying to nudge the system toward a particular wage differential. Rather, it's just a reflection of here's what we're seeing, and to the extent that there are, in general, trends across mix of different types of nurse types, for example, that are not very broadly skewed across different areas, what we're proposing here should actually be a very good representation of what's happening and for all the reasons I think other Commissioners have outlined much better than the current system that we have.

So I just thought it important for us to make that explicit, that we're not suggesting a particular system, but rather, we're just simply reflecting what's actually happening in labor markets today. And that's the best way for us to basically calibrate the wage index system.

DR. CHERNEW: I may disqualify myself for MedPAC for the jargon I'm about to use. The problem is we're trying to treat as exogenous something that's endogenous. I hope we were offline when I said that.

[Laughter.]

DR. CHERNEW: But the issue is if it was there

were fixed wages in an area and it was just a question of measuring, that would be fine. The problem with the current system and all the circularity is that what you pay, that influences what the organizations, which influences what they get paid. One of the advantages of the occupation approach is you break that connection some which is sort of better, but because of the heterogeneity and some of the other issues that have been raised, that creates another set of measurement imprecisions.

I apologize for those listening at home.

MS. KELLEY: Cheryl.

DR. DAMBERG: I want to go on the record as saying I like the direction that this is heading, and I really support this work and look forward to seeing the updates based on some of the comments received today.

You know, without doubt, the current system has many bad features, whether it's the circularity of hospital wages, the exceptions, which really have left this open to gaming. And I'm actually kind of shocked that hospitals can kind of classify, reclassify, reclassify.

And I guess, to me, I'm trying to think down road for whatever we recommend or eventually might get put in

place is kind of how to try to be forward thinking beyond sort of kind of how the labor market is changing, to try to think about or anticipate some of the unintended effects. I mean, we've obviously seen unintended effects with the existing program. So how might we make recommendations to say whatever the new system is, there aren't going to be exceptions allows, or can hospitals reclassify, and if they reclassify, they can't reclassify again for another, I don't know, 5 or 10 years. So it can't be this kind of churning activity.

So I don't know what those things might be, but I think it's prudent for us to kind of think about where some of those challenges lie ahead, for whatever the revised system is.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. I too am enthusiastic about the work, and in particular about eliminating exceptions. That can be a model for other MedPAC work and for policy more generally. And, in fact, that is kind of the way we've been working on a number of issues.

It might bear actually being quite explicit about two things in any of our reports. One is the reason for no

exceptions and the other is what Mike has repeated so many times. If you want to help certain kinds of hospitals, for example, do it with direct policies. And our safety network is trending toward that, right? If you want to help safety net hospitals, make a program to help safety net hospitals. Don't try to help them through eight different programs and muck up those other eight programs. So that's something we might consider stating pretty much every time for now, including, for example, in this report.

But the reason I wanted to speak was physicians have come up at least twice, with Jaewon and Robert, and each time, Alison, your response has been it's not relevant to this because physicians are paid out of the IPPS. But I think what Robert, at least, was saying, is that hospitals, for various reasons, sometimes will pay the physicians they employ above what they could be paid, based on IPPS. Am I right about that?

And so my question about that, I guess, would be from your point of view -- and I haven't really thought this through so I would be interested -- given that is the case, does that make any difference?

I mean, one thing that immediately comes to my

mind is you frequently talk about, in the written materials, we don't want to make what hospitals get paid depend on their employment decisions. And this is a kind of employment decision, really. There are so many Medicare policies that contribute to the hospital employment of physicians. This could be another one, depending on how we do it.

But anyway, I haven't thought it through and I would be interested to hear what you guys' reaction is, and Robert's or Jaewon's comments to, if relevant. Should this make a difference, and if so, why, and if not, why not?

DR. STENSLAND: I have no good thoughts, but I'll think about it and get back to you.

MS. BINKOWSKI: I was just going to reiterate that, again, we may bring up physicians later and how they are paid and their geographic classifications, but no physician wages, with the minor exception of certain physicians playing administrative roles, which is a very small portion, come into either current wage index or the alternative wage index.

So I think they're important questions, more generally, but they are out of the scope of what we've been

talking about thus far. But we're happy to talk about it more later.

MS. KELLEY: Lynn.

MS. BARR: I'm kind of following up on this point. I'm sort of thinking the same thing. So hospitalists are included or not included?

MS. BINKOWSKI: I'm shaking my head, not included.

MS. BARR: Definitely not included. All right. Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: This is going to be very brief, to not count against my time that I know Larry will be counting on next session.

[Laughter.]

DR. DUSETZINA: I just wanted to say, I loved the chapter. I think that when you started describing the system as Byzantine and then talking through administrative burden, and all of the gaming that is happening, it does really set itself up for me being super supportive. But yes, simplifying things, as others have emphasized. Let's have policies do what we want them to do and not kind of

build in other things here to make it more complicated and more gameable.

So I just wanted to say I'm fully supportive and really appreciated the chapter.

MS. KELLEY: Amol, did you have something you wanted to say?

DR. NAVATHE: Yeah. I just had potentially a quick question based on what Larry was saying, which is -- and this interacts a little bit with Betty's question perhaps. So a nurse practitioner, for example, not a physician, would a nurse practitioner be included in the wage index occupations?

MS. BINKOWSKI: Again, no. Super minor exceptions, but physicians, nurse practitioners, PAs, all paid separately, not part of either the current or the alternative wage index. And again, that gets to Betty's point of why are certain occupations currently paid separately and viewed as revenue generators versus labor costs? And that's a bigger question. But in terms of what's currently done they are treated differently.

DR. NAVATHE: Okay. Very helpful. Thank you.

DR. CHERNEW: So I think that's the end. So just

to summarize where I think we are quickly. There is a lot of enthusiasm for this, and I think we will go back and follow these comments and try and see if we can get to sort of policy options and recommendations going forward. When we do that, we will probably separate out issues around recommendations related to exceptions and how one might deal with exceptions, and then the recommendation about the alternative approach here. And if we do that, of course, there's upsides and downsides and heterogeneity issues in how we will sort that out.

But I think this is actually a really important issue across the system, and we move to any of the things we care about you'll see versions of this in how you might think about Medicare Advantage. You see versions of this in how we think about alternative payment models. There are big geographic differences across the country, and some of which are things that we really want to reflect in payment to make sure that beneficiaries wherever they live get access to care. And on the other hand, some of the systems that do that are imperfect for a bunch of reasons, even before they go through the sausage factory of how they're really implemented. And so it's a hard thing, and

we're going to come back and do it.

We are ahead of schedule, so as I wrote, Stacie was right. She is now going to get more time, and we all get more time, just to be super clear.

So we had 5-minute break scheduled. Let's take a 10-minute break, just to prepare ourselves. We will still have five extra minutes. We will start the drug session at 10:25 instead of 10:30.

And remember, if I got this right, we're still going to be live on this session, right? So whatever you're whispering to your friend, be careful.

[Recess.]

DR. CHERNEW: I understand that we're good, and now Part B drugs, a topic that I don't think needs much introduction. I will devote as much time to the discussion as we can.

So, Nancy and Kim, take it away.

MS. RAY: Thank you, Mike.

Good morning. The audience can download a PDF of the slides on the right hand-side of the screen.

An important driver of Medicare Part B drug spending is the price Medicare pays for drugs.

Manufacturers set their own prices for new drugs and, historically, have set high prices whether or not there is evidence that the drug is more effective than the standard of care. High prices and limited price competition among existing sole-source drugs is also a concern.

Today's session is a follow-up on the Commission's April 2022 meeting during which we discussed three approaches to improve how Medicare pays for Part B drugs. These approaches were included in our June 2022 report and reflect Commissioner input and guidance.

Since the June report, the Inflation Reduction Act contains changes to Part B drug payment. However the IRA has not negated any of the options that we will be discussing today.

I am going to move through things at a high level, but more details are in your paper that Kim and I will be happy to discussion on Q&A.

Part B covers drugs that are infused or injected in physicians' offices and hospital outpatient departments, including costly biologics like eye injections to inexpensive products like corticosteroid injections. Part B also covers other types of drugs as listed on the slide.

The Medicare program and beneficiaries spent nearly $41 billion on Part B drugs in 2020. Spending for these drugs has been growing rapidly, over 9 percent per year on average over the last decade.

The largest driver of spending growth has been the rise in the average price Part B paid for drugs, which reflects the launch of new, more expensive products, increases in the price of existing drugs, and the shifts in the mix of drugs.

Although there are many Part B-covered drugs, spending is concentrated. The top 20 drugs accounted for more than 50 percent of spending and are used for treatment of cancer, macular degeneration, and inflammatory conditions.

Most Part B drugs are paid at a rate of 106 percent of the average sales price, ASP. We will talk more about the 6 percent add-on later in this presentation.

ASP reflects the average price realized by the manufacturer for sales to most purchasers, net of most rebates, discounts, and price concessions. ASP is an average. An individual provider's purchase price for a drug may differ from ASP. Manufacturers report ASP data to

CMS quarterly, and the ASP payment rate is based on manufacturer ASP data from two quarters prior.

Exceptions to ASP+6 payment rate are listed on the slide. When a provider furnishes a Part B drug, in addition to receiving ASP+6 percent for the drug, the provider also receives a separate payment for drug administration services under the physician fee schedule or outpatient prospective payment system.

Medicare has few tools to influence prices of Part B drugs. Statutory and regulatory language require that Medicare pay for a drug's FDA-labeled indication.

The way Medicare codes Part B drugs affects price competition, which in turn affects spending.

Products assigned to the same billing code, for example, a brand and its generics, spurs price competition.

By contrast, assigning products to their own code, like single-source drugs, originator biologics, and biosimilars does not spur competition, with the manufacturer effectively determining Medicare's payment rate for the product. And Medicare's payment policies generally do not consider whether a new product results in a better clinical outcome than its alternatives.

The concerns about drug prices listed on this slide are not new. Estimates suggest that U.S. drug prices are roughly double the prices in OECD countries. Higher prices in the U.S. reflect higher launch price and more post-launch price growth.

According to some researchers, high launch prices are not necessarily related to a product's comparative clinical benefit, and some products approved under the FDA's expedited pathways are launching at high prices with uncertain clinical benefit. Aduhelm, approved under the accelerated approval pathway, is a recent example of this.

The policy options that we will be discussing will complement the IRA and aim to improve payment for drugs with uncertain clinical benefit, spur price competition among drugs with similar health effects, improve financial incentives under the Part B drug payment system, and maintain incentives for innovation.

The first two policy options address manufacturers' pricing behavior for new drugs with uncertain clinical benefit and existing drugs with therapeutic alternatives, and the last option addresses concerns about the 6 percent add-on and providers'

financial incentives.

This policy option focuses on the payment for new accelerated approval drugs. At time of their approval, there is uncertainty about their impact on clinical outcomes. Although the FDA requires manufacturers to complete confirmatory post-approval trials, some trials are never completed or are completed after many years.

To protect Medicare from paying a considerable amount for drugs with uncertain benefits, Medicare could cap their payment until confirmatory trials are completed. Several approaches could be considered for setting a cap.

Under the first approach, Medicare could cap payment based on an assessment of both the comparative clinical effectiveness and cost of the new product compared to the standard of care. We discussed this approach in April. Based on Commissioner guidance, we have decoupled it from coverage with evidence development. CMS would maintain discretion to apply CED, however.

Alternatively the cap could be set at some increment of the payment rate for the standard of care. A cap at 100 percent of the standard of care is a type of reference pricing.

Another alternative is to pay 106 percent of the new drug's ASP for three years and thereafter, if confirmatory trials have not been completed, cap payment based on the standard of care.

As an alternative to a cap, Medicare could establish rebates based on a percentage of the new drug's price. In June 2021, the MACPAC recommended increasing Medicaid rebates for accelerated approval drugs.

To implement a cap, a well-defined, transparent, and predictable approach would be key. Medicare would need to establish a process for identifying the standard of care as well as identifying sources of evidence, which could include clinical trial evidence that the manufacturer submits to the FDA and clinical evidence published in peer-reviewed publications.

We now turn to an option that addresses concerns about pricing for drugs with similar health effects. Because Part B pays each single-source product based on its own ASP, it does not spur price competition among therapeutically similar products.

In 2017, the Commission recommended a combined billing code policy for biosimilars and originator

biologics, which is a type of reference pricing that would pay these products the same average rate to spur price competition. Building on that, reference pricing approaches could be considered more broadly for single-source products with similar health effects as a way to promote competition.

So here's how a reference pricing policy for Part B products might work. Each product in a group would remain in its own billing code. Medicare would set a payment rate for the reference group. For example, the reference price could be based on the least costly alternative, an approach Medicaid used to pay for prostate cancer drugs at one point, or it could be based using a volume-weighted approach. This is the current method for determining the ASP of a branded drug and its generics. Or the reference price could be based on the lower of the volume-weighted ASPs of all the products in the reference group or the ASP of the specific product furnished. This method is currently used for select inhalation drugs.

It will be key for CMS to implement a transparent and predictable process to establish and maintain reference pricing. Some of the design elements are listed here,

including a process for defining groups of therapeutically similar products. It will also be important to provide pricing information to beneficiaries and clinicians so they can make informed decisions.

So we've just talked about two options to address high drug prices and manufacturer pricing incentives. Next, I'll talk about an option to improve provider incentives.

Medicare generally pays providers ASP+6 for Part B drugs. While clinical factors play a central role in prescribing decisions, there is concern that the 6 percent add-on may create incentives for providers to select higher-priced drugs when a lower-priced drug is available to treat a patient’s condition.

Since 6 percent of a higher-priced drug generates more revenue for the provider than 6 percent of a lower-priced drug, selection of the higher-priced drug can generate more profit, depending on the provider's acquisition costs for the two drugs.

In our June 2022 report, we explored several approaches to modify the 6 percent add-on. Today we will focus on the approach that had the most Commissioner

support at the April meeting.

So here is that option. The add-on equals the lesser of 6 percent or 3 percent plus $21 or $175 per drug per day. Let's walk through the mechanics of the approach.

First, we converted a portion of the percentage add-on to a fixed fee, so that's the 3 percent plus $21. We then added two caps. The add-on would be capped at 6 percent, its current level. This would address concerns that a $21 add-on could otherwise lead to a large payment increase for low-priced drugs.

The second is a fixed-dollar cap of $175. This is intended to address concerns about large dollar add-ons for very expensive drugs.

The numbers in this option are illustrative. Other percentages and dollar amounts could be considered.

This next chart shows how the policy option would change add-on payments for differently priced drugs. The add-on payments here are pre-sequester.

As you can see, add-on payments are unchanged for lower-priced drugs, while the add-on is reduced for drugs priced more than $700.

For drugs above that threshold, the effect of the

policy is to reduce the difference in add-on payments between higher- and lower-price drugs. For example, comparing $1,000 versus $3,000 drug, the difference in add-on payments between the two drugs is reduced by half under the policy option. And the largest reduction in the add-on differential occurs among the most expensive drugs; for example, comparing a $5,000 versus $15,000 drug.

To explore the effects of the policy option, we simulated its first-year effect on total Part B drug payments in 2019, assuming no prescribing changes.

To the extent that the policy spurs providers to substitute lower-cost drugs for higher cost-drugs, savings could be higher.

The policy option is estimated to reduce aggregate Part B drug payments by 2.6 percent in our simulation. The amount payments decrease across specialties and provider types would vary depending on the mix of drugs used.

An issue to consider in making changes to the add-on is what are the implications for a provider's ability to acquire drugs at the Medicare rate. In the past, stakeholders have raised concerns about small

purchasers' ability to acquire drugs if the add-on is changed. However, manufacturers set their own prices and have an incentive to price products at a level that providers can acquire at the Medicare rate.

Although data on providers' drug acquisition costs are limited, there is evidence that manufacturers have responded to past payment rate changes by narrowing price variation or modifying pricing patterns in ways that help mitigate the effect on providers.

So, in summary, we've discussed three policy options. The first, to address products with uncertain clinical benefit, set a cap on the payment until the post-marketing trial confirms the clinical benefit. The second, to spur price competition among drugs with therapeutic alternatives, use reference pricing; and the third, to improve provider incentives under the ASP payment system, modify the ASP add-on.

Given the different focus of each of these approaches, there could benefits in packaging them together into a multi-prong approach. Our goal for today's discussion is to get your feedback on these policy approaches as well as any ideas you have for additional

approaches.

And now I turn it back to Mike.

DR. CHERNEW: Great. Thank you.

So we're going to go to Round 1 in a second, but let me just lay out what I'd like to get out of this session. We are planning to move towards some votes in this area. So understanding things you're very enthusiastic about or very opposed to would be really good, even if you don't -- actually, you could just say love it, hate, whatever it is. That's useful.

Apart from that, think of these in three different areas. There is the problem of competition amongst similar products. That's the reference pricing biosimilars originator part. There is the issue of the incentives associated with the ASP+ model. That's two, and then there's three I'll put broadly under the heading of what to do about accelerated approval drugs, understanding that they span the range from COVID vaccines to -- I'm going to just go with not-COVID vaccines, but there's some recent examples of things that would fit into that not-COVID vaccine bucket.

So we're trying to figure out across those there

things, what you think, and in the last group, what to do about accelerated approval drugs is the most complex. And there's a subtlety in that one I'll just call to your attention. How we phrase this in terms of what CMS should do, CMS should do blank versus CMS has the discretion to use this tool if they think that a drug meets some criteria, and that's sort of how we're just framing it.

Let's go to -- I hope that was clear. You can ask Round 1 questions of like what I --

DR. GRABOWSKI: Can I just --

DR. CHERNEW: Yeah, go on.

DR. GRABOWSKI: This is my question. Do you want us to prioritize those areas or just yes, no, kind of this is -- leave your mic on.

DR. CHERNEW: I don't want you to prioritize them because I don't view them as mutually exclusive. Our view now is we are going to go say something about all three. That's the current plan, but you should call out the ones that you particularly -- again, if you don't feel particularly strongly, you don't have to say, but if you're -- what I honestly care about is if you're really opposed to something, that really is important for us to know

sooner than later. And, obviously, if you're really enthusiastic about something, that's just nice to hear.

So let's go with Dana, and then we'll -- it looks like then we're going to jump into Round 2, which is great because Stacie is first in Round 2.

DR. SAFRAN: Yeah. Just a quick question. Is there concern for any of these proposed models but especially for the ASP add-on proposal that to maintain income, facilities could begin to just increase the number of days that they're administering a drug?

MS. NEUMAN: So we do discuss in the paper that if the add-on policy changes affected prescribing patterns, then our simulations would be different from what we have done.

I think that within certain treatment patterns, there's often guidelines about how things are to be dosed. So that question would really focus in on for those products where there is leeway, would there be a response, and so we have not tried to identify that. But we have raised it as a possible incentive issue to think about.

DR. CHERNEW: Yeah. Let me just say one thing. That's an important thing. This fits into a broader area

of essentially cost shifting or supplier-induced demand, which has been a topic of research for ages.

The paradox there is if an organization could, say, give a drug for more days or whatever it is, doing so with ASP+6 is more lucrative than doing it at another number. So the question is always why did they stop, and I think the sort of target income hypothesis-type work, which is what this sort of flows out of in economics as one, that for the most part doesn't -- you know, there's some examples. We could have a longer debate, but that doesn't seem to be what's dominant. What seems to be much more dominant is if I can make more money doing more -- actually, I should pause.

I think clinical considerations is the dominant form of how people decide what to do, and I don't want to say anything that implies that that's not the case. But, at the margin, I think the evidence is pretty clear that financial incentives matter, and to the extent that you're at that margin where financial incentives matter, the response to "I get more if I do more" seems to dominate the sort of target income hypothesis, which is "If you pay me less, I will then just offset that by doing more," although

both of them are worthy of discussion and worthy of looking at.

I think on this point, Greg wants to say --

MR. POULSEN: Yeah, very much on this point, I was actually going to bring it up later but it is directly to that point. We had a group of providers who were subject to the 6 percent add-on and some that were simply being paid a salary. And we found not only a selection of which drug but also the quantity that was provided.

And so it goes to the point that you were making, Michael, which is it wasn't that they had a target income. It was you could make more by doing more, and it impacted them on the margin. I don't think anybody was making what they thought was a bad clinical decision, but it certainly colored that clinical decision.

DR. CHERNEW: And I think the other thing that is important to understand here, which is, again, I feel like there should just be a video or a link, just saying the same thing in a different context every session, is the problem in some ways, in some of these things, is there may be groups for whom ASP+6 helps or they solve certain problems, and there are a bunch of things, the inventory,

et cetera, type things, small groups, a bunch of things that are in the mailing materials which are important.

But by going to a model that does that there are a lot of other people that wouldn't have that problem that then get the ASP+6. And so you end up in a situation where you're trying to solve a problem for a small group of providers by creating a payment system that has distortions potentially across the entire spectrum of things. And so that would fit back into our targeted kind of world. If there's a problem for some providers in accessing drugs -- and by the way, I think having strong group of independent -- I'll pick on oncologists because a lot of these are cancer drugs -- is actually really important, and we worry about that in a lot of other contexts. So understand that we recognize that. But supporting that group by this mechanism might not be the right way to do it. So there will be a separate discussion about how to deal with that.

Amol is going to add something, and then I really want to go to -- oh, were you going to say something? I'm sorry. I'm not on my chat now because I was talking.

DR. NAVATHE: -- on this point, basically.

DR. CHERNEW: Okay. Good. On this point. Amol

is up. I'm just trying to figure out on chat who's on.

DR. NAVATHE: Okay. I'll start talking. So I just wanted to touch on, fill in, perhaps, some additional points about what you were saying, Michael, about what we know of the dynamics here, and I think there's been perhaps more testing of different alternative approaches in the private insurance space, and both within Medicare Advantage as well as in private plans. And most of this has happened in the oncology space as well, but I think it's relevant here. There have been a variety of different incentive schemes that have tried to offset this, either by paying bonuses based on evidence-based pathways or by changing the structure of payment on a larger level or reference pricing type approaches.

And in general I think the lesson from those approaches is that it's highly multi-factorial, and what you think might result in a particular change in a pattern for selection of drugs or a volume of drugs doesn't necessarily get you there. And so I think in some sense we should be careful that we don't try to over-engineer a little bit the solution -- and I think that's what you were saying, Michael, to some extent -- toward groups that we

might worry may have a particular response or a behavior, but designing a rational policy that cuts across what we think should apply in a very general fashion. Otherwise, we could kind of hold hostage the policy in a way that doesn't really make sense. And that's what the private sector innovation type of evidence would suggest, as well.

DR. CHERNEW: Robert is a Round 1, and then we're going to jump to Round 2 with Stacie. I think that's the plan.

Oh, I'm sorry. Scott, did you have a Round 1? Okay. Robert is going to talk now.

DR. CHERRY: Thank you. Just for clarification, how did we come up with sort of the three-year time frame for a post-market trial, vaccines being one of those where it could take considerably longer than three years before you finally have enough definitive evidence that there's a clinical benefit. There are probably other types of trials that would fall into that category, like cancer drugs, where you have to recruit a whole new cohort again, and so on. So I just wanted to know where the three years may have come from.

MS. RAY: The three years is something that

definitely that Commissioners should discuss. The three years came from researchers who proposed this sort of approach, that we adapted their approach, Pierce and Bach, from 2010.

DR. CHERNEW: You could go with a very minor tweak to say FDA says blank, or some other --

MS. RAY: Right. Right.

DR. CHERNEW: -- some other number.

MS. RAY: That's correct. I mean, we could come back to you with numbers saying, well, on average post-market trials took, the average number of years is X, and you could base it off that, or the distribution of the average length it takes to complete a post-market trial.

DR. CHERNEW: The last point I would say is there's a lot of this where CMS could have discretion. So what you would do in COVID vaccines might be very different than what you would do in another area. So I think in the discretion world this is about thinking about tools CMS could use to solve potential problems of what's going on in the accelerated approval.

So we don't want the worst examples to drive policy that limits innovation. So I should say this

accelerated approval pathway is actually very important, and although I won't claim that all drugs going through it are super high value, there are a lot of high-value drugs that will go through this, in areas that we care a ton about. And by mucking around in there, there is a connection within the incentive to develop those drugs that we have to be very, very careful with.

The problem is, as we talked about last time, which is a little challenge because we have five new Commissioners, there are examples of real situations where there might be abuses in either pricing or access to things. And so I think the way to think about what to do my "what to do in accelerated approval" bucket is to give some discretion to CMS, to supply some tools. The tools are going to be some version of CED, which we talked a lot about, which is a really strict tool. That limits not just pricing but it limits utilization. You would never want to take COVID vaccines and put them through CED because you knew you needed to get them out quickly, to various types of price regimes that you might ramp up if, for example, they aren't doing the trials. So there's a lot of evidence that the trials aren't getting done.

So just think through how we're going to blend that discretion, how we'll blend CED, and how we'll blend prices in the accelerated approval, which is admittedly complex.

Scott has a quick question.

DR. SARRAN: So just a clarifying question. Does CMS have the authority now to apply CED with teeth, meaning to say for a new drug, for example, that hey, we'll give you X number of years, and if the evidence isn't published at that time we, CMS, will pull coverage?

MS. RAY: So CMS does have the authority to use coverage of evidence development on services and items that are covered under the Medicare program. And it is applied to Aduhelm, the Alzheimer's disease, for example. That being said, of the roughly -- I forget the exact number -- let's just say roughly 25 ongoing CEDs, there are only either 2 or 3 that relate to Part B drugs. So it's not typically applied to Part B drugs as of right now.

DR. SARRAN: But my specific question, can they actually pull the coverage of a drug if the CED isn't executed in the time and manner they set out?

MS. RAY: Oh. Are you asking can CMS withdraw

coverage for a drug that doesn't get its post-market data done in the X years FDA? I do not believe they can, no.

DR. CASALINO: On this point, to your knowledge has CMS ever done anything to penalize a company that doesn't get the post-marketing clinical trial done in a reasonable time?

MS. RAY: [Shakes head no.]

DR. CASALINO: Never. That's what I thought.

MS. RAY: And to be clear, as we stated in your paper and the presentation, based on the statute and regulations, Medicare is required to pay for labeled indications and off-labeled indications for cancer drugs.

DR. CHERNEW: But again, as Aduhelm illustrated, and I think again I talk a lot about COVID vaccines. We could talk a lot about Aduhelm. I'd rather not. But they did impose CED for Aduhelm, which effectively the CED -- and they did it originally. They didn't say, "Okay, do the trials and then we'll apply it." They did it originally. That effectively dramatically reduced access to the drug. They justified that on clinical evidentiary things. So despite the FDA approval, they said for a range of reasons. And we wrote a comment letter on this I'd refer you to.

There are some unique things, like what's the effect on the Medicare beneficiaries going to be, and a bunch of things like that. So they can use CED.

It's not clear to me that CED is under- or overused in particular ways, but it is a big hurdle for drugs that might actually have a lot of value, which is why, at least in that case, I would emphasize the discretion to do it as opposed to not. So again, we were supportive. MedPAC was supportive of the Aduhelm approach, which was an approach that did not say you should do CED everything, but it was in the particular situation. We wanted to support the principle that CMS had that discretion.

So anyway, that's where the Commission was last cycle and in our comment letter on that. The issue that we're extending sort of in this cycle is there are other tools, how you think about pricing and stuff.

And I was wrong so often yesterday. I think now, Stacie. Is that right, Dana? Okay.

DR. DUSETZINA: All right. Thank you. I feel like now we've built it up too much. So it's hard to express how enthusiastic I am about this work. I think it

is so important, and I think that we have a really excellent start here. As I was thinking about how to express the enthusiasm I thought, well, I'm basically glowing like Bruce's ring light over here.

[Laughter.]

DR. DUSETZINA: You know, I think that the chapter, and you guys have done a great job of describing the growth in the Part B drug spending, and that we don't have tools to adequately addresses prices and spending growth. And I think this is an important set of issues.

So just a couple of comments. The first is that I really, really appreciate the revision and the attempts to really tease apart these issues of coverage with evidence development versus thinking about being able to set prices in absence of CED. I think that's incredibly important.

So the two options, just to be explicit, are really thinking about the first option being capping prices when CED is used, and I think that really does reflect a lack of knowledge about how the drugs work for beneficiaries. Are they safe? Very much like the Aduhelm example, I think is a great example there, and that CMS

should have some opportunities to think about also dealing with the price in that circumstance explicitly.

But I think separate and more important is having the option to deal with prices or have a price cap without coverage with evidence development, and I think that the chapter does a nice job of laying that out as the way to do that.

In particular, I think that there are some low-hanging fruit opportunities there, thinking about drugs that haven't confirmed their clinical benefit or are delayed or for which the follow-on studies, for whatever reason, have not been finished.

I also think that, as Mike has said, we have to proceed cautiously because the majority of products being improved through accelerated approval are used for treating cancers, and they also are drugs where we really don't have other alternatives for patients. So I think it is important to be very explicit that we recognize that there is this innovation and access tradeoff but also that we think that it's so important that we allow CMS to have tools and flexibilities to address prices when we think that they don't reflect the drug's benefit, for example.

Just thinking about the types of ways we might think about targeting products, you know, those with what I'll maybe call egregiously high prices. All of this is going to be fuzzy language because we have to become better at defining this. But you might know it when you see it, incredibly high-priced, low benefits on surrogate outcomes at the time of initial approval, large budget impact for the Medicare program, and also those with low evidence of benefits for Medicare beneficiaries, in particular.

You know, there were a couple of things that I think are worth highlighting and being more explicit about in the chapter. Some are related to terminology that we use, like referencing pricing. It's a big chapter. There is a lot there. But these terms, I think, get used in different ways and in different contexts. Also being explicit as we move forward on what we mean by comparative effectiveness analysis. I know this is something we all have to kind of wrestle with.

We have a lot of challenges with this pathway for the fact that we don't really always have a good comparator. So I think that what we're comparing to or how we're thinking about prices relative to a competitor is not

really the same as if we're thinking about other drug classes and categories.

Another thing I think that would be important to emphasize, and this goes back to when we don't require CED, is really acknowledging that by way of getting approved through accelerated approval sponsors are required to be doing follow-up studies. So we don't want to be redundant and have CMS collecting the same information. I know that this was one of the contentious points with CAR-T, for example, was the duplication of effort. You know, the clinical folks really did not want to be providing this information in two different ways. So I think that emphasizing that we could also be thinking about using sponsors' follow-on studies for collecting that evidence would be good.

MS. RAY: Yeah, and if I could just point out here, for the CED for Aduhelm, that's what they did. It's linked to the FDA trial or the NIH-sponsored trial.

DR. DUSETZINA: That's an excellent point. Yeah, absolutely. And I think that just kind of allowing for that because, again, avoiding redundancy and not reinventing the wheel or spending money unnecessarily would

be very important here.

I think just a couple of points. In the chapter you talk about a couple of different options for price caps, and I had a couple of kind of gut reactions. Like I really liked Options 1 and 3 better than I liked Option 2. So 1 was the CEA, Option 2 was setting a cap based on a standard of care, and then Option 3 was a rebate until trials are completed.

I think that when I was reading it, it just felt to me that Option 2 might be too harsh of a penalty. Like Option 1 is very similar to it but gives a chance for a higher price if we think that that is reasonable. That was just my gut reaction of those options. I also thought that the lack of a comparator seemed more of a problem for Option 2 than it did for the comparator effective analysis.

Okay. I think I've covered all the ground on that first topic. But I will reemphasize Mike's points up front. You know, I think we really want to emphasize giving the tools and having the option to use this and setting up a set of boundaries where we think that a company would be more, like basically making themselves eligible for this, again, kind of thinking about the

pricing that is set, the benefits that have been demonstrated, and the level of information we have about Medicare beneficiaries, and how much they benefit from these products at the time.

Okay. I also want to say incredibly enthusiastic and fully endorse the proposed reference pricing model for the biosimilars, biologic-similar drugs in the category. I think that you all have done such great work here, and I think that this is exactly where we should go.

I think it's much easier to think about this for drugs that are reference and biosimilars. That's easy to say, bundle those two things together. The other therapeutic alternatives piece is more complicated in figuring out how we define what gets to be counted as a substitute I think makes that part a little bit trickier. But I'm in support of that plan.

And then also I fully, fully support this modified combined setup for thinking about reimbursing for high-priced drugs. So getting away from the 6 percent add-on and getting to this new formula that you've put together. And I really think that you did a great job showing where it achieves greater savings and where we

don't start overpaying for lower-priced drugs.

Okay. Larry, how did I do?

DR. CASALINO: Actually I wanted to hear more.

[Laughter.]

DR. CASALINO: In all seriousness, this is complicated. Could you summarize for us in terms of the first area, the accelerated approval drugs, what you would like to see done?

DR. DUSETZINA: Yeah. So I think that ideally, we should set up a set of maybe rules or options for where we think that CMS might want to apply a price cap and then a pathway for designing what that price cap might be. I'm not sure I'm quite there on exactly specifically how it would be set up, but I do lean a little bit more towards the comparative effectiveness estimate for figuring out where a range of potential prices might fall, given the clinical benefits of the product.

But I think that having CMS have the flexibility to determine when they could use that, whether that's at the time that a new drug is coming onto the market or even more important in some ways is when companies have not been producing the evidence to show that their drugs actually

have clinical benefit. So again, these are products that are based on surrogate endpoints that we think are reasonably likely to predict clinical benefit, but often we don't have the follow-up trial data showing that clinical benefit.

So I think if you could also think about ways to potentially deal with pricing if sponsors are delayed in getting their trials done, I think that would be another way of thinking about these flexibilities.

DR. CHERNEW: I'm going to try and summarize Stacie's summary. Stacie, I'm going to watch your face to see if I get this wrong.

So in the accelerated approval space, number one, CMS has discretion. So we're basically saying they should be able to do something. We're not saying they must do something. Give them some guidance as to whether to use that discretion. The discretion will relate to price capping, not price setting. So you want to cut off the examples where the drugs are just really outrageously priced, and that might ramp up in the period after a reasonable trial should have been done.

I should be looking at Stacie's face.

DR. DUSETZINA: Yes. But I do think that having some sort of set of circumstances where you're more likely to be selected for like a price evaluation, like figuring out what those rules look like, so it's very clear that it's not across the board. But we can kind of keep that innovation incentive there but also recognizing that if a company comes out with abusive pricing or their evidence for benefits are very small or it looks like the benefit versus harm is questionable, that it's pretty clear-cut that you may be eligible for this evaluation of pricing.

DR. CHERNEW: Guidelines for application of the discretion.

DR. CASALINO: Just a question for Stacie, and actually I'm sure other people may speak to this as well. Stacie, I'm not asking this as a rhetorical question because I really don't know. Well, I'll just say, I'm all for very severe penalties or very strong incentives to complete the clinical trials, post-marketing clinical trials on time. That, to me, is a no-brainer, and something CMS is capable of doing.

My question is, how capable do we think CMS is of conducting an analysis of the relative clinical benefit of

the drug in a way that can't be successfully challenged and won't take too long a time? And also the phrase comparative effectiveness is, in some areas, has a very, very, very negative valence and we might want to be a little careful about using that phrase in any context, I think.

But anyway, how capable do you think CMS? This is not a criticism of CMS. It's a hard task for anybody to do.

DR. CHERNEW: If we do this well and I know the queue, we can get that -- that was almost the beginning, for those of the new Commissioners, of the mythical Round 3. The keyword there is "three," and we're still on two. So that means, as you go, be brief.

If I got my queue right -- I'm not sure I do -- Lynn would be next. So we'll wait for her to come back, and so that would put us to Kenny.

How did I do, Dana? All right.

MR. KAN: On reference pricing, I believe something like 15 to 20 countries outside the U.S. use reference pricing. So, for future discussion purposes, to the extent it's applicable, would it be possible to glean

learnings from those countries and what are some rules of thumb that they have used to apply that successfully?

MS. NEUMAN: Sure, sure.

MR. KAN: Thank you.

MS. NEUMAN: We can come back with that.

MS. BARR: Thank you.

Actually, right along those lines of what Kenny was talking about, I think we should all be incensed that we're paying twice for our drugs than all of the other OECD countries. Could we potentially use that as a lever? What if we said, okay, for these -- because I think one of the biggest pressures on drug pricing is actually the difference between what the rest of the country pays for drugs and what we pay for drugs, and when I was in strategic planning for a pharmaceutical company I won't name, but we would do is we would go, "Okay. France will only pay X. Spain will pay Y. The UK will pay this, and so I've got a target for margin. So the U.S. will pay the rest." So other countries are putting a lot of pressure on our prices, and we are subsidizing the R&D for the rest of the world.

Now, if it's 2x, could we get it to 1.5? And so

what I would, you know -- or, you know, maybe someday 1.25, but what I would propose we do with these drugs is, you know, you could do, "Yeah, okay, we'll take it," because what Stacie is talking about seems extremely complicated to me.

And when I was working drug-eluting stents, I mean, you know, we got into $3,000 a stent in the U.S., where everybody was paying a thousand dollars in the rest of the world, right? And so we need to do something about this. So what if we say -- and, typically, by the way, other countries price our drugs in about eight to twelve months after we do, right? So what if we say, "Okay. You know what? Stick us with, you know, whatever stupid price you want, but then you're going to owe us everything above 150 percent of the OECD," and get a rebate back? Because these countries do a very rigorous process on clinical effectiveness and whether or not these drugs should be approved and what they will pay for them, and we could leverage that to close the gap between what Americans pay for our drugs and everyone else.

So it's a type of reference pricing, but it would be based on the prices set by other countries that would

then feed into a rebate or a new price.

Thank you. I love this work.

MS. KELLEY: Greg.

MR. POULSEN: Thank you.

A lot of what I had to say, Stacie said, and I'll just put an exclamation point on that. I agree with Lynn as well.

I mean, there was a time when the U.S. GDP per capita was double, but there, OECD was -- or who are now in the OECD was. That's not true anymore, and so I think we need to be thoughtful about how we do it. I don't know the mechanism for that. I know that there are things that we can and can't do or probably can and shouldn't do.

But I would like to just throw one additional idea on looking at the administration fees to 6 percent. I think that's perverse. I think there's good evidence that it's perverse. I think that going to a per-dose would also be, to some degree, maybe a lesser degree, but still be perverse -- I think what we need probably to look at is something that's holistic. It's, you know, an administration fee for an entire course of treatment in a category of drugs that would free the clinicians to pick

whatever was most effective at the most effective dosing for the patient, without as much regard for the clinical -- I'm sorry -- for the financial implications associated with that.

I had a few others, but those are the ideas that I wanted to get on the table.

DR. CHERNEW: I want to respond. So we have five new Commissioners, and this particular topic is one which we are sort of mid-movement. So we had a cycle on it and now are coming back.

This is going to get to a question for you. The option that was presented, which has this sort of hybrid option, is a little bit of that, a little bit of ASP+, a little bit of cap. That was what came out of where we were at the end of last year.

So the most important thing and what I'd like to try and avoid is we can have a discussion of could we improve upon that, and I think that's a valuable discussion to have. But the most important thing to know is if you couldn't support the one we've had, because we struggled last time with getting to where there were three options. And we ended up with the one in this. So we can tweak it,

but if you really object to what's there, that's kind of -- you know, obviously, if you love it, that's fine too. It's sort of really --

MR. POULSEN: So let me just be clear. I think we're going in the right direction. I think this is an improvement. I think, you know, from what I just said, there's something that we might want to consider in the future that would be an improvement upon that yet, but thanks.

MS. KELLEY: David.

DR. GRABOWSKI: Great. So I'll be brief here, just to say I support the direction we're going, Mike, so no big issues here.

I did want to -- after listening to Stacie, I thought this was complicated after reading the chapter. Now I think it's even more so, not that you did anything to lessen my understanding. I just realized I don't know what I don't know, and so this is -- I think, Mike, in kind of moving forward this agenda, this is going to be challenging to kind of make certain we're all kind of -- have a firm understanding of kind of the underlying principles here, because I think -- I always find this area very

complicated, but this issue, Part B pricing, in particular.

Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Yeah. Thank you. I do appreciate all the fact that there was a lot of work that has been put into this prior to new Commissioners coming on board.

The one thing I want to address that's a little bit of a concern has to do with therapeutic reference pricing, and the specific mention on slide 14 of whether or not actually Medigap policies could assist with some of the cost sharing, my concern with that is just from an equity perspective whether that's actually a viable solution or not, because in order to purchase those Medigap private supplemental policies, you'd have to be able to afford those. So it just naturally sort of excludes another population of beneficiaries that could not necessarily benefit from an appropriate drug, and therefore, their provider may not be able to order it. So just kind of think through that a little bit.

Then I think we're directionally correct on the three-year sort of timeline for post-market trials. So it would just be nice to flesh out a little bit about what

sort of the discretionary options are for trials that may appropriately take longer than the three-year average.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. First thing, I'm very comfortable with all the options on the table, but just a couple of quick comments.

On the first discussion point of newly launched drugs without proven benefit, I wonder whether the best approach is simply to encourage CMS to apply CED more often than they currently -- or they previously have and recommend that they do it with real -- with a real defined time frame beyond which CMS would refuse to cover the drug at any -- under any circumstances, so essentially just put it back in CMS's lap.

You know, the aducanumab, I mean, as a geriatrician, I looked at the details of that drug as it was in evolution, and some of it's a good example of what can go wrong. Some of it is a bad example, in a way, because I think most people that are clinically in that space think the FDA just blew it on clinical grounds. And so everybody was sort of picking up, trying to rectify a mistake that was made at the FDA level, that the drug just

wasn't a good drug.

Again, CMS did kind of rescue, I think, us from a bad -- what would have been a bad problem by applying the CED.

So, again, I wonder on the first topic whether we're betting off, again, just reinforcing that CMS apply CED more frequently, apply it with a thoughtfully, explicitly defined time frame and be clear that beyond that time frame, if the drug has not proven benefit by virtue of a public -- you know, peer-reviewed publication, that CMS will pull coverage.

The second issue of the reference pricing, I think that's hugely innovative, and even though, clearly, when you go by the biosimilar space, there's a lot of nuance and work to be done in terms of how do you lump products together that could have the same reference price. I think it's hugely important work. So I want to strongly support that.

Of the different options there, I like the third, the third one about the lesser of the weighted average or the specific, but I could certainly live with any of them.

And on the third topic of the ASP, I really like

how you got to the lesser of the options. I think that's just -- seems really elegant thinking to get there.

MS. KELLEY: Stacie, I'm sorry. I think you had something on Robert's point previously.

DR. DUSETZINA: Yeah. It just was one thing that I had neglected to state in my diatribe.

So the point that Robert made about the equity and the cost-sharing issue, I think, is really important, and when thinking about this, there was like an exceptions approval process for drugs that were -- like some still needed that were higher priced when we did the bundled price, and I really liked that. And I liked the idea of an add-on payment.

But I really dislike the idea of requiring the coinsurance for beneficiaries in that case because I do think it is important to say this -- theoretically, they've gone through an exceptions process that shows that clinical need, and so I think we should remove reference to beneficiaries paying anything more for it. It should possibly be that physicians get a little bit more for that treatment, but the beneficiaries shouldn't be on the hook, I think.

MS. KELLEY: Dana.

MS. SAFRAN: Yeah. Thanks.

Very supportive of this direction and this work. In particular, I'm really excited about the use of levers to force the post-market evidence generation that really isn't happening, and I would say that broadly. This is a good place to start.

If I'm not mistaken, Stacie will know. These are stage 4 trials. This is the label for post-market evidence generation. Is that roughly correct?

DR. DUSETZINA: These are slightly different, I think, in just that they -- because of the accelerated approval, they've only had to show surrogate outcomes, and these are, in theory, to confirm hard clinical outcomes, but --

MS. SAFRAN: Got it. Okay.

Well, in any case, I think this lack of enforcement of requirements that do exist for post-market evidence generation is just appalling, and that this is a really great place to start, so really like the thinking there.

I also really love the idea of introducing

reference pricing here. I appreciate Lynn's point about whether some of the -- whether foreign pricing can start to be included in that, and the point, I think, that Lynn was making and that I agree with is broader than where you were considering applying reference pricing. So I don't mean to limit a focus on international prices to biosimilars, for example, but I think that is a lever that we've talked about before. I personally think I've raised it before and raised the question of, for example, knowing that other nations very often do require cost-effectiveness evidence as part of defining their pricing, why and whether we could start to include some of that evidence as well. So I really like that idea.

And then my final point was just that I do -- relevant to the question I asked in Round 1 about sort of inducing more demand, I do feel like we need to consider what mechanisms we have to mitigate the impact of driving up number of days that medications are used in order to generate more revenue, and whether that's because of a target income hypothesis or just, you know, ways to earn additional revenue, I think we need mechanisms for that. One could be tracking -- having kind of guardrails around

current utilization and how that changes over time on a per-patient risk-adjusted basis, but another -- and these aren't mutually exclusive -- could be some transparency tools around tracking that and showing facilities utilization rates, including days of use, again, risk-adjusted against peers in a value-based payment world. That might be a helpful lever in terms of end markets, anyway, where providers have a choice of which facilities they're referring patients to for these kinds of therapies, but either way, it, I think, could have a helpful effect to be showing facilities where their utilization stands relative to peers.

So those are my comments. Really great work. Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you.

I just want to add my support to all of these different options. I think that they will strengthen what CMS can do to try to get a handle on the growth and drug spending, so very supportive.

I agree that the first option is complex and would certainly be in the camp to allow CMS discretion in

terms of how to proceed in this space. I obviously don't have the same expertise as Stacie does, and I appreciate her mapping out some of the issues and recognize the complexities operationalizing that particular option. But I'm certainly supportive of moving in that direction.

I also appreciated Lynn's comment about what is the reference, and I do think looking to other countries would be an important potential reference against which prices are set.

And then, lastly -- and, you know, again, trying to think about potential unintended consequences down the road -- how might sort of reference pricing -- and I don't know if there's any evidence in this space. Do we see any evidence that the entities that manufacture and sell generics or biosimilars might raise their price kind of in response, so over time, you sort of see some elevation in the reference against which you're setting the --

DR. CHERNEW: Saw that in California once again.

DR. DAMBERG: So thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you.

Nancy and Kim, you did a fantastic job with this.

I am certainly very, very supportive of the general direction.

I think Mike and Stacie both mentioned this. I think it's worth mentioning that there is a balance to be struck here. I think we definitely want to also incentivize innovation and use of the accelerated pathways when it's appropriate. We've seen increasing use of that pathway. It's been really important to our public health in the last three years. So I think we just want to make sure we keep that in mind as we think about the approaches going forward.

I like the idea very generally about thinking about other OECD countries as a sort of informational tool, but I think we should also reflect that the U.S. traditionally has had slightly different values in terms of what it -- values in terms of innovation, and it's not inconceivable that the U.S. society would want to pay a premium for that to some extent. So I think we should just be careful as we think about this, and how we construct the rationale for our policies, I think, in some sense, we don't need some elements of this that might be potentially politically more charged than what we need to, to design

rational policy.

That being said, stepping into a couple of the detailed pieces, for the accelerated approval pathway piece, I think a couple elements I wanted to highlight. So I think in principle, the idea of using something like clinical effectiveness, cost effectiveness, comparative effectiveness sounds good, but at the same time, I think there is a heterogeneity of what type of clinical evidence that may be available at the time of having to actually make this coverage decision. And there's already a lot of debate about methodology and acceptability of cost comparative effectiveness in general, and so I think we should be fairly careful about this.

And I think the way that other Commissioners have mentioned this as in the context of making it perhaps one of the tools that CMS can use in allowing flexibility based on the clinical situation is really important. You could imagine a situation where like the COVID vaccines, there was actually quite a bit of clinical evidence that this made a lot of sense, and that would make a lot of sense. I think there's other situations where surrogate endpoints make it actually fairly hard to translate what that

comparative effectiveness or cost-effectiveness ratio would look like, and so I think the flexibility becomes really important because it certainly isn't a one-size-fits-all type of solution.

And, again, we want to be careful about creative incentives to pick harder surrogate endpoints or other things on the manufacturer side while still retaining the incentive to drive through appropriate drugs through this accelerated pathway.

Amongst the different options, I think option one, I sort of have spoken about. Option two, I think we should be careful about picking too draconian of options such as the prevalence or standard-of-care type of price. I think I favor ones that are more generous than that because it is very likely that there be extremely important clinical drugs that come through this pathway, and we want to, again, retain that incentive for innovation and reward in that setting. I think that should definitely be counterbalanced with -- and Larry and Dana and others have mentioned this already -- accountability to actually complete the post-market trials, such that you collect the evidence and can actually make a reasonable determination.

So I think having that kind of two-pronged piece, a larger incentive to get on to the market, but then also with an accountability to complete, I think that's really fundamentally important.

I think that can be done through option three with the rebates as well. So I think, to some extent, this -- the later options in the paper, within option two or option three, seem more favorable to me in general, as a general approach, but I like the idea of flexibility, the statutory authority to have flexibility.

And I think -- and Mike mentioned this. I think it would be really important as we develop this work further and get towards recommendations that we have those principles outlined. I think they are mentioned, I think, throughout the reading materials, but I think they could be codified in a much more explicit way. I would place a very big plug on that piece. I think we should try very hard to put some principles around how that flexibility would be applied in the context of the authority we hope to give the Secretary in this context.

Last two points, very brief, I very much support the reference pricing approach, and I very much support the

sort of combined approach in terms of the alternative to ASP+6 percent.

Thank you.

DR. CHERNEW: So I just want to pick up on a few things that Amol said. I think Kenny is actually going to be next. No, okay. I'm sorry. I'm still going to pick up on what Amol said, by the way. You can send me a chat, Dana, and then I'll get back in the queue.

First of all, I want to thank Kim and Nancy in the chapter, because I know most of the people listening haven't seen the chapter. There was an acknowledgment of the literature that connects financial incentives and innovation. In fact, for my taste I would even expand that some, and I think we have sort of alluded to, but we should be clear that the empirical evidence -- and again, I'll look to Stacie to see if she disagrees; I'll wait for her light to go on -- but I think the evidence is pretty clear that there is a connection between innovation and financial incentives.

There is a debate about whether you get the types of drugs and the innovative drugs that you want, which I think is still sort of ongoing, and of course, there's

merit. If you look to cases -- I'll pick Sovaldi - there is some value to some of these other drugs in the same class. So I don't think that the sort of label that, oh, this is a separate drug and it's not a big advance means it's completely unnecessary. There are a few others reasons why I think that's true.

But the broader point is I think the chapter currently acknowledges, and I think it's important that we acknowledge, that there is this connection, and that's what makes this so hard. If the drugs were bad or if we didn't have to worry about innovation, we would have a lot of different things here. So I think we have to be careful.

The other thing related to that is Nancy, in her presentation, said something very subtle. I'm not sure it was picked up. In the standard-of-care approach it is not that the price of standard of care -- it could be on the table but that's not what I consider to be on the table. It is a multiple of that. Our goal here is not to drive the price for something in accelerated approval down to the standard of care, whatever it is. But our goal is to reduce the, I'll call it -- and I'm going to again be vague because I don't know what this word means either --

unreasonable.

There are examples of pricing in this space that even though the evidence is limited your sense of what's going on may actually be considered broadly unreasonable. I don't think we're going to say that, but I think CMS should have the ability to act in that case. And as you move further in time, particularly if new evidence hasn't been developed, the bar for acting, I think, should be much lower. They should just be able to act much more quickly. We have the accelerated approval pathway because of an acknowledgment that there are conditions and there are innovations that we want to get out to Medicare beneficiaries as widely and as quickly as possible. You mentioned COVID but there are others, and cancer is a good example.

So I think we are working on that balance. The chapter will have that balance, but in the discussion per, as Amol said -- and again, I said this in part because I know a lot of the people listening haven't seen the chapter -- there is an acknowledgment of the innovation incentive tradeoff, and in case anybody is worried or not, I'll speak for me -- I won't speak for the Commission, but I would say

this is probably true -- there is an acknowledgment that want a lot of the medications to be developed. Although we do want to make sure that we preserve that innovation, we are also aware that there are a bunch of institutional things that are going on in our system that we think could be improved. I'm going to stick with that framing.

Anyway, that's where we are, and I think that's kind of where Amol, I think, outlined that well.

I obviously have no idea what's going on, Dana, so you tell me who's next.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I just can be brief. I really support this work and I really appreciate how you really helped me understand it better, maybe less, maybe better at a deeper level.

I just want to make a few points. I really support and agree with the comments that Dana brought up in her Round 1 and I think it was Greg reiterated, that we really need guardrails so that if there is less revenue there isn't this upsurge in volume. And I know the issue of guidelines was raised. I'm not confident that that's enough of a guardrail, and we also know guidelines are

subject to certain kinds of manipulation as well, so I think that's really important.

I really support the issue of the consequence for the lack of evidence that Scott and others raised. And I think this works two ways. There was just an article, and I can't find it, that companies who developed evidence did not find a benefit. And I just can't put my hands on it. I read it in the last month somewhere and I'll find it and send it. So there's no real incentive for them in the current system.

I do have a question. My understanding in terms of evidence development the way it happened with Aduhelm; the evidence shifted to be paid for by the pharmaceutical company to really by the federal government through the process. Is that correct, is that incorrect, and can we prevent that from happening?

MS. RAY: Can you say that one more time?

DR. RAMBUR: So my understanding is that because Aduhelm is now undergoing clinical trials that are through the NIH -- correct?

MS. RAY: NIH and FDA.

DR. RAMBUR: Right. NIH and FDA. So in essence,

those trials are being funded by the federal government, by taxpayers rather than by a pharmaceutical company. Am I wrong? In any case, that would be how I would lace that together, and I think that would be an unfortunate unintended consequence that we would want to make sure didn't happen. I understand why it happened with Aduhelm but I think that's at least a cautionary tale.

MS. RAY: So Medicare is required to pay the routine cost of clinical trial care. That's across all clinical trials. I mean, not specific to accelerated approval, and that also has to do with device trials. And then to get into more specifics of the policy, I will get back to you on that.

DR. RAMBUR: Okay.

MS. RAY: Because I don't want to misspeak and those details are not coming to me.

DR. RAMBUR: Right. And my understanding could be foggy. I'm just curious if we're asking for more evidence, what's the ramification for that in terms of the fiscal notes. That's all.

MS. RAY: We will address that.

DR. RAMBUR: Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. First of all, like many other Commissioners, I'm very enthusiastic about the reference pricing recommendations and changing the ASP+6. You have a number of options in each of those two categories and I don't have a strong feeling about which way to go, but I have strong support moving in those directions.

On the first point, the accelerated approval drugs, we keep mentioning innovation, and it's really important, and I think the drug companies over the last couple of decades have shown how innovative they can be, and most recently with the COVID vaccines and COVID drugs. But I think we want to be a little more discriminating.

To me, the pharmaceutical companies are extremely profitable. They have very strong incentives to innovative. And there is an argument that we shouldn't raise taxes on very high-income people because if we do, they'll lose their motivation. In other words, if I can do something that will get me $500 million, but because of taxes it will only get me $450 million, I'll have less incentive to do it. I don't really buy that argument, and

I'm not sure that pharmaceutical companies wouldn't continue to be just as innovative if they were a little bit less profitable.

DR. CHERNEW: I'm sorry to interrupt. I understand completely. I would just say that's why there's been a ton of academic research. I would defer to Stacie. But I think the evidence about what they will or won't do is -- I'm not going to say it's not controversial, but I think -- again, Stacie, I'm going to look to you -- I think the preponderance of the well-done academic study suggests we could speculate what would happen.

But there is empirical evidence that shows what has happened. And they're hard studies. I'm not going to argue that they're definitive in a bunch of ways. I don't want to make it sound like the sky is falling if marginally affect their profits. I don't think that is true, remotely. But I think the argument that they are very profitable so if you cut some they'll still innovate, is just actually not empirically true.

DR. CASALINO: Okay. Yeah, we can talk more offline.

DR. CHERNEW: Did I misspeak, Stacie, because

again, this isn't exactly my research area. I'm a voyeur in this space.

DR. DUSETZINA: I don't think we have the evidence that we would like to answer that question explicitly, but I think that Mike, in general, is correct, that we know that if we were too aggressive, like if we said, broad strokes, we're going to do this for all of these drugs, we're going to set a price cap, then money would probably leave the industry for other things. I think part of it is complicated by how trials are funded, how investments are made in the industry, and thinking about going after drug development, so relying on venture capital, relying on other investments like that.

So I think it is important to say, you know, we're talking about not everything. We're talking about setting up a set of rules for where there are kind of signals of abusive pricing, lower questionable benefit, lots of things that we don't know and don't feel as comfortable spending federal resources, like all of our funds on, and not this kind of across-the-board approach. Because I think we do want to acknowledge drug development is very difficult. It's expansive. We want investments

there, and we want investments driven towards areas where we don't have treatments, which is the whole point of that pathway is very limited options for people, with treatments being approved through that pathway, kind of by definition.

DR. CASALINO: So, yeah, I'll yield to the more knowledgeable people about this. But I still wanted to make the point, because it's easy to just kind of genuflect at the word "innovation," and I think that's too simplistic.

The last thing I had to say was, in my mind at least, and maybe I just don't understand, we're still a bit squishy on the accelerated approval drugs and what recommendation we might make there. It's really asking a lot. First of all, comparative effectiveness, cost effectiveness analysis are very charged words in the U.S. context, as we all know.

But I think it's a very hard task for anyone, and I think it would be hard for CMS. First of all, it's hard to get that evidence, and secondly, I'm not clear how that would be translated really into a price, even if that evidence is there. So in my mind, other than fairly general recommendations, I'm not sure where we are on the

accelerated approval, the first area.

And the last thing I'll say is that the coverage with evidence development is great, but if I understand correctly that doesn't necessarily translate into price, right? So saying we would like to have more coverage with evidence development, and this is important to say and I think it's great to say, but we shouldn't delude ourselves that that is necessarily going to help with price, I guess. That's it.

DR. CHERNEW: We have 2 people, 12 minutes. Do the math.

MS. KELLEY: Marge, go ahead.

MS. MARJORIE GINSBURG: Okay. I'll be brief, and I'm speaking to Lynn's comments about what other countries pay, Michael's comments. I interpreted that as we need to be careful. And all of this brings back conferences some 40 years ago. Some of you might have been there. Some of you might not have been born yet. You know, exactly the same conversations. And, of course, as we all know, Big Pharma rises up and the public rises up. The public just gets infuriated to think that we're going to stop innovation by these draconian measures to cut costs.

So my only comment is I do think we need to be careful, that we need to be, I think, more than any of the other issues where we're looking at how do we get reasonable services or reasonable costs for taxpayers and providers and beneficiaries alike. This one is touchy, and I'm very excited about the approaches we're talking about. I just want to make sure that we are very aware of the power that Big Pharma has over the general public, regardless of how little Australia pays. That's simply not relevant in the eyes of the general public. So that's all.

DR. CHERNEW: So I need to say one other thing to follow up on Larry's point, in case what I said was misinterpreted. I believe the evidence is very strong that there's a connection, broadly speaking, between financial incentives and innovation, for a bunch of reasons, despite a bunch of other things. That being said, that doesn't give, in my view, manufacturers a blank check. I think too often that's what I view -- I won't call it an unsettled fact, but that pretty strong fact is used to say we can't do anything to address what I think are clearly the more blatant abuses in the system.

So the way we're trying to balance out sort of be

careful -- and again, I should say another thing. There are a whole bunch of other drug policy issues that are sort of outside of where we're going to be. We are not talking about broad U.S. health policy on pricing drugs. We're talking about what I would consider the Medicare lane, Part B, and we're focusing on some very specific, I would say, payment inefficiencies, ASP+blank, paying for a biosimilar, vastly different than the originator. Those are clear efficiency things, and from what I've heard there is widespread agreement around those things. And then this other area, which is where we're having this discussion, is what to do with an accelerated approval drug. I wish I could tell Larry I know where we're going with this. I don't. Glad you pointed out that.

But I think that there is a concern that in the extreme there are issues that are problematic, and we want to give some ability to address what those are. We want to do it in a way that is careful about the other connections and the potential unintended consequences. So we acknowledge that this is -- I'm now just channeling Amol -- we acknowledge this is an important pathway for important drugs, and the incentives to get drugs into that pathway

are important.

And that's the balance we're trying to do. We are obviously going to be talking about this again, and so as you see the mailing materials, the tone and the explicitness as we convey this balance is, I think, going to be our challenge. But luckily, we have terrific staff rising to it.

Sorry. I screwed up the math but, in any case, it's still Kenny's turn, I think.

MR. KAN: I'm 110 percent supportive of this chapter. Great work. I know I'm catching this work midstream. Just out of curiosity, just a clarifying question, did we consider looking at moving some Part B drugs to Part D? I realize it opens a Pandora's Box but I'm just curious. Could we look at that for future cycles or is that out of scope?

DR. CHERNEW: It's not out of scope. In this context we have not done that, but there's been another example. The one that comes to mind obviously is the vaccine example, and we had a whole chapter on vaccines and this issue of where they go, in Part B and D, and we had a whole set of recommendations about that. In that case,

actually Part B was advantageous, because not everybody has Part D.

Now they've made some improvements, I would say, in the value-based insurance design space there, what they did for vaccines and cost-sharing, which is mentioned. But there are other high-value drugs that you have to worry about access to.

There are other concerns. One of the challenges with other policy -- I don't want to belabor this -- is if you create asymmetries between what you're doing between A and B, there is incentives for companies to try and push things they're doing to go in one place or the other. So I do think that's true.

I'd say the short answer, but that's past. It's in scope for MedPAC, in general. It's broadly out of scope where this type of work is going. So just so you all understand -- I'm moving this into my wrap-up. But we're going to move forward towards votes. There will be some more explicit version of obviously what we're voting on. We're going to move to make a lot of this more concrete. That is going to look a lot like the reference pricing stuff we've been discussing, the ASP+ stuff we're

discussing.

Understand that when we make recommendations, we are never telling Congress do it exactly this way. Even our Part D redesign work, where we show them a particular thing, they did something different, and I think we were quite supportive of what they did. It was in the spirit of the type of things we were saying, and that's what you're going to see for the ASP+ and the reference pricing kind of stuff.

The accelerated approval stuff, honestly, I think we are a little hazy. I think what I hear from this conversation is there is enthusiasm, ranking that enthusiasm. There's a lot of enthusiasm for encouraging that trials actually get done in a timely manner. So that, I think, has high enthusiasm. And there is, I think, some enthusiasm, of varying degrees, to find policy options to, even before you get to that period where the confirmatory trials are done, even in that window, to give CMS some discretion to address problems that they find in the system.

And there is some -- I'm going to go with principles, since I'm sitting next to Amol -- Stacie

outlined a few. We're not going to tell them mathematically if it meets the top ten drugs then let's do this, but we might say you want to look at drugs where the evidence is weaker, the market share is bigger, we know less about the impact on Medicare beneficiaries. There is going to be some set of things like that that says if there's a drug coming through the accelerated approval pathway, the evidence is particularly suspect, for whatever reason, the budgetary impact is enormous, for whatever reason, the price you're setting seems completely out of whack, despite the lack of evidence -- it's really hard to believe that's going to be justified where the evidence is. You might want to think about some price-setting approach or, if the evidence is really bad and it's a really risky drug, some CED or requiring some other evidence.

I'm not sure how that's going to get worded. I think that when I look back at the transcripts -- which, by the way, I never do, because then I can't live with myself -- but when someone here, I'm not sure who is tasked -- Jim -- is tasked with reading the transcripts, I apologize, we will then see if we can take this into a chapter that outlines that better.

But I think we have about two minutes left. Is it clear what I'm trying to say? All right. Go ahead.

DR. DUSETZINA: I think you summed it up in a great way. I wanted to just make two responses to what Larry brought up and what Scott brought up because they were things that I feel like we have talked a bit about, but they are always these unknowns.

The first may be, Larry, your question about isn't it really hard to get a price at the time of approval. Like how will we do that? You know, I think the point was made that this information is submitted by companies at the time of getting approval in other countries as part of the packet. We also know we could use the trial information itself for defining the clinical benefits of those products is what they're using to get FDA approval on those surrogate outcomes. And you could give them the benefit of the doubt that the surrogate endpoint would translate into that clinical benefit.

So I think there are ways of doing it, and we have lots of experience around the country of groups doing this. So I think there is a fair process.

I think more importantly is here are the

principles by which you are putting yourself at risk of being negotiated for a credible threat so that companies actually just price in a way that really reflects the value of the product and benefits without it having to come down to a decision or being pulled for that process.

I think, Scott, to your question about why not just do more CED, that was definitely a little bit more of the first chapter, or the last round. And they do a nice job of pointing out it's only been used three times for drugs, the most recent being Aduhelm. I think that, to me, the distinction is CED is like we don't really know if this is good for Medicare beneficiaries. We have to get better information about that, for our beneficiaries. Whereas this other broader kind of not CED but still kind of out of range in some way, like pricing or evidence, like that to me feel really different and not something where we want to tie the two together, because CED sort of feels more focused and for a slightly different purpose.

DR. CHERNEW: So first, I'm about to say thank you, but I will say it in this particular context. The issue here, in some sense, is the absence of evidence, or at least strong, rigorous evidence, does not mean that the

drug doesn't work. The FDA is a really important actor here. There are issue, I think, people have said with certain things that FDA has done, but for the most part I think they do an outstanding job of looking at the things that they're supposed to do.

And so even though the evidence might not be as strong say as we want, it is a hurdle that you have to go through to get over this accelerated approval process. And so we just want to be very respectful of that process.

So the issue with CED, and I think the reason it's been used so sparingly, is because it really limits access to drugs that went through a process that was intended to make sure a lot of people get access. There are situations. We were supportive of Aduhelm CMS work. There are situations where I think you could see it would be done. But I won't encourage them to do it because that's almost encouraging them to wait for -- the whole point is you want some things to get out before the evidence meets the level of rigor that you would otherwise want because there's no alternatives, you have some pretty good surrogate endpoints or an immediate endpoint.

Anyway, we're at 12:00, so to the people at home,

thank you for listening, and if you want to send comments, send them to meetingcomments@medpac.gov or go on the website and send us comments. We really do want to hear from you.

To the Commissioners, thanks a lot for all your time and efforts on these chapters and those yesterday. And, of course, always the biggest kudos go to the staff.

[Applause.]

DR. CHERNEW: That is for Nancy and Kim, but it's also for all the others, those here today and not. There's really a ton of work that has to happen to get all this analysis done, and we really appreciate the work that you guys do.

So with that, that was our September meeting. We will see you next for our late September meeting. Thank you.

[Whereupon, at 12:00 p.m., the meeting was adjourned.]