

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 2, 2023
11:16 a.m.

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P R O C E E D I N G S

[11:16 a.m.]

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2
3 DR. CHERNEW: Welcome, everybody, to our March
4 MedPAC meeting. We have a lot of important topics that
5 we're going to discuss today. We're going to talk about
6 the wage index, we'll talk about Part B drugs, and we'll
7 discuss post-acute care. We're going to start it at the
8 wage index discussion, and for that discussion we will lead
9 off with Alison.

10 So, Alison, take it away.

11 MS. BINKOWSKI: Thanks, Mike, and good morning.
12 I'm excited to present today on reforming Medicare's wage
13 index systems.

14 A PDF of these slides can be found in the control
15 panel on the right-hand side of the screen.

16 Today's presentation updates work from MedPAC's
17 June 2007 report and builds on information presented in
18 September 2022.

19 In this presentation, we will: provide a brief
20 overview of Medicare's current wage indexes; summarize key
21 concerns with the current approach; describe an alternative
22 wage index approach and illustrative method; provide

1 examples of how the alternative wage indexes address
2 concerns with the current approach, both for IPPS hospitals
3 and for skilled nursing facilities; and conclude with the
4 Chair's draft recommendation.

5 As a reminder, Medicare's wage indexes adjust
6 national base payment rates for geographic differences in
7 labor costs.

8 The current wage indexes: are based on data from
9 IPPS hospitals' aggregate labor costs; are calculated for
10 each labor market area, defined as metropolitan statistical
11 areas and statewide rural areas; and include numerous and
12 often non-empirical exceptions for IPPS hospitals and none
13 for most other types of providers.

14 Medicare uses these IPPS hospital-based wage
15 indexes in each prospective payment system, including those
16 for IPPS hospitals and post-acute care providers, such as
17 skilled nursing facilities. The physician and other
18 Medicare fee schedules have different geographic
19 adjustments, which are beyond the scope of this
20 presentation.

21 Consistent with MedPAC's 2007 report, the
22 Commission's key concern with the current Medicare wage

1 indexes is that they fail to accurately reflect differences
2 in labor costs across geographic areas and create
3 inequities across providers. These inaccuracies and
4 inequities stem from the data source, definition of labor
5 market areas, and wage index exceptions.

6 In particular, the current use of IPPS hospital
7 cost report data is circular for hospitals and can deviate
8 from the market-wide labor costs faced by all employers of
9 health-industry occupations; the current definition of
10 labor market areas masks differences in labor costs within
11 areas and creates large differences in wage index values
12 across some adjacent areas; and the numerous IPPS hospital
13 wage index exceptions can exacerbate inaccuracies and
14 inequities, be manipulated, and add administrative burden.

15 To avoid these concerns and more accurately
16 measure geographic differences in labor costs faced by
17 different types of providers, the Commission has identified
18 an approach for improving Medicare's wage indexes.

19 First, Medicare's wage indexes should use all-
20 employer, occupational-level wage data with different
21 occupation weights for the wage index of each type of
22 provider;

1 Second, they should reflect local area
2 differences in wages between and within MSAs and statewide
3 rural areas;

4 And, third, they should smooth wage index
5 differences across adjacent local areas.

6 To develop illustrative alternative wage indexes
7 consistent with this approach, we used all-employer data
8 from the Bureau of Labor Statistics and the United States
9 Census Bureau; developed a wage index for each county by
10 using a blend of the MSA/statewide rural area wage index
11 value and a county-level wage index adjustment, and capped
12 wage index cliffs between adjacent counties. More details
13 on the illustrative method is in the mailing materials.

14 The first key design difference between the
15 current and alternative IPPS wage indexes is the source of
16 data, including the set of employers included.

17 One result of the current wage index being based
18 solely on IPPS hospital-reported data is that the highest
19 wage index values have been growing and the lowest values
20 decreasing.

21 For example, as shown in the left-hand graph, in
22 2022, the area with the highest current IPPS wage index

1 prior to exceptions was San Jose, California, with a wage
2 index value of 1.86, a substantial increase from its value
3 in 2007. When hospitals in high wage index areas are able
4 to increase their wages much faster than the national
5 average, those increases come at the expense of other
6 hospitals that receive lower payments due to the budget
7 neutrality aspect of the wage index.

8 This is a particular concern in areas where
9 hospitals' labor costs are materially higher than those of
10 other employers, as is the case in areas with current very
11 high wage index values.

12 The alternative IPPS wage index's use of all-
13 employer data more accurately reflects market-wide labor
14 costs, which has the effect of reducing the spread between
15 the highest and lowest wage index values.

16 As a result, under the alternative IPPS wage
17 index, aggregate IPPS payments would shift away from
18 hospitals in areas with very high current wage index values
19 and towards those in areas with very low current wage index
20 values.

21 The second key design difference between the
22 current and alternative IPPS wage indexes is the geographic

1 unit at which variation in labor costs are reflected and
2 constrained.

3 Because the current IPPS wage index aggregates
4 data to broad labor market areas, it masks variation in
5 labor costs within MSAs or statewide rural areas and can
6 result in large wage index differences between adjacent
7 labor market areas.

8 For example, as shown on the figure on the left,
9 the Atlanta MSA has a single wage index value, and there
10 are large wage index cliffs between it and surrounding
11 rural areas.

12 In contrast, as shown in the right-hand figure,
13 the alternative IPPS wage index reflects variation within
14 broader labor market areas and mitigates wage index cliffs.

15 As a result, in aggregate, IPPS payments would
16 shift away from hospitals in counties where labor costs are
17 lower than their broader labor market area and towards
18 hospitals in counties where labor costs are higher than
19 their broader labor market area.

20 The third key design difference between the
21 current and alternative IPPS wage indexes is whether there
22 are wage index exceptions. While there are reasons for

1 each wage index exception, collectively they break the link
2 between an area's relative labor costs and its wage index
3 value.

4 In fiscal year 2022, 67 percent of IPPS
5 hospitals' wage index values were affected by at least one
6 wage index exception, some of which can be manipulated.

7 For example, in 2022 the Massachusetts "rural
8 floor" was based on a single high-wage hospital that
9 converted from a critical access hospital to an IPPS
10 hospital when it joined a larger system. This floor then
11 increased the wage index value for almost all Massachusetts
12 hospitals, in some cases by up to 35 percent. And because
13 the rural floor is budget neutral, these higher payments to
14 hospitals in Massachusetts come at the expense of all other
15 hospitals.

16 In contrast, the alternative IPPS wage index we
17 modeled has no exceptions and would therefore remove
18 opportunities for wage index manipulation.

19 As a result, aggregate IPPS payments would shift
20 away from hospitals receiving wage index exceptions,
21 especially when large, and towards hospitals currently
22 receiving no exceptions.

1 A related concern with the current IPPS wage
2 index exceptions is that some hospitals use them to gain
3 non-wage-index benefits.

4 In response to a court ruling, since 2018,
5 hospitals can have dual reclassifications that can be used
6 to gain non-wage-index benefits for "rural" hospitals while
7 maintaining (or increasing) their wage index value.

8 For example, in 2022, over 350 urban hospitals,
9 including large hospitals in major metropolitan areas:
10 first reclassified to a rural area and thereby gained a
11 Rural Referral Center designation, which has lower
12 eligibility for the 340B drug program; and for the over 250
13 that were teaching hospitals, increases to Medicare's IME
14 residency cap for "rural hospitals." These hospitals then
15 reclassified back to their home area (or to a different,
16 higher wage area) for wage index purposes.

17 A related benefit of the alternative IPPS wage
18 index having no exceptions is that it would remove
19 inequities between IPPS hospitals and other types of
20 providers.

21 As shown in the graph, under the current wage
22 index systems, the wage index values for SNFs are generally

1 lower than for IPPS hospitals within the same markets,
2 because only IPPS hospitals are eligible for wage index
3 exceptions.

4 For example, SNFs and other providers located in
5 areas with a very low wage index value (such as Puerto
6 Rico, and rural Alabama) are at a hiring disadvantage
7 relative to neighboring IPPS hospitals, as the temporary
8 low-wage exception that significantly increases wage index
9 values in these areas only applies to IPPS hospitals.

10 Turning to the hospital-level effects on
11 payments, while implementing the alternative wage index in
12 a budget-neutral manner would not change aggregate IPPS
13 payments, it would significantly redistribute Medicare
14 payments. Because of the large inaccuracies in the current
15 IPPS wage index, the effect on many hospitals would be
16 material.

17 For example, as shown in the figure, we estimate
18 that once the alternative wage index was fully implemented,
19 IPPS payments would decrease by more than 10 percent for 2
20 percent of IPPS hospitals. Most of these hospitals were in
21 areas with very high current wage index values (where
22 hospital-reported labor costs are much higher than those

1 among all-employers) or hospitals that currently receive
2 very large wage index exceptions.

3 On the other extreme, we estimate that IPPS
4 payments would increase by more than 10 percent for 4
5 percent of IPPS hospitals. Most of these hospitals are
6 located in areas with very low current wage index values or
7 areas where hospital-reported labor costs are much lower
8 than those among all-employers.

9 Corinna will now discuss applying the alternative
10 wage index approach to SNFs.

11 MS. CLINE: As a reminder, the current SNF wage
12 index uses data from IPPS hospital costs reports and does
13 not account for how the mix of labor employed varies across
14 different types of providers. This results in the current
15 SNF wage index inaccurately reflecting labor costs specific
16 to SNFs.

17 The alternative IPPS wage index, as just
18 discussed, would be an improvement upon the current SNF
19 wage index because it uses all-employer, occupation-level
20 data that more accurately reflects market-wide labor costs.
21 However, the alternative IPPS wage index uses hospital-
22 specific occupation weights, which heavily weigh registered

1 nurses' wages, as they make up nearly half of hospitals'
2 labor costs.

3 To more accurately reflect the relative labor
4 costs faced by SNFs, the alternative SNF wage index would
5 use the same data as the alternative IPPS wage index, but
6 apply occupation weights specific to SNFs, where nursing
7 assistants make up a greater share of SNFs' labor costs.

8 Using SNF-specific occupation weights increases
9 the accuracy of the SNF wage index because relative labor
10 costs in an area can vary across occupations and SNFs
11 employ a different mix of occupations than IPPS hospitals.

12 For example, the figure on the slide shows how
13 relative wages for registered nurses and nursing assistants
14 vary within two areas. As you can see, within rural
15 California, shown by the left set of bars, registered
16 nurses are paid wages 30 percent above the national average
17 wage for registered nurses, while nursing assistants are
18 paid only 10 percent above the national average. In
19 contrast, in rural North Dakota, shown by the right set of
20 bars, registered nurses are paid 10 percent below the
21 national average, while nursing assistants in the area are
22 paid the same rate as in rural California.

1 In general, because nursing assistants' wages
2 make up a significant share of SNFs' labor costs, each
3 area's SNF wage index should more heavily weigh the
4 relative labor costs of nursing assistants than other
5 occupations. This is different from the current and
6 alternative IPPS hospital wage indexes, which heavily weigh
7 the relative labor costs of registered nurses, as they make
8 up nearly half of hospitals' labor costs.

9 Therefore, in our example, the IPPS hospital wage
10 index value should be far higher in rural California than
11 in rural North Dakota, as it should reflect the large
12 differences in registered nurses' relative wages. However,
13 the SNF wage index value for the two states' rural areas
14 should not differ as much, as the relative wages for
15 nursing assistants are similar.

16 Turning to the SNF-level effects on payments,
17 while implementing the alternative wage index in a budget-
18 neutral manner would not change aggregate SNF PPS payments,
19 it would significantly redistribute Medicare payments.
20 Because of the large inaccuracies in the current wage
21 index, the effect on many SNFs would be material.

22 For example, as shown in left-most bar in the

1 figure, we estimate that once the alternative wage index
2 was fully implemented, SNF PPS payments would decrease by
3 more than 10 percent for 3 percent of SNFs. Most of these
4 SNFs are located in areas with very high current wage index
5 values and in areas where SNFs face materially lower labor
6 costs than IPPS hospitals.

7 On the other extreme, we estimate that SNF
8 payments would increase by more than 10 percent for 6
9 percent of SNFs. Most of these SNFs are located in areas
10 with low current wage index values and in areas where SNFs
11 face materially higher labor costs than IPPS hospitals.

12 And with that, I turn it back to Alison.

13 MS. BINKOWSKI: Thanks, Corinna.

14 In conclusion, the current Medicare wage index
15 systems are broken and have become more distorted since we
16 last visited the topic in 2007.

17 There are no perfect sources of labor cost data
18 or definition of labor market areas; however, alternative
19 wage indexes consistent with the proposed approach
20 described in this presentation would be a substantial
21 improvement over the current wage index systems, as they
22 would more accurately measure relative labor costs, be more

1 equitable across providers, and be less gameable and less
2 administratively burdensome.

3 Because many IPPS hospitals and SNFs would be
4 materially affected by the move to alternative wage
5 indexes, there would need to be a transitional period.

6 For example, the transition could be phased in
7 over a fixed period of time, or managed through a stop-loss
8 policy so that no provider experiences changes in Medicare
9 payments of more than a specified percent in any one year
10 due to the transition.

11 The Chair's draft recommendation reads:

12 The Congress should repeal the existing Medicare
13 wage index statutes, including current exceptions, and
14 require the Secretary to phase in new Medicare wage index
15 systems for hospitals and other types of providers that use
16 all-employer, occupation-level wage data with different
17 occupation weights for the wage index of each type of
18 provider; reflect local area level differences in wages
19 between and within metropolitan statistical areas and
20 statewide rural areas; and smooth wage index differences
21 across adjacent local areas.

22 As the alternative wage indexes would be budget-

1 neutral to the current wage indexes, we expect the Chair's
2 draft recommendation would have no direct effect on federal
3 program spending relative to current law.

4 With regards to the impact on beneficiaries and
5 providers, we do not expect this draft recommendation to
6 materially impact beneficiaries' access to services or
7 providers' willingness to treat Medicare beneficiaries.

8 However, transitioning to wage indexes that
9 better reflect geographic differences in labor costs would
10 make Medicare payments more accurate and equitable.

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

12 DR. CHERNEW: Great. Thank you both, and Jeff.

13 It is just eye-opening to see all that goes on in
14 this wage index world, and it really is remarkable, and
15 there's gradations of how you might react to specific
16 things that are going on. In a moment I'm going to open it
17 up to Round 1, and then we'll have Round 1 questions.

18 But just to set the stage, first, note that the
19 recommendation is more general than the illustrative
20 alternative, and so there's -- you know, we illustrated an
21 example of what one could do that would meet these
22 principles, but the recommendation itself is not to do

1 necessarily exactly that. We want the principles to
2 matter.

3 The second thing I'll say is this is moving
4 towards a vote in April, so keep that in mind when you make
5 your comments. If there's particular serious concerns or
6 whatever we're going in this direction, we need to know
7 sooner rather than later.

8 So that being said, I think we're going to start
9 with Round 1, and if I'm right, Greg is first.

10 MR. POULSEN: Thank you. I guess my questions
11 are fairly specific. I would frame them that I think this
12 was a great chapter. I liked it a lot. It was really well
13 done and illustrative and very compelling, so thank you.

14 I guess my questions are reasonably specific.
15 Since clinical folks are such a big part of the IPPS labor
16 group, how effective are we at eliminating the circularity
17 that's there? I guess what I'm wondering is, you know, if
18 this were a whole bunch of other folks that were brought
19 into that, I can see how it would help us a lot. If a big
20 chunk is registered nurses, are we effective at eliminating
21 the circularity? That ought to be the first question. I
22 have one more after that.

1 MS. BINKOWSKI: Great question. So, yes, it does
2 not fully eliminate the circularity, but it does do a
3 significant amount. For example, I will talk more broadly
4 because I can't find my specific numbers, but I think
5 registered nurses made up approximately -- registered
6 nurses working at IPPS hospitals were approximately 30
7 percent of all registered nurses. When you bring in
8 specialty hospitals, it brings it up again by another 10
9 percent; then outpatient facilities, home health centers.
10 So, yes, I'd say the plurality or the largest employer of
11 registered nurses in our clinical staff is general
12 hospitals, but it's still a minority.

13 MR. POULSEN: Thank you. I came to the same
14 conclusion. I just wanted to make sure that I was getting
15 it right.

16 My other question is really related to the
17 variation on the limits that are proposed, and I recognize
18 this isn't part of the proposal, but as people read this
19 and try and figure out how to do it, are variation limits
20 between contiguous counties applied between adjacent
21 states? So you could have two contiguous counties that are
22 each in a different state. I can imagine the differences

1 that impact those counties would be more dramatic based on
2 things like cost of taxes in different states and things
3 than might be between contiguous counties within a state.

4 So I guess -- sorry for the commentary. The
5 quick question is: Would those be applied across state
6 lines as well as within state lines?

7 MS. BINKOWSKI: Yes, we did apply those across
8 all adjacent counties, whether in a similar or different
9 state.

10 MR. POULSEN: All right. Thank you.

11 DR. CHERNEW: That's the way it was modeled.
12 There's limitations --

13 MR. POULSEN: I understand that, and I agree, and
14 I think it -- your answers were the ones that I was hoping
15 for, and so I think that's all good. I guess I just think
16 it's important because we're implying this and because next
17 time we may need to move to a vote. It's good for us to
18 know what is envisioned, so thank you.

19 MS. BINKOWSKI: And I'll add, as Mike said, the
20 bold-faced recommendation is broader in terms of the
21 approaches, and ours is meant to be illustrative consistent
22 with that. But through the notice and commenting period,

1 obviously there could be further refinements.

2 DR. CHERNEW: As an aside, I have a different
3 preferred way of smoothing. It's really not the point. I
4 think this is perfectly good getting at the main issue
5 that's being raised, and I think the data's pretty clear
6 that there's more cliffs than you would want, more
7 exceptions than you would want.

8 MS. KELLEY: Amol?

9 DR. NAVATHE: Thanks for this great work. I have
10 a two-part question.

11 The first part, I just wanted to make sure I
12 understood. So on page 10-11 of the reading materials, we
13 highlight that there's about two-thirds of hospitals that
14 qualify or that get an exception, and that the resulting
15 impact essentially on the IPPS payment rate, writ large, is
16 2.2 percent down because of the budget neutrality. So I
17 just want to make sure I -- I think I'm restating the
18 obvious, but just to doubly confirm here, that means that a
19 third of hospitals are essentially getting a cut of 2.2
20 percent to their IPPS revenues because of the exceptions
21 that are in place?

22 MS. BINKOWSKI: Correct. Or stated another way,

1 all hospitals are getting that minus 2.2 percent and some
2 are getting it offset by an exception and that
3 approximately one-third are not.

4 DR. NAVATHE: Great. Okay. So having
5 established that, the second part of my clarifying question
6 here is: So if we think about the characteristics of those
7 one-third of hospitals that are only getting the 2.2
8 percent cut without any offsetting benefit from an
9 exception, I'm curious if we've characterized who those
10 hospitals are. And I'm guessing that it's going to be
11 highly correlated with some of the simulations of our
12 illustrative proposal and how those might be creating
13 shifts. Essentially, I guess my question is: Do we know
14 who those hospitals are? Are they identical or very
15 similar to the hospitals that would benefit from our
16 illustrative proposal? Or are there other meaningful
17 differences between those groups?

18 MS. BINKOWSKI: Yes, I don't have specific
19 numbers on the characteristics, but there is a table in the
20 paper that shows what the effects are based on hospitals
21 that receive different exceptions, including those that
22 currently receive none, and the effects on them in

1 aggregate is actually relatively small because there are
2 subsets of them that are receiving no exceptions and would
3 benefit substantially, such as those in certain really low-
4 wage areas right now; and there's other ones that are
5 currently receiving no exceptions, such as those in some of
6 the really high-wage areas that we've pointed out that are
7 not getting exceptions, they just have a high wage because
8 of this circularity and labor market dynamics and market
9 power, and so -- and those would come down on the
10 alternative wage index. So it is not a heterogeneous group
11 of those that are currently receiving no exceptions.

12 DR. NAVATHE: Okay. Thank you.

13 MS. KELLEY: Okay. I have a question from
14 Cheryl. Was there any consideration given by the staff to
15 excluding Puerto Rico since it seems such an outlier?

16 MS. BINKOWSKI: So, yes, some of our -- you know,
17 in our presentation right now, we did exclude Puerto Rico
18 because it's an outlier, but it is in all of our results
19 because it is paid currently under the IPPS, and all of the
20 same approaches we think do apply to it. It does continue
21 to be one of the areas with the lowest wage indexes by far
22 and, therefore, one of the areas that is disproportionately

1 affected by the current temporary low-wage index exception.

2 MS. KELLEY: Betty?

3 DR. RAMBUR: Thank you very much. Very, very
4 important work.

5 I have a question that I brought up last time,
6 and I'm still just not clear on it. It may be clear and
7 just not clear to me. First of all, I really appreciate
8 the conclusion about the between and within effort, but on
9 page 16 it talks about the occupational mix reflecting, for
10 example, the acute care as well; the SNF will reflect SNF.
11 And here's my question: If, for example, a person -- a
12 pediatric trauma surgeon, they are going to be only
13 recruited certain kinds of places, and traditionally
14 nursing assistants have been disproportionately in nursing
15 homes, in long-term care, and LPNs somewhat. That's
16 shifting a little bit where hospitals are hiring LPNs. But
17 RNs are generalists that can work in either of these
18 settings, and traditionally, the salary has been much lower
19 in skilled nursing facilities.

20 So as I read this, this does not address that
21 particular problem. Is that correct?

22 MS. BINKOWSKI: So I think it does indirectly.

1 So we're not trying to make comparisons about the amount
2 that registered nurses are paid in different settings, but,
3 again, it's relative to the way registered nurses are paid
4 in an area relative to the national average for registered
5 nurses, and each area includes a mix of these different
6 types of settings. So this would only be a problem in
7 areas where there's a substantially different mix of, say,
8 the share of RNs that are in general acute-care hospitals
9 in that setting and skilled nursing hospitals in that
10 setting. So we're not -- it's implying that the payment
11 rates in those two settings are the same, but that, when
12 pooled together, you get similar relative wages.

13 Did that answer your question or --

14 DR. CHERNEW: Let me just jump in. So, one, I
15 think that's the right answer, and I think the tradeoff
16 here is, if you thought there was dramatically different
17 skill differences with the same occupational category or
18 whatever such that RNs -- an RN is not an RN, and that
19 they're dramatically different in one setting versus
20 another, moving away to the area level approach that we
21 have wouldn't fully recognize that if you had to hire a
22 subspecialized version of a particular occupation. And I

1 think the tradeoff, which I think is my personal view, as
2 the chapter says, is sure, you could then try and get it
3 exactly right; but when you do that, you create this really
4 other very destructive dynamic where you're basically
5 saying what you pay then feeds into your wage index in ways
6 that, you know, creates the problem that was outlined in
7 the chapter. So I think that's the tension. I think it's
8 how you would recognize that. I think the -- again, I'll
9 defer to you all, but the basic assumption is that the
10 occupation categories are granular enough to capture what
11 it costs to hire a person of that occupation category --

12 DR. RAMBUR: Just so I'm clear, so there will be
13 sort of a pool, for lack of a better word, that is the
14 skilled nursing facility registered nurses and then there's
15 sort of a different reference for acute -- is that not
16 correct? Okay. Okay, good.

17 DR. CHERNEW: I'm saying that is not the -- the
18 way it works now is based -- again, this may be a Round --
19 one and a half, Betty.

20 DR. RAMBUR: I thought it was one and a half --

21 DR. CHERNEW: Just so everybody knows, Betty said
22 this was one and a half, and I guess I'm the half. This is

1 based on the occupational categories and the granularity of
2 the occupational categories, and so the extent to which the
3 occupational categories aren't as granular as you would
4 like, that's a reasonable thing to say about this. And I'm
5 sure a lot of people will say something about that. I
6 think our view is of the -- my view. I won't speak to "our
7 view." You guys can comment. It's that the deleterious
8 consequences of doing it the current way is worse than the
9 risk you would face otherwise. But that's a topic we'll
10 have to discuss.

11 DR. RAMBUR: I just would say I think a little
12 more discussion on page 16 might help, and I can just talk
13 to you offline about that, because it wasn't clear to me
14 reading that. Thanks.

15 MS. KELLEY: That's all I have for Round 1. Did
16 you want me to move to Round 2 now?

17 DR. CHERNEW: Cheryl had sent a comment which I
18 think was more appropriate for Round 2. Why don't we start
19 with Cheryl's comment?

20 MS. KELLEY: Of course.

21 DR. CHERNEW: It was just a general view, and
22 then we can go with the queue that we have.

1 MS. KELLEY: Okay. Cheryl has this to say: My
2 thanks to the staff for an excellent chapter. I concur
3 that the current wage index is rife with problems, and the
4 chapter does a terrific job outlining the issues. I agree
5 with and support the approach outlined on page 16,
6 particularly the no exceptions element. The proposed
7 changes would address the myriad distortions under the
8 current wage index. Hospitals should not be allowed to
9 reclassify to game the system.

10 I found the statement at the bottom of page 10
11 about the exceptions being paid for by reducing the base
12 IPPS payment rate to all hospitals to be very compelling
13 and would encourage the staff to bring this forward at the
14 start of the chapter to ensure additional emphasis on this
15 point.

16 And I have Kenny next for Round 2.

17 MR. KAN: Thank you for a very insightful
18 analysis. I especially like how the analysis or discussion
19 of how the numerous exception issues are resulting in
20 accurate measures of labor costs while fostering a greater
21 inequity among providers. I am enthusiastic about
22 supporting the Chair's draft recommendation.

1 MS. KELLEY: Jonathan?

2 DR. JAFFERY: Thanks, Dana. And thanks, this is
3 a great chapter. It always feels like learning about the
4 wage index is like trying to learn a language as an adult.

5 [Laughter.]

6 DR. JAFFERY: It is great. I'm supportive as
7 well. I think in particular I really like the stuff you
8 presented about the smoothing by counties, the county data
9 and the illustrations just really pop out as why that --
10 how that works and makes sense.

11 The only other thing I just want to emphasize is
12 I'm very strongly supportive of the notion that any
13 recommendation we come to does build in some transition
14 period, and it can come in different ways. I don't know
15 how granular we want to get. The presentation talks about
16 a transition time or a stop-loss. Those are not
17 necessarily mutually exclusive either. So I just want to
18 emphasize that point. But thanks again. This is great.

19 MS. KELLEY: David?

20 DR. GRABOWSKI: Great. Thanks. First, great
21 work. I'm very supportive of the Chair's draft
22 recommendation here.

1 Several people have already noted this about the
2 smoothing, but these cliffs are really large. I know it's
3 hard to think about that in the abstract, but I'm smiling
4 because there's been several health economics papers that
5 have actually exploited those cliffs to look at kind of
6 wage differences relative to true costs and found that they
7 have a huge impact on access and quality of care. So this
8 smoothing is really going to do a lot of good. Economists
9 will lose an identification strategy, but maybe they'll get
10 a new one here with this new payment system. I know
11 everyone feels bad for us.

12 I wanted to focus my remarks on the SNF wage
13 index, and I think this is a major step in the right
14 direction. It has always struck me as sort of strange that
15 we just take this, you know, wage index off the shelf from
16 hospitals. Researchers do it. Policymakers obviously do
17 it. And it's a very -- as is noted in the chapter, a very
18 different mix of laborer in SNFs versus hospitals. So I
19 think all the problems, the inaccuracies, the inequities
20 that are present in hospitals are only more so in SNFs, and
21 so this will have a huge impact there. And as was noted in
22 the chapter, they aren't eligible for the wage

1 reclassification, so it has certainly been magnified for
2 SNFs.

3 Two comments. The first -- and I'm trying to
4 think through this -- I guess if you're taking kind of the
5 hospital kind of wage index and applying it to SNFs but
6 reweighting for the job classifications, there's an
7 assumption that kind of those differentials are consistent
8 across different sectors. And I think that's something we
9 may want to think about here, right? It's obvious that you
10 have a lot more certified nurse aides and fewer physicians
11 in a SNF relative to a hospital, but is that kind of wage
12 differential comparable? And this kind of relates to your
13 first-round question, Betty, that I'm trying to think
14 through those kind of differences.

15 Then the second comment is that the hospital wage
16 index shows up in other parts of our payment system. Home
17 health would be another example, and are we thinking about
18 kind of fixes elsewhere? Maybe we should start where we're
19 starting, but there are other applications here where we
20 might apply this.

21 Thanks.

22 MS. BINKOWSKI: Thanks, David. I'd say two

1 things on that.

2 One, you mentioned physicians, and physicians are
3 completely out of this. They are paid on a separate basis,
4 but yes. And then we did do some more preliminary work
5 looking at applying the same approach to other sectors as
6 well, and the way the current Chair's draft recommendation
7 is worded, it would be broad and it would apply across the
8 board, including to, for example, home health, and that's
9 saying you guys can discuss more.

10 DR. GRABOWSKI: That's great. Thanks.

11 MS. KELLEY: Jaewon?

12 DR. RYU: Thanks. I also like the approach; I
13 think for all the reasons stated. I'm also supportive. I
14 think it leads to a more precise kind of approach and seems
15 to also mitigate some inherent inequities with the current
16 system.

17 I think that's especially important now because
18 some of these job classes, I think nurses being the best
19 example, you know, there really is a cross-market dynamic,
20 and it's become more of a national market than ever before.
21 And so, you know, look no further than the traveler dynamic
22 and what we saw over the last several years. I think this

1 work is very important, but especially so against that
2 context.

3 I think the one thing that -- and this may be
4 overcomplicating. I certainly don't want to expand the
5 scope beyond what we had set out to do and may be not even
6 feasible. But I think all of the approach, it's still
7 within the health care occupational category, so it's sort
8 of within the occupation. And I wish there was some way to
9 capture outside the industry occupations and labor costs
10 that may exist in same or similar wage bands, because I
11 think the competition for labor is not just within health
12 care. It's now spanning into other industries that are in
13 your local markets, and if there was some way to capture
14 that dynamic -- because I think there is a relativity
15 dynamic there as well -- you know, depending on your mix --
16 let's take the SNFs as an example. Depending on your mix
17 of staffing, you're competing not against just other SNFs
18 and hospitals for labor; you're competing against other
19 industries, whether it's retail or warehousing or call
20 centers or what have you. And, you know, that
21 disproportionately hits depending on what market you're in
22 and what those dynamics are like and what those labor costs

1 are doing.

2 And so I don't know if there's a clean way to
3 capture that, to be honest, but if I had a dream, I think
4 that would be one element to incorporate.

5 MS. BINKOWSKI: Can I make one response to that?
6 I appreciate you sharing your dream, and knowing it's
7 partially incomplete, but that our -- the current BLS data
8 we use is cross-industry, so, for example, things with
9 registered nurses would also include those employed by
10 schools or other non-health care, and it also includes IT
11 staff. You know, they're weighted smaller than, say,
12 registered nurses, but those are across the board. I think
13 you were suggesting dreaming even further about
14 competition, but it is not limited to the health care
15 industry right now.

16 DR. RYU: Yes. I think that's one step, but
17 absolutely. What I'm saying is one step further, not just
18 cross-industry but it's also cross-occupation, so not just
19 limited to nurses that are, you know, employed in school
20 districts and so forth, but occupations that have nothing
21 to do with health care.

22 DR. STENSLAND: You're saying more like they do

1 physicians where you compare the physician GPCIs based on
2 what they pay for accountants and lawyers and that kind of
3 thing.

4 DR. RYU: Similar. That's right. That's right.
5 And you would only incorporate folks who were in a
6 comparable wage band. You would not incorporate the
7 software engineer in the Bay Area to estimate labor cost
8 dynamics in the ambient market. You would only look at
9 folks in similar wage bands.

10 DR. CASALINO: Could I ask a question about this?

11 MS. KELLEY: Larry.

12 DR. CASALINO: This wouldn't be taken care of by
13 the proposal as you have it now, which includes all
14 occupations in the wage index? Because, presumably, if
15 you're in an area -- maybe this isn't true, but if you're
16 in an area where you have people that could either work as
17 housekeepers in the hospital or work at McDonald's, say,
18 wouldn't the way you have of calculating the wage index now
19 take that into account the all-occupation way?

20 MS. BINKOWSKI: So trying to say this one more
21 time, I think we'd get one step towards Jaewon's dream.
22 Housekeepers, we have a housekeeper category, and that

1 would include those that are employed in hospitals and,
2 say, hotels and other non-hospital sectors. But it doesn't
3 include reference occupations that are not housekeeper --
4 that are not employed by hospitals at all but maybe are in
5 a similar wage band.

6 DR. CHERNEW: You don't have to necessarily stay
7 in that particular occupation if you were to leave doing
8 it. That's what I think the issue is. It's within
9 occupation, not within health care per se. It's some
10 occupations are more transferable outside of health care
11 than others.

12 DR. GRABOWSKI: And on this point, that was what
13 I was trying to suggest. If that got bid up, I think,
14 Jaewon, you know, if Amazon came in and bid up the wages
15 for certified nurse aides in the SNF market and that -- I
16 don't think that would be accounted for. It's a relative
17 wage issue.

18 MS. KELLEY: Robert?

19 DR. CHERRY: Yes, thank you. First and foremost,
20 I'm supportive of the proposal, and I want to thank you for
21 all the detailed work here in unpacking a new model.

22 I do want to mention -- and it's not a new

1 comment -- about this all-employer approach, because it's
2 pretty much a misnomer. And I do realize that CMS has
3 historically excluded certain groups, like physicians, from
4 the wage index for the Prospective Payment System, and this
5 really should be, I think, re-evaluated because we're
6 missing a substantial portion of the labor costs for
7 hospitals by excluding those groups. So hospitals, you
8 know, commonly employ emergency medicine physicians,
9 intensivists, hospitalists in order to make, you know,
10 their clinical operations work, as well as in selected
11 specialties, too, based on their community need, and that
12 could be orthopedic surgeons or neurosurgeons, and they're
13 actually on their payroll as part of their labor cost.

14 There also may be contracted services across all
15 specialties that could range from radiology to dentistry to
16 podiatry as well, and so I don't think this is taken into
17 consideration as well.

18 And these databases around what these salaries
19 cost for various specialties are readily available, MGMA
20 being one database that could be tapped into.

21 So although I'm supportive of this model, I'd
22 like to see future models that take into consideration

1 total labor costs, including those of physicians and other
2 specialists.

3 MS. KELLEY: Amol?

4 DR. NAVATHE: Thank you. First, I just wanted to
5 voice strong support for this work. I think it's clear
6 that this is, I think, as the chapter uses the word, a
7 Byzantine system that kind of in aggregate -- I recognize
8 that this has happened in a kind of step-wise progression
9 here. It's not that policymakers designed the system the
10 way it looks right now. But it ends up in a policy system
11 that kind of defies common-sense policy, I think, or defies
12 common sense.

13 So regardless of that, a couple of comments. One
14 is I think it would be helpful -- I did try to take a look,
15 Alison, at that table that you were pointing me to. I
16 think that there are -- there's the problems that the
17 current system is sort of creating, and then there's that
18 illustrative solution, and I think they're kind of
19 correlated together, obviously, because the illustrative
20 solution is trying to solve the problem. But I think one
21 of the pieces that is in part lost is I think we -- the
22 chapter does a nice job of characterizing which hospitals,

1 if you will, are benefitting from the current exceptions
2 system, but it doesn't do as good a job of characterizing
3 which hospitals are actually harmed by these exceptions,
4 and I think it's at a very high level. I think actually it
5 would be really helpful to build that out to better
6 understand, because I think we're kind of looking at only
7 one part of this equation. We're not looking at the other
8 part of the equation. And, presumably, one of the main
9 reasons and motivating factors across the inequities
10 element is because there are hospitals that are being
11 harmed by the way that the budget neutrality works in the
12 context of these exceptions and the structure of the system
13 in general.

14 So I think I would advocate for us trying to be a
15 little bit more specific, if you will, to point out where
16 these harms are actually translated into that one-third of
17 hospitals that don't receive any exceptions.

18 I think the second point I wanted to make is that
19 there's a statement or two in the paper that basically talk
20 about -- recognize essentially that any change is hard, and
21 any change essentially in the context of our policy
22 recommendation and the illustrative scenario that we've

1 put, that there are hospitals that do suffer or would
2 suffer hypothetically large impacts. And there's a
3 narrative in there, in the paper, that highlights that.
4 The goal here is not to harm any particular hospital, but
5 to recognize that if any hospitals were to be harmed, the
6 current system is not the best way to solve that, that
7 there are other elements, and we've done a lot of work as a
8 commission around safety-net work -- for example, safety-
9 net hospitals -- that is aiming to support organizations
10 that are serving beneficiaries that are marginalized or
11 that face undue challenges in getting access to care. And
12 so I think it -- it's in there. I think to the extent that
13 we can, I think I would elevate that a little bit because I
14 think it is a really important aspect of how the Commission
15 views this work, that this is not in some sense in
16 isolation; it's in the context of the fact that we have
17 already made strong recommendations around the safety net.

18 Thanks.

19 MS. KELLEY: Greg.

20 MR. POULSEN: Thank you. I'd like to begin by
21 sort of piggybacking on what Amol just said. I think that
22 this is going to be a really, really heavy lift politically

1 because there are a group that are going to be impacted
2 negatively. I think that emphasizing those that will be
3 benefitted is really going to be somewhat helpful.

4 What I really wanted to say, though, is I really,
5 really like the focus and refocus, and it's stated several
6 times, the no exceptions. I think that that is so
7 beneficial, and there's so many things that we've gotten
8 ourselves in trouble over the years by giving one little
9 exception, and then, of course, that is unfair to somebody
10 else, and so we do another exception, and we build on that.
11 And, candidly, I think that Amol was being really kind when
12 he said "Byzantine." It's worse than that. I mean, it's -
13 - it really does lead to just compounding of those
14 problems.

15 So I almost just snuck this in on my Round 1, but
16 I didn't want to get smacked by Mike. So I just want to
17 say thanks for what I think is a really, really good set of
18 recommendations.

19 MS. KELLEY: Larry?

20 DR. CASALINO: I also agree that this is really
21 great work, and the standard for the slides here in general
22 from the staff is extremely high. The slides are routinely

1 good. These were really an excellent set of slides, I
2 think, made complex things much clearer. I strongly
3 support the recommendations.

4 I have two pretty minor comments and then a
5 question. The minor comments are just similar to what some
6 have said earlier about another issue. I think the fact
7 that the administrative burden is much less not just for
8 the -- not just for CMS but for hospitals is really
9 important, and I think that should be stressed in the
10 executive summary, which it isn't right now, I think.

11 The other thing I think that's important that's
12 in the report, in the chapter, but not stressed and not in
13 the executive summary, I do not believe, is that this is
14 kind of a model that could be applied not just to SNFs and
15 hospitals, but elsewhere perhaps.

16 So those are my two suggestions.

17 That's all I had, but then Robert's question or
18 comment about physicians made me think a little bit.
19 Hospitals really vary a lot in how many physicians they
20 employ and what specialties they employ them in. There are
21 some hospitals that employ orthopedic surgeons, for
22 example, and then there are lots and lots of hospitals that

1 don't employ any orthopedic surgeons at all.

2 There's also -- it's not quite employing
3 physicians, but they're just paying physicians in various
4 specialties quite high daily fees for taking a call in the
5 emergency room in addition to their regular work. And I'm
6 trying to think, if you were a large hospital, a big
7 employer in an area, and you employed lots of physicians in
8 highly paid specialties, would that -- I realize the wage
9 index is figured on just more than that, so it's not a
10 completely circular thing. But I think you could drive up
11 your wage index quite a bit that way in that particular
12 situation. Am I understanding that correctly?

13 DR. STENSLAND: You could, but they don't include
14 those physician wages when they're computing the average
15 wage right now. So those physician wages are intentionally
16 taken out.

17 DR. CASALINO: No, I'm saying, Jeff, if one were
18 to follow, I think, the intent of Robert's comment, unless
19 I misunderstood it, I thought it was looking to putting
20 them in. Then would the problem that I just mentioned
21 actually be a problem potentially?

22 DR. STENSLAND: I think that could be a problem,

1 and I think more fundamentally what we're thinking is --
2 the way the system is set up is we wouldn't include them
3 because they're being paid on the physician fee schedule,
4 which is adjusted by the GPCIs, which is a separate wage
5 index system from the hospital wage index system. So
6 whether physician wages are higher or lower in some market
7 would be proxied by what the wages are for these other
8 people that go into the physician's version of the wage
9 index, which is the GPCI, which is separate for this. So
10 you've got to think these are in two separate rows, like a
11 divided highway where you have a lane for the hospital and
12 a lane for the physician, and the physician relative wages
13 are in this wage index, and the hospital relative wages are
14 in that wage index.

15 DR. CASALINO: In a non-physician wage -- right,
16 this wouldn't affect that.

17 DR. CHERNEW: Effectively I think you would be
18 double counting. If you put the physicians in, you'd be
19 paying more for the physicians for the physician stream of
20 money, and then you would be paying more for the hospital
21 in for the non-physician labor. So this is basically the
22 hospital wage index that we're talking about now, is

1 basically reflecting the non-physician -- you could think
2 of it as the facility part of the stream of money, right?
3 The physician wage index part is through the separate
4 system. Did I --

5 DR. NAVATHE: It's like Part A versus Part B,
6 essentially.

7 DR. CHERNEW: Yeah, right.

8 DR. NAVATHE: That's the easy way to think about
9 it, I think. This is the Part A.

10 DR. CHERNEW: Okay. So if I'm right, that was
11 the end of Round 2.

12 MS. KELLEY: Yes.

13 DR. CHERNEW: So what I want to do -- and we'll
14 see just how time plays out. I just want to go around to
15 get a sense -- I'm not asking for a comment as much as
16 affirmation or not about your support for the direction of
17 where this recommendation is going, because we're going to
18 come back in April with a recommendation. It's going to
19 look quite similar to this one given what we've heard in
20 this discussion, but I just want to make sure I'm not
21 missing anything. So I'm just going to start with you,
22 Jonathan, and I'm going to end with Kenny. And Cheryl I'm

1 not going to ask because she's going to have to be through
2 Dana, anyway, and she already said that she was supportive.

3 DR. JAFFERY: As did I. Supportive.

4 DR. CHERNEW: Okay.

5 MR. POULSEN: Yep.

6 DR. CHERRY: Yes, I support as well.

7 MS. GINSBURG: And I support.

8 DR. CASALINO: Likewise.

9 DR. RYU: Same.

10 DR. RAMBUR: Yes, I support.

11 DR. NAVATHE: Yes, I support.

12 DR. GRABOWSKI: I'm still supportive.

13 DR. RILEY: I too support.

14 DR. DUSETZINA: I also support.

15 DR. SARRAN: Yes, very supportive.

16 MR. KAN: Yes, very supportive.

17 DR. CHERNEW: [Comment off microphone.]

18 MS. KELLEY: Mike, your mic.

19 DR. CHERNEW: For those at home, that wasn't a
20 vote. That was just our way of making sure that in the
21 public record we got a sense of where people were when we
22 came back. So thank you for that.

1 I am also obviously very supportive of the work
2 and where this direction is going, so thank you all for
3 your comments. I do think this will be a challenge in a
4 number of ways, as Greg pointed out, and I do think it's in
5 part because we've allowed the system to get a little bit
6 out of control -- a little bit. And so I think that just
7 requires us to make changes that are otherwise more
8 impactful than they otherwise would have been. So we'll
9 keep doing this, and obviously, again, I will emphasize the
10 illustrative alternative is not necessarily -- all these
11 other issues we've raised, they would be issues that would
12 have to be taken into account by CMS as they began to deal
13 with it, so the heterogeneity within occupations, adjacent
14 counties across states, some of those other types of
15 things. But I think directionally what is very clear to me
16 from this chapter is that we have created a wage index
17 system in the hospital space and beyond that isn't really
18 capturing -- it's capturing a lot of things beyond
19 legitimate wage differences, and that becomes problematic,
20 particularly in the budget-neutral context where others get
21 hurt.

22 So at any rate, that's where we are. The answer

1 to your question you sent me, Dana, is, yes, we can start
2 lunch earlier. So we are going to -- barring any other
3 comments, we are going to take a break now. We are going
4 to come back at -- I think we come back at roughly 2:00.
5 We will have what will be a -- oh, yes. For those at home
6 who want to comment on that, please submit your comments to
7 MedPACcomments@medpac.gov or you can go on the website and
8 there will be a place where you can submit your comments.
9 We sure do look forward to hearing them. Some of you have
10 submitted other comments. You know we will engage.

11 We'll be back at 2:00, and we will be having what
12 I'm sure will be a very lively discussion on pricing for
13 Part B drugs.

14 So that's where we are. Okay.

15 [Whereupon, at 12:11 p.m., the meeting was
16 recessed, to reconvene at 2:00 p.m. this same day.]

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1 AFTERNOON SESSION

2 [2:00 p.m.]

3 DR. CHERNEW: Hello, everybody. Welcome to our
4 afternoon session, and welcome to Lynn, who has made it out
5 of, I think -- what was it? Nine feet of snow, Lynn?
6 Twelve feet of snow? Ten feet of snow? So we're glad to
7 have here, and this is obviously going to be a particularly
8 important discussion -- I think, Nancy, you're starting --
9 about the price of Part B drugs. Nancy.

10 MS. RAY: Good afternoon. The audience can
11 download a PDF of the slides in the right-hand side of the
12 screen.

13 Before starting, I'd like to thank Corinna Cline
14 for her help with developing this chapter.

15 In June 2017, we made a number of
16 recommendations, including using a type of reference
17 pricing policy, to spur competition between biosimilars and
18 their originator biologic. In our June 2019 report, we
19 discussed extending this policy to improve price
20 competition for drugs with therapeutic alternatives. And
21 in our June 2022 chapter, we added to our agenda addressing
22 the payment of accelerated approval drugs and improving

1 financial incentives under the Part B drug payment method.

2 Today's session is a continuation of our June
3 2022 work focusing on approaches that aim to maintain
4 incentives for innovation with affordability for
5 beneficiaries and taxpayers.

6 Specifically, during today's session we will
7 continue our September and January discussion of the three
8 policies to improve Medicare's payment for Part B drugs.

9 While the Inflation Reduction Act contains
10 changes to Part B drug payment, it has not negated this
11 policy package that we are discussing today.

12 The first two policies address manufacturers'
13 pricing behavior and uncertainty about the clinical benefit
14 of some accelerated approval drugs and the lack of price
15 competition among drugs with similar health effects. And
16 the last policy addresses concerns about the 6 percent add-
17 on and providers' financial incentives.

18 There was good consensus among Commissioners for
19 the policy package we discussed in January. Now we are at
20 the stage to present the Chair's draft recommendations.
21 The goal for today's session will be to solicit feedback on
22 each of the Chair's draft recommendations with the intent

1 of having final recommendations for you to vote on in April
2 and publication of this work in the June 2023 report.

3 I am going to move through things at a high
4 level. You have seen this material in January, and there
5 are more details in your paper which we are happy to
6 discuss on Q&A.

7 The Medicare program and beneficiaries spent \$42
8 billion on Part B drugs in 2021. Spending is growing
9 rapidly, about 9 percent per year on average over the last
10 decade. The largest driver of spending growth has been the
11 rise in the average price Medicare Part B paid for drugs,
12 which reflects post-launch price growth, launch of higher-
13 priced products, and shifts in the mix of drugs.

14 Estimates suggest that U.S. drug prices are
15 roughly double the prices in OECD countries. The higher
16 prices in the U.S. reflect higher launch price and more
17 post-launch price growth than in other countries.

18 Part B drug spending is concentrated with the top
19 20 drugs accounting for more than 50 percent of spending
20 that's used to treat cancer, eye, and inflammatory
21 conditions.

22 Most Part B drugs are paid at a rate of 106

1 percent of average sales price -- ASP. We will talk more
2 about the 6 percent add-on later in this presentation. ASP
3 reflects the average price realized by the drug
4 manufacturer for sales to most purchasers net of most
5 rebates, discounts, and price concessions. ASP is an
6 average. An individual provider's purchase price for a
7 drug may differ from ASP.

8 Exceptions to ASP+6 payment are listed on the
9 slide. When a provider furnishes a Part B drug, the
10 provider also receives a separate payment for drug
11 administration services under the physician fee schedule or
12 outpatient prospective payment system.

13 Medicare has few tools to influence drug prices.
14 The way Medicare codes Part B drugs affects price
15 competition, which in turn affects spending. Products
16 assigned to the same billing code -- a brand and its
17 generics -- spur price competition. By contrast, assigning
18 products to their own code -- single-source drugs,
19 originator biologics, and biosimilars -- does not spur
20 price competition with the manufacturer effectively
21 determining Medicare's payment rate for the product. And
22 Medicare's payment policies generally do not consider

1 whether a new product results in a better clinical outcome
2 than its alternatives.

3 The Chair's package of draft recommendations aims
4 to address payment for accelerated approval drugs, spur
5 price competition among drugs with similar health effects,
6 improved financial incentives under the Part B drug payment
7 system, and maintain incentives for innovation.

8 This policy addresses payment of accelerated
9 approval drugs. The accelerated approval pathway is
10 designed to expedite the approval of potentially promising
11 products for cancer and other complex or rare conditions by
12 reducing the development time needed to bring a drug to
13 market compared with the traditional approval process.

14 At the time of their approval, for some
15 accelerated approval drugs there is uncertainty about their
16 impact on beneficiaries' outcomes because accelerated
17 approval is based on a surrogate or intermediate clinical
18 endpoint that is reasonably likely to predict a clinical
19 benefit rather than a direct measure of clinical benefit.

20 According to the Food and Drug Administration,
21 using surrogate endpoints creates a risk that patients
22 could be furnished a drug that later is shown not to

1 provide an actual clinical benefit. Although the FDA
2 requires manufacturers to complete confirmatory post-
3 approval trials showing clinical benefit, some trials are
4 delayed. According to the Office of Inspector General,
5 more than one-third of accelerated approval drugs have at
6 least one trial past its completion date.

7 Medicare's payment for Part B drugs does not spur
8 manufacturers to complete their confirmatory trials on time
9 because current law does not differentiate Medicare payment
10 between a drug approved under traditional versus
11 accelerated approval.

12 Despite the lack of evidence about a drug's
13 clinical benefit, some accelerated approval products are
14 launching at high prices with uncertain clinical benefit.
15 Aduhelm is a recent example of a drug in which the
16 manufacturer originally set a price that many considered
17 excessive because of its uncertain clinical benefit.

18 This leads us to the Chair's draft recommendation
19 1 which aims to make Medicare a more prudent purchaser of
20 health care services while ensuring access to high-quality
21 care for Medicare beneficiaries, spurring manufacturers to
22 complete their confirmatory trials in a timely fashion, and

1 maintaining incentives for innovation.

2 The recommendation reads: The Congress should
3 give the Secretary the authority to cap the Medicare
4 payment rate of Part B drugs and biologics that are
5 approved under the accelerated approval program if they
6 meet any of the following criteria:

7 A, did not complete their post-marketing
8 confirmatory trials within the deadline established by the
9 manufacturer and the Food and Drug Administration;

10 B, offered a clinical benefit that is not
11 confirmed in post-marketing confirmatory trials;

12 C, are covered under a coverage with evidence
13 development policy;

14 Or, D, have a price that is excessive relative to
15 the upper-bound estimates of value.

16 This draft recommendation is expected to decrease
17 program spending relative to current law. The draft
18 recommendation is expected to generate savings for
19 beneficiaries through lower cost sharing, and it is not
20 expected to adversely affect beneficiaries' access to
21 needed effective medicines.

22 This draft recommendation is expected to result

1 in more timely development of evidence about the clinical
2 benefit of accelerated approval drugs for beneficiaries and
3 providers. We also expect continued provider willingness
4 and ability to care for beneficiaries.

5 In terms of implementing this policy, here's how
6 it could be structured. Once a manufacturer verifies a
7 drug's clinical benefit, payment could revert to current
8 law. During the January meeting, Commissioners supported
9 setting the payment cap based on the clinical benefit and
10 the costs of the new drug relative to the standard of care.
11 We envision that the Secretary could operationalize the cap
12 using a rebate under which manufacturers would pay Medicare
13 back for the difference between Medicare's payment rate and
14 the cap.

15 MS. NEUMAN: We next turn to a policy that
16 addresses concerns about pricing for drugs with similar
17 health effects. Because Part B pays each single-source
18 drug and biologic and biosimilar based on its own ASP, it
19 does not spur price competition among therapeutically
20 similar products. In 2017, the Commission recommended a
21 combined billing code policy for biosimilars and originator
22 biologics, which is a type of reference pricing that would

1 pay these products the same average rate to spur price
2 competition.

3 Building on that recommendation, a policy to
4 extend reference pricing beyond biosimilars by applying a
5 single ASP-based payment rate to drugs and biologics with
6 similar health effects would spur price competition.

7 To that end, the Chair offers the following draft
8 recommendation. It reads: The Congress should give the
9 Secretary the authority to establish a single average sales
10 price-based payment rate for drugs and biologics with
11 similar health effects.

12 In terms of implications, the draft
13 recommendation is expected to decrease Medicare program
14 spending by spurring price competition among manufacturers
15 and creating incentives for providers to select lower-
16 priced products.

17 In terms of beneficiaries, the draft
18 recommendation is expected to generate savings for
19 beneficiaries through lower cost sharing, and it is not
20 expected to adversely affect beneficiaries' access to
21 needed medicines.

22 In terms of providers, aggregate payments to

1 providers are expected to decrease over time as
2 manufacturers reduce drug prices and that translates into a
3 lower ASP. However, provider profitability might increase
4 because of the two-quarter lag in Medicare's ASP payment
5 rates and declining drug prices and providers opting for
6 the lower-priced product.

7 Under this draft recommendation, we expect
8 continued provider willingness and ability to care for
9 beneficiaries.

10 In terms of implementation of the policy, here's
11 how it could be structured.

12 Each product in a reference group -- that is, a
13 group of products with similar health effects -- could
14 remain in its own billing code. Medicare could set a
15 payment rate for the reference group based on the volume
16 weighted ASP of all products in the reference group similar
17 to how payment is determined for brand and generic drugs.

18 To define reference groups, the Secretary could
19 consider various factors, including organizing reference
20 groups by clinical indications and drug classification and
21 ease of implementation, beginning with:

22 One, biosimilars and originator biologics;

1 Two, drugs approved under FDA's 505(b)(2) pathway
2 and related brand and generics products. Your paper has
3 more detail on this, but 505(b)(2) products typically have
4 the same active ingredient as existing brand or generic
5 drugs and are approved by the FDA under an abbreviated
6 pathway where they can reference clinical studies by the
7 original drug's manufacturer.

8 And, three, drugs for which reference pricing has
9 been implemented or previously considered -- for example,
10 viscosupplement for osteoarthritis and erythropoietin-
11 stimulating agents for anemia.

12 Now, moving to the third policy that focuses on
13 improving provider incentives under the ASP payment system.

14 Medicare pays providers a percentage add-on for
15 Part B drugs. While clinical factors play a central role
16 in prescribing decisions, there is concern that the
17 percentage add-on may create incentives for providers to
18 select higher-priced drugs when a lower-priced drug is
19 available to treat a patient's condition.

20 To address concerns about incentives associated
21 with the percentage add-on, the Commission has developed a
22 three-part approach to restructure the ASP add-on that

1 could improve financial incentives. That approach would:
2 maintain the current 6 percent add-on for lower-priced
3 drugs; reduce the add-on for higher-priced drugs, by
4 reducing the percentage add-on to 3 percent and adding a
5 fixed fee of \$24; and for the most expensive drugs, placing
6 a fixed dollar cap on the add-on of \$220 per drug per day.

7 Although most Part B drugs are paid based on ASP,
8 when ASP data are lacking, drugs are paid based on a
9 percentage add-on to wholesale acquisition cost, or WAC.
10 WAC is generally a higher price than ASP because it doesn't
11 incorporate discounts. A policy to eliminate the WAC add-
12 on would improve incentives and reduce excess payments.

13 This brings us to the Chair's draft
14 recommendation. It reads: The Congress should direct the
15 Secretary to reduce add-on payments for Part B drugs paid
16 based on average sales price to improve financial
17 incentives, and to eliminate add-on payments for Part B
18 drugs paid based on wholesale acquisition cost.

19 In terms of implications, the draft
20 recommendation is expected to decrease Medicare program
21 spending.

22 In terms of beneficiaries, it is expected to

1 generate savings for beneficiaries through lower cost
2 sharing and is not expected to adversely affect
3 beneficiaries' access to needed medicines.

4 In terms of providers, add-on payments to
5 providers would generally decrease except for lower-priced
6 drugs. There could be increased financial pressure for
7 some providers (depending on factors such as manufacturer's
8 pricing response to the policy); overall, the policy is not
9 expected to affect providers' willingness and ability to
10 serve beneficiaries.

11 In terms of implementation considerations, a
12 couple of things to note.

13 When implementing the reduced add-on, CMS should
14 assess the separate drug administration payment rates under
15 the physician fee schedule and outpatient prospective
16 payment system to ensure they are adequate.

17 Similar to other payment changes, CMS should
18 monitor utilization patterns among providers following
19 implementation of the policy.

20 So this brings us to the end of the presentation.
21 We are happy to answer any questions on the material
22 presented or in your paper.

1 As mentioned at the outset, the Chair's goal for
2 today is to get your feedback on the draft recommendations.

3 DR. CHERNEW: Great. Kim, thank you. Nancy,
4 thank you.

5 I will make some broader comments, so maybe I'll
6 do that between Round 1 and Round 2, and we'll just start
7 with Round 1. I think we can jump in, and if I'm right
8 Jonathan is the first person in the queue for Round 1.

9 DR. JAFFERY: Thanks, Mike. Thanks, Nancy and
10 Kim. This is a great chapter and a really clear, excellent
11 presentation. I have two questions. The first one is on
12 Policy 1. You talk about operationalizing the payment cap
13 through a rebate potentially so the question is how do you
14 see that impacting beneficiary cost. And the second
15 question is on Policy 3. I'm just wondering what you are
16 thinking about with dollar add-ons, the inflation index or
17 index in some other way?

18 MS. NEUMAN: On the first policy, if it's
19 operationalized through a rebate, it is possible to share
20 the savings with a beneficiary by reducing the
21 beneficiary's cost sharing up front. Currently that is how
22 it is going to work with the IRA's inflation rebate for

1 Part B drugs. The beneficiary shares in the rebate. And
2 so it could work the same way with this policy.

3 DR. JAFFERY: [Inaudible.]

4 MS. NEUMAN: Yeah.

5 DR. JAFFERY: Okay, great. That's good to know.

6 MS. NEUMAN: Yeah. And then the second one was on
7 indexing the add-on.

8 MS. RAY: The add-on.

9 MS. NEUMAN: Yeah. So we have added into the
10 paper the idea that that is the policy choice, that you all
11 or policymakers in implementing this could consider. You
12 could potentially index that flat add-on to some measure of
13 inflation, either CPI -- that's sometimes used in certain
14 drug policies -- or drug price inflation, or some
15 combination of that kind of approach. That would be one
16 option to think about.

17 DR. JAFFERY: Thank you.

18 MS. KELLEY: Lynn.

19 MS. BARR: Thank you. A great chapter and I
20 really enjoyed the work. I have one question, and I'm
21 really glad you brought this up, about sequestration. So
22 we're not really talking about ASP+6 versus ASP+3. We're

1 talking about 4 and 1, right? And I have a concern --
2 right, because you said that it's actually 4.3 percent --
3 and so we go down to 3 and this payment is meant to cover
4 the fact that not everybody gets the average, right? And
5 so this is to help pay for the acquisition cost of the
6 drugs. So if we're really only giving them -- and the
7 lowest of the three is the option -- we're going to give
8 them 1 percent of the cost of the drugs, in many cases.
9 And I'm just wondering, do you have data that shows that
10 that's enough?

11 MS. NEUMAN: So data on providers' acquisition
12 costs for drugs is limited. We have some discussion in the
13 paper where we talk about what has been done to look at
14 that in the past. We've done analysis looking at sort of
15 invoice prices for Part B drugs, based on limited data from
16 a while ago. And what that analysis showed was that
17 manufacturers have responded in the past to policy changes,
18 like the implementation of the ASP payment system in 2005,
19 and then the sequester in 2013, in ways that the data
20 suggest they have changed their pricing patterns in
21 response to the policy to mitigate their effects on
22 providers. So there is the potential for manufacturer

1 response to this policy as well.

2 MS. BARR: But since we are doing a "lesser of"
3 they have got a lot less wiggle room, right? Yeah, I'm
4 just concerned. That's my question, is 1 percent enough,
5 and I'll leave it those in the room.

6 DR. CHERNEW: I'm sorry for having to jump in.
7 The clarifying question, for which I think you were spot on
8 is, the 6 is not really a 6. There is a sequester which
9 was noted. And so ASP+6 is sort of what it is known as,
10 but because of the sequester the effective amount is less.
11 Whether or not we believe -- and we can have a separate
12 conversation -- the details of the alternative, once you
13 apply the sequester to it is enough, is a completely valid
14 point. I just want to reserve that point around too.

15 MS. BARR: Oh, okay. Thank you.

16 DR. CHERNEW: So I mean, again, I'm just trying
17 to keep us -- we're good?

18 MS. NEUMAN: Yeah, I agree, and just to add on to
19 that, just the clarification portion of it, in your paper,
20 in Table 9, you can see what the percentage add-on would be
21 for differently priced drugs, and you can subtract the
22 sequester off if you want, which is about 1.6. So you can

1 see at the lowest it's going to be, as you said, the 3
2 minus the 1.6. For drugs that are not quite as expensive
3 it ratchets, and that table can show you sort of. It can
4 help you think through that.

5 MS. KELLEY: Greg.

6 MR. POULSEN: Thanks. This is just a little bit
7 related to Lynn's question, and probably the most naïve
8 question we'll have. What is the reason for having a
9 higher total amount for more expensive drugs than for less
10 expensive drugs? Is it for the potential loss of
11 inventory, for the holding cost? What is the validity for
12 having Payment X for a \$1,000 drug and Payment Y for a
13 \$5,000 drug? What is the difference in the underlying cost
14 for the provision of that?

15 MS. NEUMAN: Are you asking what was the
16 rationale for the 6 percent add-on?

17 MR. POULSEN: Well really, yes, but it's maybe,
18 if we think that they are all essentially the same cost for
19 provision, why would it not be a consistent amount rather
20 than a consistent percent, if that makes sense. And I
21 applaud what we are already doing. I'm just asking the
22 question (a) why was it the way it was in the first place,

1 and (b) if there's no justification for that should we be
2 looking at a solid amount rather than some sort of
3 graduated percentage amount, if that makes sense. Because
4 you guys have put solid amounts on both ends of the
5 spectrum. But anyway, just a thought on that.

6 MS. NEUMAN: So originally when they established
7 the 6 percent add-on there was no explicit statement of its
8 purpose. One theory is that because prices can vary around
9 the average that the percentage add-on gives room for some
10 variation. And so as we've thought about the policy, we
11 have structured this illustrative example as keeping the
12 percentage add-on in there for the lesser expensive drugs,
13 where it's not as big a dollar amount, so that that still
14 remains. But as the drug gets more and more expensive you
15 reduce that percentage portion of it, so that you are still
16 allowing a bit for you're ratcheting it down as the drugs
17 become more expensive.

18 MR. POULSEN: Gotcha. That makes sense. I just
19 wondered if there was a -- actually, I think a number of
20 us, and I certainly have, have seen the perversity of the
21 percentage as it has been, and that it's led to different
22 clinical decisions which I think were inappropriate. And I

1 think you've got that.

2 I guess what I'm wondering is as opposed to this
3 recommendation, or its actually not part of the
4 recommendation but the lead-on up to the question, why are
5 there percentages there at all as opposed to flat amounts
6 representing the costs associated with that? Thanks.

7 That may not be a clear question.

8 DR. CHERNEW: I think it was a clear question. I
9 will try and answer it. I'm not sure. I was just looking
10 at Nancy and Kim and they were looking at me, and I'm
11 looking at Larry. It's just the way that the whole guy
12 vision goes. Larry, you were going to say something, and
13 then I will say something.

14 DR. CASALINO: Yeah. This is something that I
15 never understood and I'm not sure I do now, but this might
16 help. You know, in ophthalmology, for example, the price
17 of an intravitreal injection medication, Lucentis, is like
18 \$1,700 now per dose, and for a cheaper alternative it is
19 about maybe \$50. And that's definitely affected
20 ophthalmologists' use patterns.

21 The reasons they give, at least, and I think you
22 probably know these already Greg, and they are related

1 reasons, one is that the drug is really expensive to the
2 practice, and so it has to be stored carefully and you have
3 to try to make sure to use every dose, and to do that you
4 have to hire someone to do it, and then you're still going
5 to lose some doses. So those are the costs.

6 But yeah, so you can why for a really expensive
7 drug there might be some higher add-on, but why it should
8 be \$224 or whatever is a question I will leave to others.
9 There's some validity to those arguments, in my opinion,
10 but what it translates to and what it actually is --

11 MR. POULSEN: No, I think that makes total sense,
12 and I'd assumed that there was some sort of inventory
13 holding cost, something like that, loss, things like that.
14 That all makes sense. I just wanted to make sure that we
15 have been thinking about that explicitly.

16 DR. CHERNEW: Again, I'm going to try to give a
17 clarifying answer to what was, in fact, a clarifying
18 question. A few things that it's important to acknowledge,
19 and I think Kim, and it may have been Nancy, said this
20 point. It is important to get the admin fee part right. It
21 is not clear that the costs of administering the drug
22 varies with the price of the drug, but it is important, as

1 with all fees, that we get them set correctly. So the
2 argument you need to pay us more because of the admin fee
3 isn't a very compelling argument to me. The solution is to
4 fix the admin fee. Don't pay more for the drug.

5 The issue you asked explicitly was why the
6 percentage formulation, historically, because as the
7 chapter, I think, lays out correctly, when you pay, as a
8 percentage of the price, there is a whole lot of distortion
9 area effects, and there are two. One is which drug is
10 chosen, which has been emphasized, but also, and I think
11 answered this in your other answer, what the actual pricing
12 of the drug is. Like my incentive to set the price changes
13 if the users of the drug are going to get paid a percentage
14 of that price, and that's another sort of a problem.

15 The advantage of the percentage rates, it did, I
16 think in an easy way, account for variation in the price of
17 what people actually acquire, because they're not all
18 acquiring it at the same price, and it does account, to
19 some extent, for inventory holding costs, which may be a
20 percentage actually of the price. The problem is the
21 deleterious consequences of that approach seem to outweigh
22 the benefits of that approach, and to the extent that we

1 want to solve some of those problems we might try and do it
2 in a way that doesn't create the other disadvantages, which
3 is what is basically going on here.

4 The recommendation of what we have, the policy
5 option if you will, is an explicit notion that a fixed
6 percentage across the entire range of price just seems way
7 too dysfunctional. Whether, as it moves through the
8 process, we end up with exactly these numbers or exactly
9 these cut points in particular ways, that is a somewhat
10 separate issue. I think the broader point is to move away
11 from a flat percentage add-on, certainly one of this
12 magnitude, towards a system that pays differently for drugs
13 that are very expensive and not as expensive and in the
14 middle. I think that's, again, a reasonable view. I
15 wouldn't hang my hat on should it be 3 percent plus \$24 or
16 4 percent plus \$30.

17 MR. POULSEN: No, I get that, and I appreciate
18 it. I think this discussion has clarified it for me,
19 because I think we've seen, I've certainly seen the
20 corrosive effects of what I think was the distortion you've
21 talked about, and I also think that the three approaches
22 make sense. I just wanted to make sure that we all

1 understood the reasoning behind that, and I think it's done
2 thoughtfully. So thanks.

3 MS. KELLEY: Scott.

4 DR. SARRAN: I had two questions. First, it
5 seems to me, in both the first and the second proposal,
6 there's a certain amount of almost clinical discretion
7 that's going to need to be factored into the process of
8 setting either the price, in the first proposal, and when
9 is the price greater than the expected benefit. There's
10 some inherent subjectivity in that, I think. And then the
11 second one, in terms of when you move beyond the first sort
12 of groupings that you would do to the sort of simple ones,
13 biosimilars and things like that, there is some clinical
14 discretion, I think, that comes into play in terms of
15 defining the relevant grouping.

16 And so my question is, how do you see that
17 discretion getting managed and adjudicated, and a corollary
18 of that is do we think we need to be, no pun intended, more
19 prescriptive or directive on how that should be handled?

20 And quickly, my second question is a
21 straightforward one, unlike my first one, which is, I'm
22 just curious. What percent of Part B drugs lack a relevant

1 ASP and therefore need to be adjudicated on WAC?

2 MS. RAY: Okay. Let me take your first question
3 on the clinical discretion. I think one way that the
4 Secretary could operationalize it is to use some of the
5 same tools that commercial payers and Medicare Advantage
6 plans use in developing their formularies and prior
7 authorization policies that they implement for both Part B
8 and Part D drugs. So they could rely on the same group of
9 -- the acronym is escaping me --

10 MS. BARR: P&T?

11 MS. RAY: Yes, that's right. Thank you. Thank
12 you -- those committees to help advise the Secretary in
13 identifying, for example, the reference pricing of drugs
14 with similar health effects. P&T. That's right.

15 DR. SARRAN: So those groups don't really exist
16 on the fee-for-service. It's just something to think
17 about.

18 DR. CHERNEW: Yeah. There are layers in this, so
19 the easiest one is the top bullet points, where it's like
20 biologic, biosimilar, right? As you get further down the
21 requirement of clinical expertise becomes a bigger deal. I
22 don't think we would expect, and I think the chapter

1 outlines this, to go all the way right at once. I think
2 the way you should think through this is when there's an
3 opportunity, CMS should do this, but they don't have to go
4 build everything around this area where there's going to be
5 some level of clinical nuance. But I think there are a lot
6 of places where the clinical nuance of biologics and
7 biosimilars where it's less of a concern.

8 I don't know if that's a good answer to your
9 question, but that's --

10 MS. RAY: Correct, and, in fact, in the paper we
11 do explain that in prior years the agency did apply a type
12 of referencing called the least costly alternative for
13 certain groups of drugs.

14 DR. SARRAN: I am sure we all know this, but
15 there will be a lot of noise around that, exactly how that
16 gets operationalized, if we get that far.

17 MS. NEUMAN: So the second question was about
18 drugs paid based on wholesale acquisition cost. New drugs,
19 when they are first launched, we lack ASP data for two to
20 three quarters. And for those first quarters the drugs
21 will be paid based on WAC. There can also be situations
22 where ASP data is not reported and a drug might have to be

1 paid based on WAC. That should be less common than the new
2 drug situation.

3 DR. CHERNEW: I think there is a Cheryl --

4 MS. KELLEY: There is a Cheryl question. Two,
5 actually. Her first question is, is there a reason why
6 provider acquisition costs for Part B drugs are not made
7 transparent, and is this something that could be required?

8 MS. RAY: So provider acquisition costs, I know
9 the OIG has, in the past, studied that for specific drugs,
10 but it required obtaining the cost information from actual
11 providers. They were, I believe, eye docs they did one
12 report on, and, of course, they did a report on dialysis
13 facilities -- it always come back to ESRD.

14 I mean, I think it would be helpful to have more
15 information about provider acquisition costs, but it is an
16 undertaking I think the OIG would have to consider.

17 MS. KELLEY: And the second question is, could
18 drug manufacturers game the set of indications to limit the
19 reference groups in which the drug would be grouped? How
20 much of a risk do you think this is?

21 MS. NEUMAN: So the way the chapter has discussed
22 reference pricing is for the Secretary to begin with those

1 areas that are the most straightforward to implement. And
2 so those would be products where all indications could be
3 included in the reference group. So that's where we would
4 envision the Secretary would start.

5 MS. KELLEY: Go ahead, Larry.

6 DR. CASALINO: Sorry. I just came in at the last
7 minute. I decided it was a Round 1 question.

8 I think this has been indirectly alluded to
9 already, but the question about putting the burden on the
10 Secretary to determine net clinical benefit is tricky, I
11 think. And we haven't talked about it today but you go
12 into some detail, which I think is good and well done, and
13 you do reference some organizations that make these kinds
14 of estimates.

15 But you did talk about the effectiveness
16 analysis, and although I don't think you used the word
17 QALYs, quality adjusted life years, both of which I think
18 have been historically unpopular with Congress, to say the
19 least, in certain constituencies. And then on page 4 you
20 also talk about a good faith effort toward doing the post-
21 marketing studies.

22 So I don't disagree, necessarily, with any of

1 this, but I just want to ask, I guess, as a Round 1
2 question, would you expect -- supposing that this was
3 actually done, would you expect just endless lawsuits
4 around, well, what is the net clinical benefit? Was this a
5 good-faith effort or not? No, you're not allowed to use
6 QALYs or CEA? What's your sense of that?

7 MS. RAY: Oh, that's a good question. So, yeah,
8 there are other -- so let's just take on the QALY issue
9 first, and I think there's other options besides QALYs that
10 researchers can use in conducting cost-effectiveness
11 analysis in comparing, you know, a drug to its alternative,
12 such as the equal value of life year is one way to, I
13 think, address that issue.

14 I think in -- I think in terms of the setting the
15 cap based on the net clinical benefit of the product, I
16 mean, I think that takes into account both the price of the
17 new product as well as its expected benefit over the
18 standard of care versus just some discount off of -- I
19 don't know -- either the manufacturer's ASP or the standard
20 of care, as we've laid out in the paper.

21 Do I think that requiring -- do I think that such
22 a -- do I think that that would result in lawsuits? I

1 mean, I don't know. I don't know. I think one way to get
2 - yeah, go ahead Mike.

3 DR. CHERNEW: What I took from your answer is
4 there's not a clarifying answer to -- it's a reasonable
5 question. I don't think we have a strict answer, yes, no,
6 whatever it is. I have a mild hunch -- not that I have
7 more information -- that this broad issue is going to come
8 up again when we get to Round 2 in how it goes around. I
9 will say that there's a distinction between the two
10 examples you gave. The way this is phrased now, I just
11 want to point out, the recommendation is phrased "The
12 Secretary shall have the authority to..." not "The
13 Secretary shall..." The good-faith effort part is, again,
14 a little bit of a negotiation back and forth, but I think
15 it's pretty clear the FDA says the trial should be done,
16 it's not done. The way it's set up now the Secretary has
17 to decide what that is, be some discretion, and it's really
18 about the confirmatory trials.

19 The value part, which is -- we'll call it Bullet
20 D -- is a much more complicated issue. It's unclear how
21 that's going to play out, and I'm hoping that much of the
22 discussion we're about to have is around -- I'm sure we

1 will have some of it. If not, I'll raise it. I suspect
2 others will. That will actually be a core issue for us to
3 think through how the recommendation is playing out.

4 So I'd like to save the narrow question of will
5 there be litigation to a broader discussion about how we
6 should think about that bullet.

7 DR. CASALINO: The reason I was hesitating,
8 whether this is Round 1 or Round 2, I think if I wanted to
9 say this is unworkable so think of something else, that's
10 clearly Round 2. And that's actually not an argument that
11 I want to make. So that's why I asked, you know, what did
12 you think about what's likely to result and would this be
13 too complicated, endless lawsuits. But other Commissioners
14 may have Round 2 --

15 DR. CHERNEW: So, again, I am going to allude to
16 a version of this in a moment, but now I think the Round 1
17 queue keeps...

18 MR. KAN: Sort of an adjacent question to Larry's
19 question -- and, by the way, this is great work. Thank
20 you. It's very thought-provoking and intellectually
21 stimulating.

22 Sort of an adjacent question to Larry's question

1 on comparative effectiveness. I'm curious. Is that -- I'm
2 supportive of all three recommendations, but on Policy
3 Recommendation No. 1, were there any learnings that you may
4 have gleaned from looking at how some of the European
5 countries do this?

6 MS. RAY: I think -- in our -- which year report?
7 -- we looked at the process for Germany, and in terms of
8 how they approach the pricing -- the pricing of a new drug.
9 Even in -- I think there are some lessons learned there.
10 It was in our June 2019 report.

11 DR. CHERNEW: If I can take that as a jumping-off
12 point for some of this, first, just to respond to that.
13 There's obviously a lot of information about how one might
14 assess value, in particular, whether or not a drug is
15 priced above what I think the wording -- and I should know
16 the wording better, I apologize -- the upper-bound estimate
17 of value, some version of that. But I will just emphasize
18 for those who stay at home, this recommendation is nowhere
19 close to doing what they do in many other European
20 countries in terms of drug pricing. It's limited because
21 it's through the accelerated approval process. It's about
22 a cap; it's not about setting a price. It's about doing it

1 when the price is really egregiously high. It's not about
2 sort of finding some price we think is reasonable in the
3 negotiation phase. I think it's really -- this, what I'll
4 call Bullet D, is really about where -- I don't know what
5 the right word is here, and I think we're going to have a
6 big discussion of it -- where there really is something
7 that you look at it on the outside and you're, like, this
8 is just not right. It's not sort of getting to where you
9 might ultimately want to be in a different world. It's
10 about figuring out where there's a real egregious pricing
11 problem and trying to prevent that from happening. At
12 least that's the spirit of it, which is very different than
13 what they do in a lot of the other European countries,
14 although certainly some of the analytic things that are
15 done might be reasonable. We don't envision -- I don't
16 envision that being where this is.

17 So we're about to go into Round 2, but I want to
18 emphasize two points. This is a little complicated because
19 there's three recommendations, and they all address
20 somewhat different issues, and each of them have different
21 nuances. Somewhere I think we would start in widespread
22 agreement, like how we think about the pricing of biologics

1 and biosimilars. That's not so controversial. When we get
2 to similar drugs in the same thing, that becomes a little
3 bit more of a stretch in certain ways. When we think about
4 the recommendation on the price caps, there's four bullet
5 points there, and the ones about you haven't completed your
6 trial is a very different situation than you have launched
7 -- you have set an excessively high price or some version
8 of that. So I want to just say two things and then we'll
9 go to Round 2 questions.

10 The first one is -- and it's important to say
11 this for our audience at home and for us here -- one of the
12 big challenges with drug price anything is the interaction
13 between the pricing and innovation. And as I think I have
14 said in the past, and I believe I am a believer that there
15 is a connection, whether you want there to be or not, in
16 the way in which drugs are paid for and the amount and type
17 of innovation you get. We can debate the merits of that,
18 but I think there is a discussion of that that will grow,
19 and actually you guys did a great job of that in the
20 chapter, so I want to acknowledge that.

21 In that spirit, I want to also make sure that
22 people understand that as a general point I think the

1 Commission -- and I'll let Nancy and Kim respond, but I
2 think it's true in the material -- is very -- I will
3 emphasize that -- very supportive of the accelerated
4 approval pathway, that it is a really -- we often talk
5 about Adulhelm, but understand it's also COVID vaccines,
6 right? So there are a lot of new cancer medications there,
7 things that we really do want patients to have access to
8 and we really should be appreciative, I think, of the great
9 strides that have been made in collective innovation. And
10 I want to make sure that it's clear that we are very aware
11 of both the value of that innovation and the connection of
12 that innovation to the various rewards.

13 That being said -- so I don't want anything in
14 the tone of this discussion and what you hear to make
15 people think that we are trying to shut down the
16 accelerated approval pathway or discourage innovation in a
17 significant way. I do think there are aspects of it that
18 are problematic in how prices are set, particularly like
19 the timely completion of trials that I think deserves some
20 attention. That's in some ways a different body of thought
21 than, say, high prices at launch, and we'll have a
22 discussion there. So that's just one -- I wanted to

1 emphasize our support for the accelerated approval pathway
2 and innovation more broadly.

3 The second thing I want to say, which is on a
4 different part of this, and at risk of triggering Larry,
5 although better sooner than later, is there's a concern --
6 and I think it's a legitimate concern -- that if we change
7 some of these things related to ASP+ or whatever it is
8 that's going on, that we will induce consolidation of
9 certain specialties into big systems, and when you do that,
10 there's a whole series of other problems that arise. You
11 have site-neutral issues we'll discuss later and a whole
12 bunch of other things.

13 And so I will say that that is an issue that I'm
14 quite aware of, actually quite sympathetic to, broadly
15 speaking. My general view is you shouldn't pay a
16 percentage of drugs and cause -- I don't know what words
17 you used, Greg -- cause all the other problems associated
18 with this method of payment because you're worried about
19 consolidation. I think there's other things, too, to deal
20 with in consolidation. Site-neutral, by the way, would be
21 one. But there's a bunch of other aspects of things that
22 we have to worry about in terms of payment.

1 I think the point of that is it is important to
2 make sure that independent specialist practitioners can
3 survive in a reasonable way with whatever new pricing
4 models comes in place. I generally think that should be
5 done through things like the administration fee and other
6 processes, because if you do it as a percentage of the drug
7 price, you create a whole other set of pathologies. But I
8 want to make sure, because it hasn't come up a lot, that
9 this issue about consolidation or not and the impact on
10 consolidation is one that has been front and center in a
11 lot of the general thinking about how we do these, and I
12 think it motivates why the presentation emphasized the
13 importance of the admin fee and related things.

14 So, Larry, if you're triggered, get in the Round
15 2 queue. You're already there, actually.

16 [Laughter.]

17 DR. CHERNEW: Or you soon will be. But I did
18 want to emphasize those points, and now we're going to go
19 through, and I know...

20 MS. KELLEY: Mike, I think Stacie --

21 DR. CHERNEW: Yeah, Stacie -- well, Stacie is
22 first, and she has been so, so, so patient. But, anyway,

1 thank you. Go ahead.

2 DR. DUSETZINA: Okay. Thank you so much for this
3 great work. I really love this chapter, and I'm really
4 proud to be able to be a Commissioner while you all are
5 working through this important chapter and topic. So I'm
6 going to start with the easiest ones and then work my way
7 to harder ones.

8 So Policy 2, the single payment ASP blended, love
9 it, love everything about it. So fully supportive of that
10 as is.

11 For Policy 3, modifying the add-on payment,
12 absolutely supportive. There are a couple of just minor
13 notes of things. I've had different conversations with
14 people who would be differently affected by the policy
15 changes over the last month or so, and I think that it
16 could be beneficial to be clear about the 6 percent versus
17 4.3 percent issue in the chapter, or clearer, because I
18 think to Lynn's comment, I guess when I read it, I thought
19 we wouldn't go less than 3. But if we're saying we'll
20 reduce it and then there's sequester on top of that, I
21 think we just want to be clear if that's what we mean.

22 I guess I was thinking it would be, like, 3 after

1 having accounted for moving from 4.3 down to 3, instead of
2 going from 6 to 3. So I just think that we want to be
3 really clear about that.

4 I think the other would be how we got to that
5 \$220, and from re-reading it, it seems like it's the 75th
6 percentile or something, and then -- but making sure that
7 that's really as clear as possible in the chapter so that,
8 you know, people who are affected by this payment change
9 really understand the logic of how we got there.

10 And then I think to Mike's last point there
11 about, you know, how we're paying for things, there's so
12 many different work streams that we have going on that I
13 think touch on how we might pay other sites of care better,
14 so that the ones that are like stand-alone infusion or
15 physicians' offices, they have payment challenges, and
16 they're using drugs to subsidize more of their services
17 than other sites of care. And so it might just be worth
18 pointing to some of these other work streams about how to
19 pay better in different sites of care. I think we kind of
20 get there with the recommendation that points to like
21 monitoring, are we paying enough for administration and
22 things like that. But it's probably that it's gotten us

1 most of the way there, but just having heard from
2 stakeholders in this space, I think it is a legitimate
3 thing that they point out. They're fairly efficient sites
4 of care delivery, and we don't want to actually penalize
5 really efficient and convenient sites of care. But we
6 don't have to subsidize them through the drug payment, so I
7 think it's very much our principles, pay for the things
8 that we want to be paying for, or pay them better in
9 different ways.

10 Okay. Now for the accelerated approval. So I
11 think going back also to -- okay. First, totally
12 supportive and I'm very glad we're doing this. The three
13 first pieces of this are easier than the fourth one. So
14 when we talk about having a cap or a rebate whenever the
15 confirmatory trials are delayed, when they fail their
16 confirmatory studies, or when there's coverage with
17 evidence development, to me those are absolutely clear-cut,
18 slam-dunk yes, like no question. And part of me wishes we
19 could just say "The Secretary shall do this..." I would
20 love to be able to be that strong on that language.

21 However, Bullet 4, the piece that's the price
22 that is excessive relative to the upper bound of the

1 estimates of value, I don't know that we're there yet to be
2 able to say concretely enough that the Secretary shall do
3 that. So in some ways, it almost feels like we have to --
4 we have language that isn't as strong as I would like on
5 the first three bullets, because the fourth bullet is just
6 a little bit trickier.

7 For the fourth recommendation, I think he
8 challenge I have, you know, I kept trying to figure out
9 like how could you set parameters that were really clear
10 for when it met these goals, and I think you all have done
11 a great job of trying to outline some of the things from
12 our discussion last time. But it still feels a little bit
13 squishy to me, and it's just -- it's really hard to define.
14 I've been trying very hard personally to think about how to
15 set a parameter that could say here would be the rules when
16 this would happen. But it trips me up a little bit because
17 I guess in my mind, I would hope that if we really were
18 concerned about the safety and effectiveness of the drug
19 and Medicare beneficiaries, there would be CED, and then it
20 would be covered in one of the prior bullets.

21 So I guess what I would say is I am still very
22 supportive of this, this fourth item. I just struggle with

1 whether it's as concrete as it needs to be in order to,
2 like, be as directive, I guess, with the -- if we were able
3 to say more solidly these first three, absolutely this
4 should just be not just have the authority, but you should
5 do it.

6 The fourth one I think we're close, we're getting
7 there, but I still struggle with it a little bit.

8 DR. CASALINO: Would you make a recommendation
9 for the fourth one yourself, Stacie?

10 DR. DUSETZINA: I think that -- I would still be
11 comfortable with the Secretary having the authority to do
12 it. I just -- it seems the other three are so clear-cut to
13 me that being able to say this should just definitely be
14 done -- go ahead.

15 DR. CHERNEW: I'll try and be more explicit,
16 which is good that Stacie was the first one to speak
17 because this can then hopefully shape some of the
18 discussion, at least on this point. So if you change the
19 recommendation so the wording was "The Secretary shall"
20 instead of "The Secretary has the authority to," that would
21 be something that would be, I think -- now, I'm trying to
22 speak for you, Stacie, so check me if I get this wrong.

1 That would be okay on the first three bullets,
2 not for the fourth. The fourth bullet there are basically
3 two possibilities. Possibility 1 is you just keep it
4 separately where the Secretary has the authority to, and
5 you carve it out, which is complex -- again, I'm parsing
6 Stacie's language -- because there are a whole bunch of
7 unknown things there. We can try and be more concrete.
8 And you worry about a bunch of the innovation in our
9 actions because you don't know when you're developing a
10 drug where it's going to end up in the whole grand scheme
11 of things.

12 So an alternative would be to have the chapter
13 discuss this potential problem and what's going on but not
14 have it in a recommendation. That has the disadvantage of,
15 if the Secretary is going to be the authority, you say, "We
16 worry a lot about this but now it happens. What are you
17 going to do?" And that's sort of where the problem is.

18 And so the thing that I grapple with that's
19 problematic is if you trust the Secretary is going to be
20 reasonable on how they apply all of this, then you don't
21 worry about it quite so much, and you think if you have a
22 good drug, or a reasonably good drug, you will end up being

1 safe. If you are worried, though, who knows who the
2 Secretary is going to be or how it's going to be applied,
3 given it's vague, it could have really deleterious,
4 potentially deleterious consequences or -- and I don't
5 think Stacie said this, but in a separate thought I'll say
6 it now -- you worry that, for example, a drug that is
7 reasonably good, the company decided not to go through
8 accelerated approval. They decide to just go through
9 regular approval, denying people the access to it for two
10 years but avoiding any price cap risk.

11 I don't know, Stacie, if you want to comment that
12 that is a risk, but I think that is the tension -- again,
13 Stacie, I am going to turn it back to you -- the tension is
14 how to balance the wording or the inclusion of the last
15 bullet when there's a very legit case -- and again, I'm
16 going to let Nancy and Kim comment -- that for drugs that
17 really have pretty, pretty weak evidence that they provide
18 any real, meaningful -- they might be better but really
19 marginal, at best, with an exorbitant price, and you want
20 some mechanism to prevent that from happening. That's the
21 concern.

22 On the other hand, you really, really, really

1 don't want to deny people access to drugs that really could
2 be improving because of the process of innovation and then
3 the pathways of approval that go on. That is the balance.

4 DR. MATHEWS: I'm going to jump in here. First
5 and foremost, from a very mechanical perspective, depending
6 on how the rest of this conversation goes, parsing out
7 those first four bullets is something we can easily
8 contemplate, and if the first three are covered by
9 something more prescriptive, if that's where the Commission
10 ends up, and given, I think, the technical term was
11 "squishiness" of the fourth one, that might require some
12 different wording and could even compose a standalone
13 recommendation in and of itself.

14 I do understand the squishiness here. There is a
15 lot of ambiguity in the phrase "as written," and it
16 involves a lot of value-laden words -- you know, egregious,
17 price relative to the standard of care, what does egregious
18 mean, how do you measure the standard of care. I get all
19 that. I think we have 17 people around this table who
20 could help clarify and put some more specific parameters
21 around this.

22 But I still think there is some value in pursuing

1 this. One, it is the only one of these elements that would
2 allow the Secretary to deal with a situation like Aduhelm.
3 And the second is one of the reasons that prior attempts to
4 do this kind of things have foundered -- and Nancy, here
5 I'm thinking of least costly alternative back in, what,
6 2010, thereabouts -- it was challenged in court on the
7 basis of an improper application of the Medicare reasonable
8 and necessary standard. And I can't remember what happened
9 to functional equivalence along that same period of time.

10 But what something like this would do would be to
11 explicitly clarify in law that the Secretary does, indeed,
12 have the authority to do something like this. Again, a
13 totally different layer of how do you do it, what is the
14 evidence, do you do it for notice and comment, what are the
15 technical advisory panels. All of that still pertains, but
16 at least giving the Secretary the explicit authority would
17 be an improvement over where things stand now.

18 DR. DUSETZINA: I think it sounds excellent that
19 you can parse those bullets out with a slightly different
20 language in those recommendations. That would make me
21 extremely happy.

22 You know, I actually think that the language that

1 is used in the chapter is very good. I mean, I realize it
2 is very difficult to say what this is, but I do think there
3 is more kind of -- you know, would this mean that we would
4 have to do cost effectiveness or whatever we decide, on
5 every single product to be able to identify which ones meet
6 that threshold? Because I think we kind of feel like we
7 have a gut reaction of something that's coming through that
8 meets the threshold, but it's like that seems like, to
9 Larry's points about lawsuits, one that would get the
10 Secretary into a lot of trouble.

11 But I really like the idea of parsing them out so
12 that the first set are stronger and the other one is still,
13 we think this is important because we actually do think
14 that this is important to have tools to be able to
15 intervene if necessary.

16 I think the other kind of broader point is that
17 it is really easy to get hung up on the Aduhelm example,
18 but, you know, and Mike points this out more often than I
19 do, but a lot of these drugs are really good drugs and it
20 just takes a long time to get to the clinical benefit
21 piece. And so we want to keep that balance and keep those
22 incentives there, and recognize that we don't want to harm

1 drug development that actually is good, but we also know
2 that there's a lot of taking advantage of this time on the
3 market when you can set a high price. And maybe you're
4 more inclined to do that if you don't think your drug is
5 that effective, or might not make it through the clinical
6 benefit kind of level.

7 So I really appreciate the idea of breaking those
8 apart, a strong recommendation on the first three but still
9 should have the authority to do the fourth one.

10 Thank you both so much for this excellent work.
11 It really is fantastic.

12 MS. KELLEY: I have Lynn next.

13 MS. BARR: Thank you. I'm very enthusiastic for
14 this work and I think you did a great job. I am fully
15 supportive of Policy 1 and Policy 2. I am supportive of
16 Policy 3 and eliminating the WAC add-on. That just seems
17 to be obvious.

18 I am struggling a little bit with the idea that
19 this 6 percent is to pay for inventory costs. That's what
20 it is. I mean, you asked, Greg, so let's just say this is
21 the cost of managing an inventory, right? You get a
22 separate administration fee. Right?

1 MS. RAY: You get a separate administration fee
2 but some have also interpreted the plus-6 as to account for
3 price variation among individual providers.

4 MS. BARR: But that's inventory costs, right? So
5 when I say inventory costs, it cost me more than the
6 average sales price. It cost me less than the average
7 sales price. So I've got cost of acquisition. I've also
8 got waste, right? I've got a drug that I don't use. So
9 these are typically multiuse vials, right. So I buy the
10 drug, I dispense it, and that 6 percent is to keep me whole
11 in all of that, right?

12 MS. NEUMAN: From the waste point, we pay for the
13 full single-use vial, whether it's used or not, Medicare
14 does. For the multiuse vials they would pay only for
15 what's used. So it depends on which products. Some in
16 just single dose, some do come in both, and a few come in
17 multi only.

18 MS. BARR: Got it. So for multiuse there is a
19 risk.

20 I mean, where I'm getting on this is the question
21 of volume. Is there high-volume providers where their
22 inventory -- so if I'm a big company, my inventory costs

1 are a lot less than if I'm a small company, because I don't
2 have that kind of turnover. And I wonder if we need to be
3 thinking about the add-on payment differently. And I've
4 heard other comments from the Commissioners about physician
5 offices.

6 And so I'm just worried about physician offices,
7 low-volume rural providers, that aren't going to be able to
8 buy these drugs and provide access to them if there's too
9 much of a financial loss. And so I'm wondering, should we
10 be looking at this a little bit -- so there could be a
11 mechanism where you'd say, "Okay, you know what? If you
12 order this much of the drug you get the 6 percent, but if
13 you order this much of the drug, you're in the 3 percent,"
14 or whatever that number is. I think we might want to think
15 about it differently because I imagine their costs are
16 different. Do you disagree?

17 DR. CHERNEW: Well, we will have a discussion
18 about that point, more discussion, but I will say -- and
19 you answered this in response to a few of these questions -
20 - the actual price you're being charged is a little bit
21 dependent on the way that they get paid. So the drug
22 companies have an incentive to make sure that people get to

1 buy the drug. And so if you don't pay as a percentage of
2 fees, they have an incentive to give you a price that will
3 enable you to still use the drug. So the price that you
4 see now isn't necessarily the price you would see if the
5 payment mechanism was different.

6 MS. BARR: Right. They don't go to single-dose
7 vials because nobody is able to buy it?

8 DR. CHERNEW: My view is -- and we can have a
9 broader discussion. I'm not an expert and I would defer to
10 others who are -- is I would expect that they would find a
11 way to make sure that their customers get access to the
12 drug and that a lot of this would be taken out, and where
13 the pricing ends up and other sort of financing ways of
14 dealing with this problem.

15 MS. BARR: Well, but as a business, I'm going to
16 pay attention to the 80 percent of business, and I'm going
17 to price for the 80 percent. I'm not going to price for
18 the 20 percent that are small.

19 DR. CHERNEW: No, but the price --

20 MS. BARR: Okay, discriminate.

21 DR. CHERNEW: Yeah. In other words, they're not
22 charging everybody the same price anyway.

1 MS. BARR: Right. But as a small provider I
2 don't have the negotiating power. I just wondering, I
3 would suspect the 6 percent came from somewhere, and it was
4 probably based on physician offices. And now we've got
5 hospitals. No, you don't think so, Jim? Who knows. All
6 right. I'm just worried about low-volume providers and how
7 this would affect them.

8 MS. RAY: Yeah, and I just want to point out, for
9 the lower-volume rural providers, I mean one thing to keep
10 in mind in this policy is that for the lowest cost drugs
11 their payment remains the same. It is still 106 percent of
12 its ASP. So if you think that the low-volume rural
13 providers are more likely to be furnishing the less costly,
14 non-cancer drugs, then their payment rate under this policy
15 is not affected.

16 MS. BARR: Yeah. I think it's mostly around the
17 biosimilars. But again, if we do reference pricing it's
18 going to take care of a lot of problems. So obviously,
19 like reference pricing would sort of solve a lot of the
20 issues that we worry about, like people using things
21 differently.

22 I also want to comment on Stacie's point that I

1 think for a long time I thought we were talking about 6
2 percent versus 3 versus 4.3 versus 1, and I'm just not sure
3 it's enough. And I'm particularly concerned about low-
4 volume providers.

5 Other than that -- and eliminating the WAC add-on
6 seems like a no-brainer, 1 and 2 seem like a no-brainer as
7 well. Thank you.

8 MS. KELLEY: Amol.

9 DR. NAVATHE: Thanks. I also want to voice that
10 this is fantastic work and I really appreciate you taking
11 this on and driving it forward. I will also try to
12 organize my comments around the recommendations, although I
13 might go into reverse prioritization of what Stacie did,
14 because [inaudible] to an extent.

15 Maybe I can start with Recommendation 1. I think
16 Larry's points actually really resonate with me in a very
17 broad sense, which is that we are in a very tricky
18 situation around these drugs, in general, because the whole
19 idea behind an accelerated approval pathway is that we want
20 to get drugs to patients faster, drugs that have promise,
21 drugs that explicit, not even implicitly, explicit we know
22 are being approved on surrogate endpoints and therefore we

1 have less clinical data on their effectiveness.

2 And so defining something like what is the
3 clinical benefit ends up with a presumably large confidence
4 interval, and we don't know where we're going to land in
5 that confidence interval either. And so defining value,
6 defining clinical benefit, all these elements is really
7 challenging.

8 The second contextual point is at the same time I
9 strongly believe aspects of what Mike said and Stacie said,
10 which is we do want innovation to continue, and at least
11 conceptually or theoretically, based on how these sort of
12 pricing cap type policies end up getting implemented, I
13 think the economics literature would say that there's
14 certainly a way that they could have a chilling effect on
15 innovation, and that affects generations of people down the
16 road. So I think we have to be very careful and
17 thoughtful.

18 The third contextual point, I think, is that many
19 of these elements, we have the word "value," I think, in
20 Part D right now -- sorry, Bullet D I think is what Mike
21 termed it -- in Bullet D, and there's a lot of value
22 ladenness to the question of what a cap should be.

1 And I think one of the amazing things about our
2 U.S. society, but one of the things that makes it really
3 hard to agree upon anything in American society is that we
4 have a lot of different values and the heterogeneity of
5 opinion and preferences around how much we would pay or not
6 pay for things, which is different than I think many other
7 countries that sometimes we look to, for example, just to
8 pick some Scandinavian countries which are a lot more
9 homogenous and have much smaller populations.

10 So I think that context is really important, I
11 think, for us to approach this work because we have to be
12 careful. We have to be careful that we are not just using,
13 quote/unquote, Commission values to then make
14 recommendations. We should make recommendations that I
15 think our flexible enough, to some extent, to be able to be
16 implemented in ways that reflect broad heterogeneity of
17 values that exist in our society.

18 So those are my broad contextual points, but I
19 think are relevant and inform the next set of comments that
20 I am going to make.

21 For Recommendation 1, I think it might be useful
22 to think about this in the context of what we think we want

1 to happen generally versus what is going to happen on an
2 exception basis. In other words, let's view the world for
3 a second, Recommendation 1, through the world of
4 exceptions. And I think if we look at A, B, and C, those
5 seem like relatively clear situations where they are,
6 either through volitional intent or not, something that is
7 agreed upon such as a confirmatory trial isn't happening in
8 the time that it should happen, or doesn't happen. It's
9 very clear there's something agreed upon, something that's
10 not executed.

11 So I think to some extent there we would say to
12 the extent that we don't want a price cap to occur in that
13 setting it should be on an exceptional basis. We would
14 generally want it to happen, and there might be some cases
15 where there's something completely unforeseen -- COVID
16 pandemic, something else happens that really disrupts the
17 way that a confirmatory trial could occur, and so we would
18 want the Secretary not only to have the authority and
19 perhaps be driven through language like "shall" to
20 institute a price cap, but we may also want them to have
21 the authority to call an exception and say, "You know what?
22 This doesn't really make sense in this case, on an

1 exceptional basis." And personally I think that applies
2 nicely to A, B, and C, this nothing that it should happen
3 usually and we may only not want it to happen in an
4 exceptional basis.

5 To the extent that we all agree upon this idea of
6 having price caps for this notion of excessive pricing
7 relative to value, which is, I think, the way that it is
8 currently worded, I think there we probably should think
9 about this on an exception basis of, well, for the most
10 part it should be okay, but we want the Secretary to have
11 the authority to do this, in the exceptional circumstance
12 where we truly have this excessive situation.

13 And I think that does lead us to Jim's point, to
14 very explicitly different language that we want tied to
15 Bullet D -- I'm trying not to call it Part D -- to Bullet D
16 than to A through C.

17 And so I'm also fully supportive of this idea of
18 we sort of separate out how we think about this language,
19 because the way that we want these, I think, based on the
20 Commission dialogue and chapter and the data that we have,
21 that the way want this to work is conceptually very
22 different for A through C than it is for D. And I think

1 that would strengthen A through C, which is basically
2 saying that by default we are going to get a price cap, but
3 on an exception basis we won't, and on D we are, by
4 default, essentially we wouldn't get a price cap on an
5 exception basis, we would.

6 And I think it does have some risk, Larry, that
7 you're pointing out, around litigation, but I think another
8 part that's broadly important is I think if we do look
9 across the pond, if you will, at other developed countries,
10 I think oftentimes the way the aspects of those drug
11 pricing systems work, to some extent, are on, quote,
12 "threat of some government intervention."

13 And so I think to the extent that we can bring a
14 little bit of rationality to how manufacturers would be
15 thinking about this, using this notion of granting the
16 Secretary authority to intervene on price caps if it is
17 required, I think we might be able to accomplish what we
18 need to accomplish without getting this chilling effect on
19 innovation and without creating some sort of undue
20 litigation or other things that we would otherwise want.

21 So those are my thoughts on Recommendation 1.

22 Actually, I'm just going to go through and say

1 Recommendation 2 I have no further comments and I am fully
2 supportive of.

3 Recommendation 3, so in general I am very, very
4 supportive. I think the work is really strong. I think
5 that I fully ascribe to this point that manufacturers will
6 respond their pricing based on the pricing system that we
7 have in place, and I think they have a clear incentive, in
8 a good way, to get patients to use their drugs, and so they
9 will help us, effectively "us" being the broader we of
10 society, solve this issue of how to get smaller clinics or
11 others access to the drug.

12 My thought here, actually -- and this is a little
13 bit of a late-breaking one -- is in the context of the way
14 that Recommendation 3 is worded, it is very broad in the
15 sense that we are saying reduce the ASP add-on. And I
16 wonder if that's insufficient, if that doesn't quite get us
17 there. Because that means reducing the ASP add-on could
18 just mean moving ASP+6 percent to ASP+5 percent or 3
19 percent, or something else like that. And based on the
20 presentation today and some of the dialogue, at least, it
21 seems that what we want to do, in fact, is we are perhaps
22 less worried about whether it's \$220 or \$250 or 3 percent

1 or 4 percent. What we are more interested in is mitigating
2 this ASP+6 percent way of pricing, that is inducing this
3 distortion.

4 And I think that's not currently captured in the
5 language of Policy 3 recommendation, and I would be curious
6 to hear other Commissioner thoughts on whether we should be
7 articulating that in the language of Policy 3 to get at
8 this point that we want to move away from a system that is
9 predominately, particularly for the non-low-cost drugs, one
10 that is a share, a percentage of the price but rather one
11 that ends up having some kind of flat, fixed fee at the
12 higher end, whether it's 75 percent higher or something
13 else.

14 So that's one thing I just wanted to add, and I
15 thought it would be useful to get Commissioner feedback on
16 that point, because right now we have a very high level but
17 vague recommendation that perhaps doesn't get us to where
18 we exactly want to go, based on the presentation.

19 Thank you.

20

21 MS. KELLEY: Robert? Oh, I'm sorry. Greg is
22 next and then Robert.

1 MR. POULSEN: Well, I was going to start where
2 Amol ended, so thank you. I'm very supportive of the
3 recommendations overall, and I think that's great. I had
4 really one tweak and one ongoing concern, and my tweak,
5 which may be a little bit more, is just where Amol came
6 from. I think that, you know, after our discussion, if we
7 were to head down the path of something that -- and I
8 assume there isn't a holding expense. I assume there is an
9 expense associated with inventory, and it's going to be
10 more for a \$10,000 item than for a \$10 item, and I get
11 that. And with that in mind, I would be inclined to do
12 something that looks like the middle of your three
13 suggestions, which would be a percent plus a dollar amount,
14 and the percent would be small. I don't know what it
15 should be, but let's for the sake of argument make it 2
16 percent plus an X dollar amount associated with what we
17 think is appropriate from that perspective, and that it
18 would look like -- the total would look not radically
19 dissimilar than what we have here, so we wouldn't spend
20 more or less money than what's here, but that we would tie
21 it to something that reflects that there is an expense
22 associated with very expensive drugs, but that we don't

1 want it to be any more than, Amol's point, the amount that
2 is an actual expense, because I have experienced the
3 perversion that it creates among clinicians, and I think
4 we'd love to get rid of that. I think that is something
5 that is worth getting rid of in the system today.

6 So if we decide not to go down that path and
7 stick with the language and the examples that we have, I
8 would still say that's a big step in the right direction
9 and I like it. I think we could take it one more degree
10 along that path and it would be beneficial.

11 The other thing I guess I would throw in -- and I
12 don't want to just be the person with the wet blanket here,
13 but I like this. I think all of this is good. I'm
14 absolutely positive I think it's one step that we need to
15 take before we take more steps, because the fact of the
16 matter is, given the capabilities that we have with
17 pharmaceuticals, I can easily imagine a situation where 50
18 percent of Medicare beneficiaries, including me, will in
19 any given year be using one of these very, very capable and
20 expensive drugs. Let's assume they are very capable. They
21 do great things. We love the idea of having them. But
22 they are very expensive, and they're likely to continue to

1 be, even with these recommendations.

2 And I think that there -- I don't think that the
3 recommendations here will materially change our United
4 States position relative to other countries. I think we're
5 still likely to be dramatically more expensive.

6 And I think there was a case to be made for that
7 back in the -- maybe back as far as 1975, you know, when
8 the United States stood out distinctively economically in
9 the world. That's no longer true. There are many, many
10 countries on a per capita basis that do just as well or
11 better than the U.S., and I don't think it makes sense for
12 us to be spending X times what other countries do. And I
13 think this is an appropriate and progressive step to help
14 us along that pathway, but I don't think it changes our
15 position. It doesn't fix the problem. I think that we're
16 going to have to pick up the very, very unpleasant and
17 unpopular idea of looking to international comparisons at
18 some point in the future, and there's no reason we should
19 be paying X dollars more for a new drug than is paid in
20 Sweden, Switzerland, Great Britain, France, Japan.

21 Thanks.

22 MS. KELLEY: Robert?

1 DR. CHERRY: Thank you and, you know, hats off to
2 the staff for this exercise in threading the needle.
3 Really difficult to do, and I think really a heavy lift, so
4 thanks for all of that.

5 I think like many of the other Commissioners, I
6 was also tripping up with Policy 1, Bullet 4, regarding how
7 the Secretary is to determine the upper-bound estimates of
8 value. And there are examples, you know, within the body
9 of the pre-read materials about how that might be done.

10 I think at the end of the day, though, it's going
11 to require the development of a detailed objective tool to
12 really determine what value is. That's not currently
13 outlined in the proposal, and that may, in fact, be okay.
14 It might be in some aspects out of scope, you know, for
15 this particular proposal.

16 With that being said, on my part, anyway, there's
17 a healthy dose of skepticism whether that can be applied
18 universally to drugs that are brought forward through an
19 accelerated drug approval process, mainly because we're in
20 a market-based price system, and so that makes it really
21 challenging.

22 If I were to put some nuanced language around

1 this, around Bullet Point 4, I probably would say, you
2 know, if feasible or whenever feasible, because that would
3 give the Secretary some more latitude regarding that bullet
4 point. I think in the body of the report, I might add, you
5 know, that the Secretary shall have the authority to
6 develop such a tool to determine the upper estimates of
7 value when applicable, because I don't think that whatever
8 tool is going to be developed is necessarily going to be
9 universally applied to every drug that's brought forward to
10 them. So there could be a couple of nuances that could be
11 introduced that might make, you know, some or many of the
12 Commissioners comfortable.

13 The other thing regarding Policy 2 -- and I know
14 Stacie was very comfortable with it -- it actually seemed
15 also, you know, challenging in some aspects. I'm in favor
16 of it. Don't get me wrong. But if you think about just
17 like one class of drugs, low molecular weight heparin,
18 which these drugs work with a very similar mechanism of
19 action, they each have different efficacies. And so
20 because of that, you know, one may be applied for treatment
21 and prophylaxis for DVT, or deep venous thrombosis; another
22 might be applied for unstable angina; another one might be

1 applied for heart attacks or myocardial infarctions that
2 are non-Q wave, another one for ST wave elevation for
3 myocardial infarction.

4 So because of all those differences, even with
5 similar mechanisms of action, I could see there being a lot
6 of wrangling going on in terms of the reference pricing
7 even within similar classes of drugs. So it doesn't mean
8 that it shouldn't be done. I only mention it because of
9 the level of difficulty regarding this particular proposal
10 and series of policies.

11 Nevertheless, I'm supportive of it, though.

12 Thank you.

13 MS. KELLEY: Stacie, did you have something on
14 one of Robert's points?

15 DR. DUSETZINA: Yeah, I think this is maybe going
16 to that kind of value assessment or the way we -- like, one
17 piece maybe to think about for framing here, it goes also
18 to Larry's comment about lawsuits, is we could add
19 something in the chapter to maybe point to the Inflation
20 Reduction Act and the methods that, you know, they're
21 working to define what is a fair price for a drug. They
22 mentioned cost-effectiveness. They mentioned not using

1 QALYs. But they have a lot of detail in there about
2 information they could collect from manufacturers for
3 deciding what is a fair way to pay, and maybe that does
4 sort of de-risk the -- like, we won't know as much about
5 these drugs at that time, but we could kind of reference
6 that there are methods that are being developed and defined
7 right now by CMS for the purposes of drug price negotiation
8 or setting a new fair price. I think we should reference
9 that and say that would be one way or a key way to maybe
10 think about doing that and kind of avoids the guardrail
11 issues that were just mentioned, I think.

12 DR. CHERNEW: One of the few things I'll just
13 point out is the difference from the Inflation Reduction
14 Act is there's drugs that you believe -- that you now have
15 a pretty good sense of pretty high value. Then there's
16 drugs that you're really pretty sure they're priced above
17 what you think would be reasonable by most analyses. There
18 is a very wide gray area. Bullet Point 4 in this
19 recommendation is really designed basically to give the
20 gray area more to the firm as opposed to not, because of
21 the innovation incentive. When you're out in the Inflation
22 Reduction Act world, you've been out for a longer period of

1 time, and they're trying to do a different activity. You
2 could still use the same -- I do think there's something to
3 learn about what they're doing --

4 DR. DUSETZINA: Well, you --

5 DR. CHERNEW: -- but our whole point is the
6 threshold and the way we envision the threshold being is
7 very different because of the --

8 DR. DUSETZINA: But I think even just as a
9 framework, I mean, they include a substantial amount of
10 information that's collected from the companies, and you
11 could weight that in different ways because it's newer
12 versus older and things like that. But I think it would be
13 a shame not to at least point out that that's the type of
14 language they're using in their recommendations. And I
15 think also to the point about the Recommendation 2 and the
16 other classes and drugs, I completely agree, and I wonder
17 if maybe mentioning something more about the formularies
18 and P&T committees and a little bit more explicitly that
19 that would be more complicated as you get a little bit
20 farther away from the biosimilar or the alternative pathway
21 that they're sort of like the easy ones that we would start
22 with. But I think that it would be important to say this

1 would have to be done with intentionality around putting
2 those same products that have different -- potentially
3 somewhat different uses. I think that could be done
4 through just being more explicit about the need for
5 clinical input.

6 MS. KELLEY: David.

7 DR. GRABOWSKI: Great. Thanks. First, great
8 work, Kim and Nancy. Overall very positive about where
9 we're going with this body of work.

10 I'm going to focus, similar to other
11 Commissioners, on Policy 1, and I'm really glad I'm
12 following other Commissioners here because it has really
13 helped sort of shape my thinking.

14 The four bullets, similar to Stacie and Amol, I'm
15 -- I believe we should strengthen those first three
16 bullets. I think Amol said that really well. The first
17 three are very discrete or kind of black-and-white. You
18 know, they did not complete post-marketing confirmatory
19 trials, did not have a clinical benefit, are covered under
20 a coverage with evidence development policy. I can really
21 see kind of how those would play out.

22 I am, similar to Stacie and Amol, very worried,

1 though, about Bullet D. It just seems quite sort of gray,
2 I think was -- or "squishy" was Jim's word and "gray" was
3 Mike's. But, you know, this issue of what is value, Jim, I
4 was going to tease you. When you said the 17 Commissioners
5 could help, I was going to joke back, and say you're going
6 to get 17 different opinions and hear about what is value,
7 and then to Amol's point, if we take that out, I don't know
8 if our collective kind of views are going to match everyone
9 else's.

10 But I'm also worried beyond just the squishiness,
11 this issue of kind of the potential drag on innovation, I
12 think Larry's point about the risk of litigation really
13 kind of makes me pause there and think we should sort of
14 strengthen language on the first three bullets under Policy
15 1, but maybe kind of take -- talk about Bullet 4 in the
16 text, but I wouldn't favor kind of the current language
17 there.

18 Thanks.

19 MS. KELLEY: Scott.

20 DR. SARRAN: Yes, as I read through the materials
21 and then listened to the presentation and particularly
22 listened to comments, there were three pieces of context

1 that went through my head that lead me to a suggestion.

2 The first is I think we have to recognize we have
3 in the U.S. neither a cultural nor an operational framework
4 for dealing with value or cost-effectiveness. It just
5 doesn't exist. So that's a reality, whether we like it or
6 not.

7 And the second is with respect to potential
8 negative impact on innovation and funding of innovative
9 therapies, I think it's useful to recall that it's not just
10 the absolute amount of dollars that might be impacted in
11 terms of downstream ability to recap investments via high
12 sales prices, but it's the uncertainty of those dollars --
13 right? -- because if you -- in classic business truism is
14 you can bake in almost anything if you know what it is.
15 You can work your way around that. Uncertainty can have a
16 chilling effect.

17 And then the third is just this whole concept of
18 let's not let perfection be the enemy of good. So pulling
19 all those together, my suggestion on Policy 1, which is
20 largely consistent with what we just heard, is let's
21 strongly double down on the first three scenarios. They
22 get us, I think, a lot of value for beneficiaries and for

1 CMS, and they're straightforward, they're hard to argue
2 with in the public domain, you know, huge amount of value
3 creation.

4 And then maybe for the fourth, which I think does
5 have the potential to be, you know, chilling and
6 adversarial and all of that, maybe we -- and, again, since
7 we don't have a framework for dealing with the fourth
8 bullet point in the U.S., and the fourth part of Policy 1
9 really sort of jumps past our not having a framework, maybe
10 the language could be, should be something to the effect of
11 "The Secretary shall develop a framework for evaluation of
12 potentially inappropriate, out of boundary" blah, blah,
13 blah, you know, value. Because if we get to there, then
14 operationalizing that is a lot easier. But we're trying to
15 kind of jump past there. So maybe there's a way to do
16 that.

17 And then just a very minor point on Policy 2,
18 which I think is just so darn good, and it a little bit,
19 Robert, builds off you, I think there's a little lack of
20 clarity about how we'll define the relevant drugs for
21 comparison, and I might suggest we incorporate into the
22 phrasing "similar mechanisms of action." And, Robert, you

1 point out even when you have similar mechanisms of action,
2 you can still have some significant nuances. But I think
3 at least including that as well as drug classification --
4 because I think, again, we want as little uncertainty as
5 possible in that so pharma can understand, okay, this is
6 when I might get pulled into that grouping versus, no, I
7 don't need to worry about it in these other circumstances.

8 MS. KELLEY: Larry.

9 DR. CASALINO: We always say "Great work," but
10 that's because it is. I think the Commissioners are
11 constantly amazed at the quality and consistently extremely
12 high quality of what we get, so thank you.

13 I agree, I think pharmaceutical innovation is
14 incredibly important, and I would say it's only going to
15 keep becoming more incredible and more important even in
16 our lifetimes. It's incredible what that industry has done
17 in our lifetimes and what it can do. And I do agree that
18 price and innovation have some relationship, as Mike has
19 emphasized a number of times.

20 That said, you know, I don't -- I'm with Greg in
21 that I don't believe that the U.S. needs to finance the
22 cost of pharmaceutical innovation for the world. And to a

1 considerable extent, that's what we're doing, right? I
2 mean, we really are. And I do think it's true that if the
3 pharmaceutical companies couldn't make quite as much on the
4 price side in the U.S., they would be tougher in their
5 negotiations with other countries, with some success.

6 So I guess, first of all, I'll tie that into
7 something in just a minute. I think there has been kind of
8 a consensus, at least at this end of the table, with Jim
9 and Amol and Stacie and Scott on the first three bullets
10 under Policy 1, and the fourth bullet, some good
11 suggestions. And I do think we need to do something there,
12 and maybe Scott's suggestion about something, which I think
13 Robert also essentially suggested, just "The Secretary
14 shall develop a way to do this" is good. But this might be
15 a part, I would strongly suggest, in the chapter to bring
16 in the rest of the world issue, not in the sense of who's
17 going to finance drug innovation, but in the sense of there
18 are other countries that pay half what we do for drugs,
19 that do have methods, standard methods that are pretty good
20 for evaluating the benefit of drugs -- right? -- and for us
21 to kind of ignore that almost and just mention it -- this
22 is not a criticism. I'm talking about it's a constant

1 frustration to me with the U.S. health care discussion, we
2 can't learn anything from the rest of the world, it's un-
3 American, right?

4 I think the 1-D would be the place to say we pay
5 twice as much, other countries have a way of determining
6 the clinical benefit, the Secretary should take a look at
7 that and develop a method for evaluating net clinical
8 benefit. So that's all I'll say about Policy 1.

9 Policy 3 I want to jump to, just I actually like
10 pretty much all the suggestions for Policy B. I think that
11 I just want to provide a little more context there, the
12 large practice issue. So there's a paper out there, a
13 pretty good paper that estimates that the average retinal
14 specialists makes \$237,000 a year more if they shift most
15 of their use of intravitreal injections to Lucentis rather
16 than the cheaper alternative that costs about \$50. You
17 know, that's substantial, and ophthalmology practices
18 depend on that, right? Rightly or wrongly.

19 So a couple of points that leads me to -- oh, and
20 the other thing they did, by the way, large practice, small
21 practice, the large practices do get large volume rebates
22 or discounts from the pharmaceutical companies that are not

1 available to the kind of practices Lynn is talking about.
2 But they also make 2 percent buying these things with
3 credit cards. This is not anecdotal. This is in the
4 article. They pay for these hundreds of thousands of
5 dollars, easily, quickly, adds up to many hundreds of
6 thousands of dollars, they pay for them with credit cards.
7 They use credit cards that they basically get 2 percent
8 back on. That's pure profit for them, and it's a big
9 enough number to not be ignored, if you compare it actually
10 to the kind of numbers we're talking about in the paper,
11 for Recommendation 3. So that should be understood, I
12 think.

13 And one thing that hasn't been mentioned is
14 transition. So for practices like oncology practices and
15 ophthalmology practices that are raking in that kind of
16 money off, you know, very expensive drugs at the ASP+6
17 percent, like Greg and all of us, I think, that's not a
18 healthy incentive structure to have in our system. But
19 stopping it overnight might be disruptive, too. So as
20 another policy recommendation in other areas, we might want
21 to consider some kind of transition. But I agree with
22 the recommendations as they are.

1 Then the last point, I don't think we've had
2 enough discussion about Policy 2, and it may be simply that
3 I don't understand it. Is there any reason that there
4 couldn't be -- I think the recommendation as it is now is
5 for some form of reference pricing, but not -- but to
6 continue letting each drug have its own ASP in the classes
7 we're talking about? Did I get that wrong or is that
8 correct?

9 MS. RAY: Each drug would remain in its own
10 billing code.

11 DR. CASALINO: That's what I meant.

12 MS. RAY: But it would be assigned a reference
13 price.

14 DR. CASALINO: So why couldn't we -- would it add
15 anything to give each drug -- to give the same class of
16 drug the same billing code instead of letting each one have
17 their own and still do some form of reference pricing? Is
18 there any reason that couldn't be done?

19 MS. RAY: So I think that could be done. What we
20 discussed earlier, I think in the September meeting, is
21 that for various reasons we might want to -- certain
22 Commissioners felt like keeping them in their own billing

1 code would be more advantageous in terms of the use of
2 claims data, for example, for pharmacoepidemiology
3 purposes, and in those instances in which a medical
4 exception would be necessary.

5 DR. CASALINO: Wouldn't it be possible to let
6 them have their own identifying code for research purposes
7 but -- just not possible? -- but to give them all the same
8 billing code in terms of payment purposes?

9 DR. CHERNEW: I think -- I'm going to -- just for
10 time I'm going to push on because this is beyond what we
11 contemplated. So I think there's -- we'd have to really
12 think through the benefits of that relative to just doing
13 this and all the administrative costs of how that all would
14 play out. But I think what I will say, which I think is
15 important as we go through here, because we are getting
16 toward the end, is right now the recommendation is general,
17 and you could read the recommendation as let's do least
18 costly alternative, and then you could focus on the places
19 where that's really hard or -- which is how I read the
20 chapter -- let's do it in the easy places and, you know,
21 it's not a call for the Secretary to do least costly
22 alternative across the board. It's a call to start with

1 some of the low-hanging fruit places, the biologics, the
2 originators and biosimilars, the 502 whatever letter,
3 right?

4 When you get to this other thing, which is taking
5 all of the air time, I think you get into a lot more of
6 this complexity, and I'm uncertain about whether or not the
7 recommendations should maintain that level of breadth,
8 which I think has some value in particular cases where
9 you'd to want to do it, but it does add to a level of
10 confusion. And so that's a recommendation tension that,
11 based on this discussion, I'm struggling with.

12 DR. CASALINO: So, Mike, this is actually a
13 separate point that I was just asking about, which is
14 separate billing codes. But that's okay. I'm happy to
15 pass that by now. But are you saying we should have a
16 recommendation that basically says let's do some form of
17 reference pricing?

18 DR. CHERNEW: No. I think what I'm leaning
19 towards is the following: keeping it exactly the same, and
20 making sure in the text that we are very clear -- and I
21 think we are, by the way -- that what we are really
22 recommending is do this in the places where we know you can

1 do it, where there's not all of these complications being
2 raised, so biologics, the originator and the biosimilars;
3 and that while we understand there may be other places you
4 can do that, and so that's covered by the recommendation,
5 we recognize that is a much harder thing to do, and this
6 recommendation shouldn't be interpreted as telling the
7 Secretary they need to go across all of the drugs and build
8 a full-fledged, complicated reference pricing or least
9 costly alternative model. I don't think that's the way --
10 that's not the way I read this recommendation. I read the
11 recommendation as let's take the ones where I think we all
12 agree, and there's probably some other ones clinically that
13 we could get to agree to easily; we want to make sure
14 that's included. And when it gets really complicated, the
15 Secretary can ponder how that plays out. But that's not
16 really the crux of what this recommendation is. And I
17 think the text has to make that distinction. The
18 recommendation right now is just vaguer, somewhat
19 intentionally.

20 DR. CASALINO: No, I'm good with that.

21 DR. CHERNEW: Okay. Just to get -- so we have
22 one, two, three, four more people -- four more people left,

1 and I think the first of those people is Betty, if I have
2 this right. And just be aware of the time we have.

3 DR. RAMBUR: I will be very --

4 DR. CHERNEW: We'll go a little long, but we have
5 about ten minutes.

6 DR. RAMBUR: I will be very brief and just try to
7 amplify, if I may. I really appreciate the insights of the
8 Commissioners, and I just want to comment to the staff that
9 I think you did a brilliant dissection of the issues and
10 the trade-offs, and I think it should be required reading
11 for every person in the United States who's interested in
12 drug prices and every health professional student.

13 I can't help but think about this issue from the
14 perspective of the end user, the person using the drug,
15 including the false hope and the harm and the suffering, so
16 I strongly support the strongest language in Recommendation
17 1 and 1 through 3. And I wanted to comment on the
18 statement that caps have a chilling effect on innovation.
19 I have to ask you, does that also have a chilling effect on
20 patient outcomes? Because as we see it, those are not
21 always the same. So I really like Scott's suggestion about
22 thinking about some kind of framework for value. It may

1 not be able to be in this time, but what are the trade-offs
2 in terms of what we're really getting?

3 I also very much like the inclusion of the
4 international pieces that were mentioned, I think, by Larry
5 and Greg and others, and so I'm very enthusiastic about
6 this work and having a bit more, you know, description in
7 some of these areas will take us far. So thank you.

8 MS. KELLEY: Kenny.

9 MR. KAN: Outstanding work by the staff in
10 balancing many complex issues. I'm very enthusiastic of
11 the Chair's recommendation on all three policy proposals.

12 Regarding Policy 1, Bullet Point 4, Stacie's
13 concern regarding the squishiness of the price capping
14 framework resonated initially with me, back in January and
15 even today. However, I still remain comfortable with this
16 price capping proposal as the recommendation is to grant
17 the Secretary the authority and thereby the flexibility to
18 cap prices when drug prices get egregious.

19 However, as a guardrail gains potential abuses of
20 such authority, I support Robert's and Stacie's idea of
21 possibly inserting a value assessment nuance in the report
22 which references the need for clinical input, potential

1 consistency with the spirit of the IRA, and a price setting
2 framework of tools.

3 Finally, I wish to pile on Amol's and Scott's
4 idea of not letting perfection be the enemy of the great.

5 MS. KELLEY: Marge.

6 MS. GINSBURG: Right after I posted my Round 2
7 comment, Robert stole my thunder.

8 [Laughter.]

9 MS. GINSBURG: That always happens.

10 About Policy 2 and the reference pricing, it's
11 been troubling me all along and then he was able to
12 effectively articulate why it's a problem, and I really do
13 think it's a problem because I think every drug
14 manufacturer will find variations in the health effects of
15 their drug that will make the reference pricing almost
16 impossible. And I would love -- I love the concept of
17 reference pricing. I'd love to see if there's a way it can
18 be applied here. But I have to admit I'm really cynical
19 about whether that is going to work in this whole area of
20 medical care.

21 Otherwise, great report, love it all, and very
22 excited about what the next steps will be. So thank you.

1 MS. KELLEY: I have a Round 2 comment from
2 Cheryl.

3 She says: I agree with Greg's point that these
4 steps are improvements, but there is still a great deal of
5 work to do to stimulate more competition and reduce drug
6 spending. She supports Policy 2 and 3. She concurs with
7 Stacie's recommendations to separate the A through C under
8 Policy 1 to state that "The Secretary shall" do those three
9 things, and then to have D stand alone and give the
10 Secretary the authority to do this, to provide discretion.
11 This may serve to temper the launch prices to avoid the
12 Secretary needing to trigger the D option.

13 She suspects manufacturers will want to get the
14 drugs to market faster to recoup development costs and will
15 choose the accelerated path rather than run them through
16 the standard process.

17 Note on page 3 the CED policies have been rarely
18 applied to drugs, only three times since 2005. She concurs
19 that determining value is complex.

20 That was the last person in Round 2, except that
21 Stacie, I think, had another point she wanted to make if
22 there was time. I do think there's time, Mike. Is that

1 all right?

2 DR. CHERNEW: We'll have an abbreviated Round 3.
3 I think Stacie and Amol wanted to make a Round 3 comment.
4 I don't know, Stacie, if you added your comment earlier.

5 DR. DUSETZINA: No. I just wanted to make -- so
6 Cheryl's comment was a great tee-up for this. It sounds
7 like mostly consensus around the separating out the points
8 on Recommendation 1. In addition to saying the Secretary
9 should have the authority to do that, I do think that going
10 to maybe Scott's comments about being really clear or
11 trying to develop some sort of framework when this would be
12 applied to de-risk it, you know, so it would -- it would be
13 the Secretary, you know, shall have the authority to do
14 this, but should create criteria by which -- you know, so
15 that companies can understand, you know, if you meet any of
16 these things, you will be evaluated and potentially have a
17 price cap. So I wonder if we can include a little bit more
18 language about them defining when this would be triggered
19 as clearly as possible, because I think that is the risk of
20 the piece today.

21 DR. NAVATHE: I'm next? Okay. So two quick
22 things.

1 One thing is on Rec. 1, I would personally urge
2 us to include something about exceptions for A to C as
3 well, so allowing for exceptions.

4 [Comment off microphone.]

5 DR. NAVATHE: For A to C, just allowing the
6 Secretary to also have exceptions, you know, as I was
7 saying kind of in the context of whatever, unanticipated
8 COVID pandemic.

9 And then for Rec. 3, I wanted to actually offer
10 potential alternative language that is in spirit raised
11 somewhere but tries to capture some element of we don't
12 want to just go from ASP+6 to ASP+5 percent, that we want
13 to actually shift the system a little bit. So, very
14 quickly, my restatement would be something to the effect
15 of: "The Congress should direct the Secretary to shift
16 add-on payments for Part B drugs paid based on average
17 sales price to methods that lower payments and improve
18 financial incentives, and to eliminate add-on payments for
19 Part B drugs paid based on wholesale acquisition cost."

20 DR. CHERNEW: As an aside, we're not going to
21 have a discussion of that point.

22 I take that back. We will have a discussion of

1 that point. We're not going to have it now. So let me do
2 just -- did you want to add --

3 DR. MATHEWS: [Off microphone.]

4 DR. CHERNEW: Do you want me to go first?

5 DR. MATHEWS: Yeah.

6 DR. CHERNEW: Okay, so let me try and summarize
7 where I think we are.

8 There will be recommendations in April you will
9 be asked to vote on. I'm not going to go around and ask
10 you your opinion of them now. There's three different
11 recommendations and the recommendations have different
12 points. It's pretty clear where there's consensus on the
13 bit about -- with Recommendation 1 on the first three
14 bullet points, I think we have reasonable consensus on
15 wording, and we should get close enough to where I think we
16 can be -- you'll see more material.

17 On the fourth bullet point, what's clear is
18 there's a lot of discomfort with aspects of it. What's not
19 clear is whether that's simply solved by making it "The
20 Secretary shall have the authority to..." and then keeping
21 it; or whether it needs to have more explicitness about,
22 you know, what the criteria are and stuff, and so we will

1 talk about what to do with the bullet point given this
2 conversation.

3 With the issue of the similar drugs being --
4 we've been talking about reference pricing. It's pretty
5 clear there's consensus about what to do in the sort of
6 cases where it's really basically the same thing, today
7 there's some biosimilars, and there's uncertainty about
8 what to do when you're trying to think about a more broad
9 reference pricing mechanism. And I think we're going to
10 have to think through how that plays out in the text to be
11 clear what we want and how we may have to change the
12 wording on the recommendation to be clear. But I think
13 there's actually widespread consensus on the points;
14 there's just uncertainty about what it means for the actual
15 wording of the recommendation and implementation.

16 On 3, I think, again, there's widespread
17 consensus on the point that the existing broad system
18 creates a bunch of bad incentives, but there's some
19 clarification about where the sequester comes in; is this
20 pre- or post-sequester? What do we actually -- how
21 specific is it? You know, the recommendation doesn't
22 actually have in it the policy option. As I say, the

1 recommendation is more general as written and even as Amol
2 said it. So I think we will think through the actual
3 wording of Recommendation 3, but I think there's general
4 consensus that we are balancing a desire to make sure that
5 people can hold the drugs, we don't drive consolidation,
6 that the administrative prices are right, but address what
7 we see is a really serious incentive problem associated
8 with the current way in which the drugs are paid for, ASP+X
9 percent, because the X percent seems to be big enough that
10 it's causing some problems.

11 So we will -- I think the right word is "massage"
12 the language and keep the spirit of where we were, but I
13 thought in general there was a lot of enthusiasm for the
14 spirit and a lot of massaging going on. So I'll just --
15 well, Jim's going to say his conclusions, so I will give
16 mine as thanks to Kim and to Nancy for all of this. This
17 is really a big area, and I think it's outstanding work,
18 and I look forward to working over the next month to come
19 back with refinements to this.

20 Jim, you're up.

21 DR. MATHEWS: Just a final comment to set
22 expectations.

1 One, this was an extremely productive discussion,
2 especially given the complexity of the material that we've
3 been dealing with. And I think the guidance we have has
4 been helpful to get us to the April meeting and the June
5 report.

6 Obviously, one of the most complicated issues
7 does relate to Bullet D in Recommendation 1, and to just do
8 a sidebar a little bit, the point that the United States
9 does pay multiples with respect to the price for drugs
10 relative to other developed countries is -- it resonates.
11 It carries a lot of weight. And at one point in this
12 process, we did contemplate using international reference
13 pricing in order to kind of temper that phenomenon, and we
14 wrote this up, I believe -- I can't remember the chapter --
15 2019 where we looked at the pros and cons of using
16 international reference pricing, and it involves things
17 like trying to crack open proprietary contracts between a
18 manufacturer and another sovereign government, things like
19 manufacturers using different NDCs in the United States
20 than they do in other countries, making comparability
21 difficult. And so at the time the Commission did not
22 pursue an international reference pricing approach.

1 Part of that, the way other countries do this
2 does indeed involve a value assessment framework that does
3 not exist on a national basis in the United States, but
4 there are private entities that do this kind of thing.

5 That said, I am, as an institutionalist, looking
6 at this from a MedPAC perspective, I am extremely hesitant
7 to try and develop a recommendation that the Secretary
8 develop such a framework in the time between now and the
9 April meeting, which is effectively tomorrow in the world
10 we operate in. It's not to diminish the substance of the
11 idea, but we have not had a public deliberation of how it's
12 done in other countries, what kind of inputs are involved,
13 what kind of processes are involved in terms of public
14 presentation, appeals, that kind of thing. And so I'm
15 extremely hesitant to embark on that for the April meeting,
16 and my preference would be -- obviously we'll talk with
17 Mike and Amol -- would be to sort of work with the current
18 -- you know, Bullet D construct in light of this
19 conversation.

20 DR. CASALINO: I think I agree, Jim. I'm not
21 sure anybody was saying that we should make a
22 recommendation that, you know, we will use the European way

1 of doing it, or whatever. I think it was more the way the
2 text is worded that we move the information about how it's
3 done elsewhere, and the question of proprietary companies
4 in the U.S. It is already, I guess, in Bullet Point D, but
5 I think it should be prominent there. I see our role as
6 making policy recommendations to Congress, but I guess --
7 and maybe you may not agree with me. I think it also
8 inevitably has to be helping Congress think about things.
9 And if we -- the frame of thinking about things about how
10 other countries are doing it, not so popular in Congress or
11 the U.S. but that's not a reason for us not at least to
12 throw it out there, not as a recommendation but as
13 something that's more prominent in the report. We don't
14 need to get into the details of how they do it or anything
15 like that, just, yes, it can be done; because, otherwise, D
16 looks really squishy. But the idea is that if you get the
17 idea that there are ways to do it, and here they are on a
18 very highly level, I think that's helpful.

19 DR. CHERNEW: We are going to take a break and
20 come back, because I want to have enough time to do the
21 post-acute chapter. But I will say for those at home, this
22 issue about the gap between America and international

1 prices, which is a much bigger issue than we're talking
2 about here, which is really largely accelerated approval
3 drugs to one particular pathway. And so it is certainly a
4 feature of the American system that we pay more than other
5 countries. The problem we were trying to solve was not
6 that problem, just to be super clear. We're trying to
7 solve a much narrower problem in a much more specific
8 place. That doesn't mean we can't allude to bigger
9 problems in the American health care system, but we are --
10 and as I think I said before, the processes that are used
11 in those other countries, for a whole range of reasons, are
12 much -- are trying to solve a much different problem
13 because they're setting prices, they're setting much lower
14 set of things for the international system than what we're
15 trying to do here. We're trying to -- one way to think
16 about it is this Bullet Point D is designed to give a tool
17 to cut off the very worst abuses, not solve a broader
18 question about what a fair price would be for a drug to
19 accelerated approval. And because of some nuances in the
20 American system, like if you get too strict, this will go
21 through the other process and you won't get the drugs, how
22 one would deal with that is much more complicated than

1 we're anywhere close to doing, at least in this chapter.

2 So I guess it's my prerogative to have the last
3 word, so I'm going to take that. We're going to take a
4 five-minute break. We're going to come back and talk about
5 unified PAC. So, again, thank you all.

6 [Recess.]

7 DR. CHERNEW: Okay. We are back, and we are
8 going to now hear a presentation on unified post-acute
9 payment, which is a long body of work that we have been
10 doing for a quite a long time, and I think Carol, you are
11 going to start, and then Kathryn.

12 DR. CARTER: Mostly just me.

13 DR. CHERNEW: Okay. Mostly just you. For moral
14 support. That's the kind of teamwork we --

15 DR. CARTER: She was very involved.

16 DR. CHERNEW: Yeah, I'm sure. It is wonderful to
17 have both of you there. Carol, go ahead.

18 DR. CARTER: Okay. Good afternoon. Before I get
19 started, I want to remind the audience that they can
20 download a PDF version of these slides in the handout
21 section of the control panel on the right hand of the
22 screen.

1 Today's presentation is the third in a series to
2 prepare a mandated report on a prospective payment system
3 for post-acute care. This draft is our best attempt to
4 reflect where we think Commissioners are with regards to
5 recommending a PAC PPS. We've shifted the emphasis from
6 stating that implementing a PAC PPS is imperative to
7 outlining the key design and implementation issues that
8 will confront policy makers if they choose to move forward
9 with a unified payment system.

10 Today, I'll briefly recap the Congressional
11 mandate and its rationale for a unified payment system and
12 summarize the conclusions about the design that we've
13 already talked about. Then I'll present new material on
14 considerations for implementing a PAC PPS, including
15 whether there should be a transition, the level of
16 aggregate payments, and companion policies that would need
17 to accompany a PAC PPS. I'll highlight the key takeaways
18 and then present the chair's draft recommendation.

19 The IMPACT Act of 2014 required the Secretary to
20 develop uniform patient assessment items and quality
21 measures so that patients and outcomes in the four settings
22 could be compared. It also mandated three reports on a

1 prospective payment system for post-acute care.

2 The last report is due on June 30, 2023. The PAC
3 PPS design must span the four PAC settings -- that is home
4 health agencies, skilled nursing facilities, inpatient
5 rehabilitation facilities, and long-term care hospitals --
6 and base payments on patient characteristics, not the
7 setting.

8 The Act does not require that a PAC PPS be
9 implemented.

10 There were a couple of reasons why policymakers
11 were interested in a PAC PPS. Our work and that done by
12 others had found that beneficiaries who look similar in
13 terms of their condition and comorbidities can be treated
14 in different settings. But because Medicare uses separate
15 payment systems for each setting, payments can differ
16 substantially. A unified payment system would change that
17 and base payments on patient and stay characteristics.

18 In addition, there were shortcomings in the
19 payment systems in place at the time. The home health and
20 SNF PPSs encouraged providers to furnish unnecessary
21 rehabilitation therapy, while the LTCH payment system
22 encouraged LTCHs to admit low-acuity patients. Since the

1 IMPACT Act, CMS has made substantial changes to these
2 payment systems, and I will note that no changes have been
3 made to the IRF PPS during that period.

4 Turning to the design of a PAC PPS, our study and
5 that done by CMS and ASPE demonstrated that a unified
6 payment system was feasible and could establish accurate
7 payments. The designs could also establish relatively
8 uniform profitability across different types of cases that
9 would dampen the incentives to selectively admit or avoid
10 certain types of cases.

11 We concluded that the CMS/ASPE prototype would be
12 a good starting point for a design. In large part, it is
13 consistent with the preferred features identified by the
14 Commission. However, it adjusts the payment rates by the
15 setting, thereby undermining the design's uniformity. If
16 CMS proceeds with refining a design, this feature should be
17 phased out over time.

18 As I said at the beginning, we are not
19 recommending the implementation of a PAC PPS. But if
20 policymakers choose to proceed, there are three broad
21 considerations for refining the design. The first is
22 whether to prioritize uniformity or accuracy when there

1 would be a tradeoff between them. To support the main
2 objective of a PAC PPS, policymakers should accept less
3 accuracy for uniform design features. Deviations from
4 uniform elements should be limited to those needed to avoid
5 access problems for beneficiaries or that would otherwise
6 create large distortions in payments. For example, an
7 adjuster for home health stays would be needed to avoid
8 large overpayments to home health agencies and large
9 underpayments to institutional providers.

10 Second, policy makers would need to re-evaluate
11 each payment adjuster. Adjusters should have a conceptual
12 relationship to the costs of care. And then question would
13 be, should Medicare pay for those cost differences? The
14 need for the adjuster and its size should be based on
15 empirical evidence.

16 Finally, CMS should consider the incentives
17 inherent in the design. For example, do they encourage
18 efficient care? Do they discourage patient selection?

19 Turning to implementation, there are two issues
20 that I'll briefly discuss. The first is whether there
21 should be a transition to a PAC PPS and the second is
22 whether a PAC PPS would be implemented to be budget neutral

1 to current levels of payments.

2 A transition policy would help avoid payment
3 shocks to providers. It would give them more time to
4 adjust their costs and practices to the new payment system.
5 However, a transition would delay redistributions of
6 payments. During a transition, payments would be a blend
7 of current, setting-specific payments and PAC PPS payments.

8 Our estimates of the impacts on payments suggest
9 the need for a transition. Changes in payments would vary
10 widely across providers. Obviously, the magnitude of the
11 impacts would depend on the details of the design.

12 We estimated that over half of providers would
13 experience changes in payments of 10 percent or more.

14 The wide range in impacts and the size of them
15 indicate that a transition would make sense.

16 We also evaluated whether the transition would
17 need to be long or short. One way to think about this was
18 to look at the relationship between the current levels of
19 profitability and estimated changes in payments. If the
20 providers that would experience the largest decreases in
21 payments were the most profitable or if providers that
22 would experience the largest increases in payments were the

1 least profitable, then maybe a short transition would be
2 preferable.

3 We found that changes in payments were generally
4 inversely related to provider profitability. Of the
5 providers whose payments would decrease by at least 10
6 percent, the majority were relatively profitable. They had
7 payment-to-cost ratios greater than 1.1. That is, payments
8 were 10 percent higher than costs. Of the providers whose
9 payments would increase by at least 10 percent, the
10 majority were relatively unprofitable. Their payment-to-
11 cost ratios were below 1, at 0.9.

12 We concluded that a transition should be short so
13 that the redistributions in payments would occur sooner.

14 Turning to the level of payments, if a PAC PPS is
15 implemented, policymakers would need to decide whether
16 aggregate payments under the new system should be set to
17 equal to those under the current PPSs, that is, or whether
18 the level of payments should be lowered to more closely
19 align payments to costs. A reduction could be implemented
20 at once or over multiple years. We modeled three
21 scenarios. Our results are similar to our analyses in
22 2018, when the Commission recommended lowering the level of

1 payment and having a short transition.

2 Our updated results are shown in the table. On
3 the left, we see that if a PAC PPS were implemented with no
4 transition and no reduction to the aggregate level of
5 payments, then aggregate payments would be 14 percent
6 higher than aggregate costs. In the middle, you can see
7 the results of if the level of payments were lowered by 5
8 percent, but there was no transition, aggregate payments
9 would be 8 percent higher than costs. And on the right, we
10 show what the results were if a 5 percent reduction was
11 phased in over three years, and that is the first year we
12 are seeing, in that year payments would be 12 percent
13 higher than aggregate costs.

14 So far, we've focused on the design of a PAC PPS,
15 and that is the circle at the top. Our work and the work
16 done by the Secretary have demonstrated that a uniform
17 payment system is feasible. But implementing a PAC PPS
18 would require companion policies identified by the other
19 circles. They include aligning benefits and cost sharing,
20 implementing a value incentive program, and developing a
21 common set of conditions of participation for providers.

22 These companion policies pose additional

1 challenges to implementing a PAC PPS, and we are going to
2 talk about each one in turn.

3 Currently, coverage and cost sharing rules vary
4 depending on the PAC setting where beneficiaries receive
5 their care. For example, a prior hospital stay is required
6 for coverage for SNF services, but not if the care is
7 received in the other PAC settings. Co-payments are
8 required when beneficiaries use institutional post-acute
9 care but not home health care.

10 When distinctions between settings narrow,
11 benefits and cost sharing should be aligned. Changes to
12 coverage and cost sharing could have significant
13 implications for some PAC users and program spending. For
14 example, requiring cost sharing for home health care could
15 restrict services for some beneficiaries. Eliminating the
16 prior hospital stay for PAC coverage is likely to raise
17 program spending.

18 We expect that aligning benefits and cost sharing
19 would be controversial and would be a multi-year
20 undertaking.

21 Currently, Medicare's Conditions of Participation
22 differ by setting, each with its own cost implications.

1 When providers are paid under a uniform payment system,
2 they should face the same regulatory requirements and the
3 associated costs.

4 In the past, the Commission proposed shifting
5 requirements that are based on setting to requirements that
6 would be commensurate with the acuity of patients the
7 provider treats. This proposal is described in more detail
8 in the paper. An overhaul of the Conditions of
9 Participation to a common set of condition-defined
10 requirements would be a substantial departure from current
11 policy and could raise requirements, and the associated
12 costs, for some providers. This is another dimension of a
13 PAC PPS that would be a multi-year endeavor.

14 Another companion policy would be having a value
15 incentive program. By tying payments to a provider's
16 performance on a given set of measures, Medicare would
17 increase the value of its purchases. Especially under fee-
18 for-service, a value incentive program dampens the
19 incentives to generate unnecessary care or to lower costs
20 in ways that could harm patient care.

21 The Commission has done extensive work on the
22 design features of a value incentive program for post-acute

1 care. In a congressionally mandated report in 2021, the
2 Commission evaluated the current SNF value-based purchasing
3 program and recommended eliminating it and replacing it
4 with a new program. In another mandated report, in 2022,
5 we outlined the key decisions policymakers would need to
6 make to develop a value incentive program to span the four
7 settings, and we have discussed the key design features,
8 shown in the middle box. Since the IMPACT Act was enacted,
9 CMS has developed several measures that are consistent
10 across the four settings.

11 In addition, we underscored the need for CMS to
12 develop measures of patient experience and measures of
13 functional status that are accurate. And we also discussed
14 the need to define and measure the social risk of a
15 provider's patient population.

16 The companion policies present a host of
17 challenges to implementing a PAC PPS. Aligning benefits
18 and cost sharing will involve tradeoffs that are likely to
19 be controversial.

20 A common set of Conditions of Participation would impose
21 new requirements for providers, and some of these would be
22 relatively easy to align but others will be more

1 complicated.

2 Regarding a value incentive program, CMS would
3 need to conduct additional development work on performance
4 measures, such as a measure of patient experience, and a
5 measure of the social risk of a provider's patient
6 population.

7 Two separate bodies of work, ours and that
8 completed by CMS/ASPE, found that designing a PAC PPS is
9 feasible and could establish accurate payments. And while
10 designing a payment system would be relatively
11 straightforward, implementing the companion policies would
12 not be. Each is likely to be controversial, will require
13 considerable resources to develop, and take many years to
14 implement.

15 The changes CMS has already implemented to the
16 SNF, HHA, and LTCH PPSs are substantial and corrected
17 shortcomings in the then-current PPSs. Given the
18 considerable agency resources that would be required to
19 implement a unified payment system, CMS could consider
20 smaller-scale, site-neutral policies that would address
21 some of the overlap in the patients treated in different
22 settings.

1 Over the coming years, the Commission will look
2 for such opportunities. In the meanwhile, the Congress
3 should implement the Commission's standing recommendations
4 to lower the level of payments to home health agencies,
5 SNFs, and IRFs.

6 At the outset, I mentioned that the Commission
7 will not be voting whether to implement the PAC PPS. This
8 is because the complexities to implement such a payment
9 system and CMS's limited resources, the changes CMS has
10 already made to three of the setting-specific payment
11 systems, and your feedback over the past three discussions
12 of a unified payment system. Rather the Commission will
13 vote on whether to forward the entire report to the
14 Congress, with the report outlining the considerations
15 policy makers would need to make if development work
16 proceeds.

17 The chair's draft recommendation reads:

18 The Commission forwards to the Congress the
19 report on the unified post-acute care payment system
20 required by the Improving Medicare Post-Acute Care
21 Transformation Act of 2014.

22 This language is essentially identical to the

1 recommendation that was made back in 2016.

2 And with that, I'll turn the discussion back to
3 Mike.

4 DR. CHERNEW: There's a lot of history at MedPAC.
5 I have been around MedPAC for a long time and I have seen a
6 lot of history, others even further than me. Nothing
7 captures that history as much as the work we've done
8 related to this sort of post-acute care activity. It is
9 unbelievably important. So I guess in the spirit of
10 Larry's comment complimenting the staff, I will say both
11 great job, but understand that is a blanket great job for
12 this report, past reports, reports prior to the past
13 reports, and all the stuff in between.

14 This has been a long time coming. As the
15 materials point out, since we started there has been a lot
16 of movement in the direction that we encouraged when we
17 started the idea sort of unifying post-acute care.

18 So that was a longer, but I think deserved,
19 exceptional thank you for all that was done here. There is
20 a lot of, lot of, lot of complexities, and I am guessing
21 that even David has learned a ton about the regulatory
22 nuances about what it takes to be different types of

1 providers and what means to be the same type of service,
2 and all the rules that these providers have to live under,
3 which is really extraordinary.

4 Anyway, all of that said, one reason why my
5 speech is a little bit longer is I'm waiting for the Round
6 1 queue to fill up. How is the Round 1 queue looking,
7 Dana?

8 MS. KELLEY: I don't have a Round 1 queue.

9 DR. CHERNEW: There we go. We are going to start
10 with a Round 2 comment, and that is going to go to David.
11 So David, why don't you start us with Round 2.

12 DR. GRABOWSKI: First, thanks, Carol. Super
13 work. Amol just joked. You threw a perfect game here. No
14 Round 1 questions, so you've done it. Congratulations.

15 First, I'm definitely in favor of the Chair's
16 draft recommendation. I like the design features outlined
17 in the chapter regarding the PAC PPS. I think the point
18 was made during the presentation, but I'll just reemphasize
19 it, that the policy landscape has changed considerably, and
20 Mike, I loved the way you framed that, that it's really
21 changed in a way that's very consistent with a lot of our
22 recommendations over the past 7, 8 years, in terms of

1 shifting from SNF and HHA payment systems very much built
2 on therapy to ones built on patient characteristics, and
3 that is very consistent with our unified PAC work, and then
4 obviously the site-neutral payment system for LTCHs.

5 So I just wanted to make a series of comments,
6 largely on the new material that was in the readings. I
7 won't subject anyone to my comments again from September,
8 Part 2. One thing I did learn -- Mike was teasing me
9 there, but I had learned and forgotten. The issue that I
10 think I and others had raised back in September was just
11 the importance of functional status, and that needs to be
12 coded accurately. It is currently not. It is self-
13 reported by the different post-acute care providers.

14 You make this great point on page 13 about the
15 activities not attempted, or ANA, coding and how if that's
16 coded it immediately defaults to the most dependent
17 category. That's ridiculous. Like it's hard to get
18 providers to code accurately, but that seems like low-
19 hanging fruit we could fix. I had lost sort of track of
20 that point, so that was something that Mike, said, yeah,
21 that's a red flag. There you go, something that we could
22 really implement, to hopefully make the coding a bit

1 better.

2 I do think ultimately it is going to take greater
3 oversight and auditing on the part of CMS to really enforce
4 the quality of the coding, but at least in the short term
5 maybe there are some other steps we could do.

6 The second point I wanted to make was around
7 implementation. I think you don't need the three years. I
8 don't want to sound like our former colleague, Bruce
9 Pyenson, here, who wanted to sort of implement everything
10 tomorrow. I think you can take a year or two, but I don't
11 think you need a long runway here, just given we have
12 already made this transition in home health and SNFs. So I
13 don't think you need a lot of time.

14 I really like that bullet point -- I think it was
15 on the second-to-last slide, the designing of payment
16 system will be relatively straightforward. Implementing
17 the accompanying policies would not be. I think those
18 companion policies are really tricky.

19 I was just going to run through three of them
20 with some thoughts, the first being cost sharing. I know
21 we have talked about this at prior meetings, how we have
22 just really kind different cost sharing across fee-for-

1 service sectors here, home health no cost sharing, SNF
2 starts at Day 21. It's a real kind of mix and match. So,
3 in theory, unified payment would have kind of unified cost
4 sharing.

5 I like the concept that was raised in the chapter
6 around could you think about this from more of a value-
7 based perspective, and I'm not just sucking up to Mike
8 here. Could you actually think about directing folks to
9 kind of higher value settings, and you mentioned maybe kind
10 of greater cost sharing and some of the lower value
11 settings for particular types of patients. I like that
12 concept a lot. It would take a little more thought about
13 how that actually gets set up. I don't necessarily -- I
14 think you need unified cost sharing or a form of cost
15 sharing. You could think about very different levels
16 across the four sectors.

17 The second point I wanted to make was on the
18 three-day rule. I have been a big supporter of the three-
19 day rule. This is a requirement for SNFs, that in order to
20 qualify for services in traditional Medicare you need to
21 spend three days in a qualifying hospital stay.

22 During the pandemic we have been studying what

1 happened, and not surprisingly there was a big increase.
2 But what we are finding is a lot of that increase was for
3 COVID patients, and it seems like it really kind of
4 increased during periods of big COVID outbreaks and then
5 was a lot lower when COVID was less prevalent.

6 And so I'm wondering. You know, I've
7 historically been very resistant, especially for the long-
8 stay nursing home residents, but I don't know if the three-
9 day rule is quite the deal breaker, I once thought it to
10 be. And I wonder if there's a way to kind of think more
11 carefully about that, that if you really wanted to have
12 uniform requirements and needed to drop the three-day rule,
13 I think there is a way to do that such that you wouldn't
14 see the floodgates open in terms of SNF use.

15 The final point I just want to double down on, on
16 the PAC VIP. I think that's a great idea, and that's
17 something that I hope MedPAC continues to pursue,
18 regardless of where the unified PAC goes, but thinking
19 about common measures across the four settings, also
20 thinking about patient experience measures. Dana is not
21 here for this meeting, but I know she has been a big
22 proponent of trying to identify better measures across the

1 four post-acute care settings. So I want to see us
2 continue to pursue that work, regardless of how the unified
3 PAC payment plays out.

4 I'll stop there and just once again say, Carol,
5 great work, and I'm very excited about where we've ended up
6 with this. Thanks.

7 DR. RAMBUR: David, I was wondering if you can
8 just clarify a bit why you've been supportive of the three-
9 day rule, because I've always been a little bit on the
10 other side of it, because it seems hard to imagine that
11 people are going to be breaking down the barriers to get
12 into a skilled nursing facility.

13 DR. GRABOWSKI: Certainly community. It has
14 never made a sense. But for long-stay nursing home
15 residents it's been a way to take somebody who is
16 associated with a \$200 payment rate, send them down the
17 street to the hospital, they stay the three days, they come
18 back at \$600, \$700 a day. And so it's been an incentive to
19 actually hospitalize folks. The three-day rule is a way to
20 guard against those kind of unnecessary hospitalizations.
21 In a world without kind of the three-day rule the concern
22 was that it would just convert long-stay nursing home

1 residents who are \$200 a day to \$600 a day, without any
2 kind of intervening health care.

3 DR. CASALINO: In the community, you're right.
4 It drives clinicians nuts.

5 DR. GRABOWSKI: It drives them nuts, yeah.

6 DR. CASALINO: You want to spend days on
7 hospitalization? Fine. I'll put them in the hospital and
8 expose them to all kinds of things, and so on and so forth.
9 It made no sense for a community.

10 DR. GRABOWSKI: No, and I hear this all the time
11 from physicians.

12 MS. KELLEY: Greg.

13 MR. POULSEN: Okay. I really like this as well.
14 I support the recommendation completely. I guess I just
15 wanted to maybe take a quick trip down memory lane because
16 I may be the only person here who was actually involved in
17 discussions about whether to implement DRGs or not. That
18 was a while ago, folks. Okay, Betty, great. Thank you.
19 Bless you. I feel better.

20 But some people may not remember, and you
21 probably don't, that there was a big discussion about
22 whether it would put sophisticated, big hospitals out of

1 business or little community hospitals out of business.
2 You're going to pay the same to both of these radically
3 different sized and capable organizations? It's kind of
4 worked out. So I think that there is history here that
5 suggests that people will figure out where the appropriate
6 place to locate folks is, and that that doesn't necessarily
7 have to involve differences in payment for that to work.
8 So I think we've got history here that suggests that that's
9 capable, and it was right here with CMS.

10 The other thing, though, that I guess I would say
11 is as I reread this and reread some of the other things, I
12 think there's an implication that some people might read
13 into this that home health -- it's the thing that's not
14 like the others in the three. And you could read into it,
15 just kind of the way the tone is in some places, that while
16 we really overpay for this, and it may imply that it's low
17 value, and I think that the contrary is frequently the
18 case. That's the place that, if it works, that's the most
19 cost-effective place for people to be. You can tell that
20 from the capitated groups. That's where they want to get
21 people. That's where they'd much rather have them in than
22 any of the other three.

1 So it's just tone. I just want to make sure that
2 we don't imply that home health is -- we agree it should be
3 paid less. I voted for that along with all of you. It
4 clearly has a lower cost. But that shouldn't imply that
5 that's not the place that people should be. The in-fact is
6 that we're getting tremendous value there in part because
7 we're getting a whole lot of free caregiving that's being
8 implied.

9 And there was one implication there that I think
10 is important and that is should the cost sharing to the
11 consumers be differential for home health? My argument is
12 it already very much is because it's family members and
13 others that are paying a big portion of the pay by
14 providing the caregiving.

15 So that's not a big deal at all to me but my
16 sense was that you could read this and imply that you think
17 that home health is lower value thing, and I just wanted to
18 make sure that the way we do the tone doesn't ever feel
19 that way. Thanks so much.

20 MS. KELLEY: Robert.

21 DR. CHERRY: Thank you. Great report, really
22 well done. Just constructive feedback.

1 In the pre-read materials on Table 1 it does
2 mention that these patient characteristics would establish
3 accurate payments across the patient populations based on
4 currently available data. I have no doubt that of the
5 accuracy of the data. My question is, is it both accurate
6 and equitable, because I don't think race, gender,
7 ethnicity is currently taken into consideration into the
8 model, so the social risk factors is not really fully
9 elucidated.

10 So I mention this with a cautionary tale. For
11 quite some time kidney function has been evaluated using a
12 blood test called a creatinine test, and you had to adjust
13 for race in order to understand the accuracy across
14 different populations. And now many practitioners are now
15 using a blood cystatin test instead, which doesn't need to
16 adjust for race.

17 So when we are talking about various patient
18 characteristics, and particularly when using coded data,
19 there could be problems where there could be inequities in
20 terms of using this particular model, particularly if the
21 model is going to be used for beneficiary cost sharing.

22 So I would suggest, actually, to be able to

1 actually analyze this across different demographic groups,
2 just to make sure that it's both accurate and equitable.
3 Otherwise, really great work. Thank you.

4 MS. KELLEY: Amol.

5 DR. NAVATHE: Thanks. I also wanted to echo
6 Commissioner comments that this is a fantastic portfolio of
7 work that has evolved over many years, and I commend you,
8 Carol, on driving a lot of that.

9 I just wanted to highlight a couple of points. I
10 think generally, of course, the work is really strong and I
11 support the draft recommendation. I think there are a
12 couple of pieces that are in the report that are worth
13 highlighting, and I think one of the points was it's really
14 important to get the incentives right here. I think, for
15 example, on page 27, I think, essentially there's a
16 discussion of there's a tradeoff between model accuracy and
17 getting incentives right, and we need to get the incentives
18 right, perhaps acknowledging that we're going to have a
19 little bit less, quote/unquote, "pure model accuracy" in
20 terms of the spending model itself. But that paired with
21 the transition that actually offers an opportunity for us
22 to get to a payment system that is more rationalized and

1 that works better for beneficiaries and the like.

2 In terms of some of the other additional points
3 that David covered also, I'll just touch on them briefly.
4 I also support the value incentive program. I think
5 rethinking cost sharing here is important. For example,
6 even if it's modest, I think a small amount of cost sharing
7 in this space of home health may be warranted, given what
8 we see in terms of use and payment rates and the like. And
9 if this kind of mechanism, if you will, of the unified PAC
10 PPS, where we are headed, can be a mechanism to do that,
11 along with, I would say I'd support the reduction of
12 payments to a certain extent, given that there's so much
13 overpayment that hasn't been addressed, despite our payment
14 update recommendations over several years. I would
15 definitely support that, again, importantly, in the context
16 of the transition period that you have outlined. Thanks.

17 MS. KELLEY: Lynn.

18 MS. BARR: Thank you. Great work and I support
19 the Chair's recommendations. I'd like to just plus-one on
20 Amol's comment, and sorry Greg, but there's so much abuse
21 of home health in certain parts of this country that I
22 think actually coinsurance would be really important to try

1 to rein it in.

2 DR. CHERNEW: I think MedPAC has a recommendation
3 about that, that was probably my first time around. But
4 anyway, sorry. I don't remember DRGs, just to be super
5 clear.

6 [Laughter.]

7 DR. CHERNEW: Okay. So I think now we have one
8 more. I think Marge wants a Round 1 question. This is
9 Round 1 now. We're just repeating.

10 MS. GINSBURG: Sort of.

11 DR. CHERNEW: You can make it a Round 3, Marge.

12 MS. GINSBURG: I guess this is more of a comment
13 to the other comments about home health. Fifty years ago I
14 was a home care nurse with the VNA in San Francisco, but it
15 had a big impact on my views about home care, which back
16 then, of course, was fabulous.

17 What I'm commenting on is I've always been
18 opposed to the idea of the consumer cost sharing for home
19 care, and the abuse of home care these days, they were
20 coming from the clients. They are not demanding this.
21 They are not asking for more than is needed. My concern is
22 that people will refuse it if they don't have the cost

1 sharing adequately covered by a supplemental plan or
2 something.

3 When the doctor says you need to go to a nursing
4 home or you need to go to a sub-acute setting or something
5 else, that's fine when you're going to another setting.
6 But somebody's coming to my house to help me figure out how
7 to use my walker and how to make sure that I'm taking my
8 meds right? Very important things. I worry that they are
9 more likely to turn it down if they have to pay for it.
10 It's a very different view than when you are moving a
11 patient to a different inpatient setting. It really is
12 different.

13 So I just didn't want to put all the blame of the
14 abuse of home care, put any of the blame on the abuse of
15 home care on clients. That's not where it belongs. So
16 thank you.

17 MR. POULSEN: Which is not to say that it doesn't
18 occur. I totally agree with you, it does.

19 MS. BARR: It's anecdotal but the stories that I
20 hear is that the home health agencies are offering
21 basically, "We'll come to your house. We'll do your
22 dishes. We'll clean up a little bit. It's free." And

1 people are like, "Okay." And so it's that little bit of
2 cost sharing. And again, 80 to 90 percent of our patients
3 have supplemental insurance.

4 MS. GINSBURG: Right, and I agree. I'm probably
5 naïve. Fifty years ago home care was probably very
6 different than it is now. None of that happened back then.

7 MS. BARR: But it is a really important service,
8 and I do value it highly.

9 DR. CHERNEW: So we are not making a
10 recommendation, in case those are listening at home, about
11 cost sharing or not. We are raising a bunch of issues
12 about how to unify across these things.

13 And if I have followed this correctly, Dana, that
14 was the end of Round 1, and de facto, the subsequent Round
15 2.

16 So let me make a general comment about where I
17 think we are and how we've come to this position. There
18 have been incredible improvements. There are a lot of
19 nuances. The chapter is unbelievably good at both raising
20 the issues, in general, comparing them to what CMS has
21 begun to develop, that they may or may not do. I'm not
22 sure what will happen given the ways at getting at some of

1 these issues in a much more targeted as opposed to unified
2 way. But I think what happens often is you start with,
3 there are a lot of similar patients that are overlapping.
4 Let's unify this. And then you realize these places where
5 they're not overlapping becomes a really big problem, and I
6 think actually the path that the world took was probably
7 better than the path would've been otherwise.

8 I'm going to give Cheryl the last Round 2
9 question in a minute.

10 But the only other thing I would say about some
11 of this is, as important as this is, if we move to more
12 population-accountable models we have less of a concern
13 about all of these. Some of these problems are
14 exacerbated, in my mind, by complex fee-for-service
15 interactions, and one of the motivations, I think -- and I
16 think we've seen in all the alternative payment models that
17 post-acute is the ATM for ACOs, is my general view, and to
18 some extent all the episode models as well.

19 I think that's valuable in figuring out, to the
20 point of this conversation, where the incentives need to
21 lie. And so, again, we have a report that I think does
22 exactly what it should do, and I think it sets the exact

1 right tone, and we hope that the readers of this report,
2 those people listening, really find value in it. I think
3 all of the Commissioners did. But I think where policy is
4 now is actually probably a reasonably good place, and to
5 the extent that it is going to help continue to move the
6 ball forward, I think that's all probably a good thing.

7 You were going to say something with Cheryl. So
8 Cheryl now has a comment. Dana is going to get the last
9 Cheryl word. Dana.

10 MS. KELLEY: Okay. Cheryl says, "This is
11 important work and many thanks to the staff for all the
12 work in this space over multiple years." She supports the
13 Chair's proposed draft recommendation. She would encourage
14 staff to ensure that the language in the report strongly
15 recommends advancement of the development of the VIP, even
16 if CMS does not move towards a unified post-acute PPS.
17 "Measures to ensure that post-acute care providers are not
18 stinting on care are critical, as are measures of overuse
19 of care."

20 She supports inclusion of outcome measures and
21 measures of patient experience, and also strongly supports
22 the need to address the problems in coding functional

1 status. "And we should recommend that CMS should move on
2 the proposed strategies to improve this information, even
3 without a unified PAC PPS."

4 DR. CHERNEW: Okay. So again, thank you for
5 this. Are there staff comments, any reactions? Jim?
6 Other Commissioners on this or other things you want to
7 revisit?

8 Okay then. We are going to close. I would like
9 to invite all of the folks at home to send comments to
10 meetingcomments@medpac.gov or go to the website and you can
11 send us comments on any of the topics we discussed today or
12 anything else that you happen to be thinking about.

13 We really do appreciate the staff for all of the
14 work that you have done. Thanks to the Commissioners for,
15 I think, a wonderful set of comments. And thanks to the
16 people at home for tuning in.

17 We are going to start tomorrow, with, I think,
18 will be lively discussions of site-neutral payment and
19 Medicare Advantage. Actually, it's in the other order. I
20 think it's Medicare Advantage first, and then site neutral.

21 So again, thank you very much, everyone. Have a
22 wonderful night, and we'll see you tomorrow morning, 8:30.

1 [Whereupon at 4:52 p.m., the meeting was
2 recessed, to reconvene Friday, March 3, 2023, at 8:30 a.m.]
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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

Friday, March 3, 2023
8:31 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM, FACP
KENNY KAN, CPA, CFA, MAAA
GREGORY POULSON, MBA
BETTY RAMBUR, PhD, RN, FAAN
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JAEWON RYU, MD, JD
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P R O C E E D I N G S

[8:31 a.m.]

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DR. CHERNEW: Good morning, everybody, and welcome to our Friday session. We have two terrific topics. The first one happens to be a passion of mine and has gotten some attention lately. That's Medicare Advantage. And then we'll talk about site-neutral payment, another topic we've spent a lot of time on here at MedPAC.

So, without further ado, I'm going to turn it over, and I think, Luis, you're starting.

MR. SERNA: Correct.

Good morning. Medicare beneficiaries who have both Part A and part B can enroll in an MA plan. In 2023, the majority of eligible beneficiaries are likely to be enrolled in MA. In today's presentation, we are going to discuss the challenge of determining MA payment rates in an environment where using fee-for-service as the basis for MA payment rates creates the bias in favor of MA plans and where MA is the predominant.

We'd like to thank Katelyn Smalley for her help with this presentation. As a reminder, the audience can download a PDF version of these slides in the handout

1 section of the control panel on the right side of the
2 screen.

3 I'm going to start by discussing how Medicare
4 uses fee-for-service spending to pay MA plans and explain
5 how this creates a favorable bias for MA plans. Then we
6 will note some concerns about the effect of declining fee-
7 for-service enrollment on MA benchmarks and present three
8 alternative approaches for setting MA payment rates that
9 are less dependent on fee-for-service spending data.

10 We plan to include the material discussed today
11 as part of an informational chapter without recommendations
12 in our June report.

13 The MA program allows beneficiaries to receive
14 their Medicare benefits through private plans. These plans
15 cover the standard Medicare benefit, and nearly all offer
16 extra benefits. Payments to MA plans are based on plan
17 bids, benchmarks, and quality scores. Each year, plans
18 submit a bid for the amount they think it will cost them to
19 provide Part A and B benefits, including medical costs,
20 administrative expenses, and profit. Each plan's bid is
21 compared to a county payment benchmark, which ranges from
22 115 percent to 95 percent of local fee-for-service

1 spending. By law, the MA benchmark is the maximum amount
2 Medicare will pay for an MA plan to provide Part A and B
3 benefits. Thus, the key takeaway for this presentation is
4 that MA payments are directly tied to fee-for-service
5 spending.

6 County benchmarks are based on the average fee-
7 for-service spending for a beneficiary with average health
8 status. This is calculated by standardizing spending to a
9 risk score of 1.0. Risk scores increase payment for MA
10 enrollees who have higher expected costs based on their
11 demographics and medical conditions. On average, risk
12 scores predict costs accurately but will underpredict or
13 overpredict costs for each beneficiary.

14 Underpredicted costs occur when actual costs are
15 above the predicted costs. Overpredicted costs occur when
16 actual costs are below the predicted costs.

17 MA benchmarks assume that on average the accuracy
18 of the risk adjustment model will be the same per fee-for-
19 service and MA enrollees.

20 However, MA plan and beneficiary incentives may
21 cause differences for MA enrollees that are not accounted
22 for by the risk adjustment model, leading to favorable

1 selection for MA plans. This favorable selection occurs
2 prior to any differential coding between MA plans and fee-
3 for-service.

4 MA plans may influence favorable selection
5 through care management restrictions that are unlikely to
6 occur in fee-for-service, such as narrow networks and prior
7 authorization.

8 In addition, MA plans have an incentive to
9 require at least some cost sharing for many services to
10 avoid unnecessary care. These plan incentives may
11 influence self-selection of beneficiaries by avoiding
12 beneficiaries or encouraging disenrollment from
13 beneficiaries who have certain health conditions and seek
14 care from providers that may be out of network, such as
15 cancer centers and psychiatrists.

16 In addition, some beneficiaries may seek to
17 mitigate perceived delays in care that may result from
18 prior authorization.

19 Further, beneficiaries who expect to use more
20 medical services may prefer to stay in fee-for-service and
21 purchase comprehensive Medigap coverage.

22 The research literature suggests that risk scores

1 on average overpredict spending for the MA population.
2 Again, this is before any coding differences occur between
3 fee-for-service and MA. Because MA benchmarks rely on
4 risk-standardized fee-for-service Medicare spending, they
5 reflect the higher level of costs associated with the fee-
6 for-service enrolled population rather than a plan's
7 enrollees. This results in MA plans experiencing favorable
8 selection. To the extent favorable selection occurs, it
9 allows plans to bid lower than fee-for-service spending
10 before producing any efficiencies in care delivery. This
11 creates both overpayments for MA plans and introduces bias
12 in the comparison of risk-standardized spending between MA
13 and fee-for-service enrollees.

14 We conducted an analysis to understand the extent
15 of MA favorable selection and payment benchmarks. We
16 compared the last year of fee-for-service spending for
17 beneficiaries who switched from fee-for-service to MA with
18 the spending of beneficiaries who remained in fee-for-
19 service, and we adjusted for the geographic distribution
20 and risk scores of MA entrants.

21 We tracked beneficiaries from the time they
22 entered MA through their enrollment status in 2010. As

1 shown in the figure on slide 6, beneficiaries that remained
2 in MA tended to be those that initially had greater
3 favorable selection.

4 As you go down this chart, the longer a
5 beneficiary remained in MA, the more likely it was that
6 they were favorable to MA plans when they were in fee-for-
7 service, as indicated by the green bars, getting further
8 away from 100 percent of the expected fee-for-service costs
9 prior to MA enrollment.

10 For example, let's start with the top two rows
11 corresponding with beneficiaries that entered MA in 2018.
12 The original cohort of MA entrants in 2018, indicated by
13 the dashed line, had spending that was 96 percent a fee-
14 for-service in the year prior to enrolling an MA. By 2019,
15 only a small share of these beneficiaries were no longer an
16 MA. However, enrollees that either disenrolled from MA or
17 died were unfavorable to MA plans, and those that remained
18 in MA were relatively favorable. Thus, when we restricted
19 the MA entrants to those that remained in MA for two years,
20 the top green bar, this sub-cohort of beneficiaries had
21 spending that was 94 percent of fee-for-service.

22 Now let's look at the bottom row in figure. The

1 original cohort of MA entrants in 2012, indicated by the
2 dashed line, had spending that was nearly 90 percent of
3 fee-for-service in the year before MA enrollment. This
4 includes beneficiaries that either died or disenrolled from
5 MA. When we restricted the MA entrants to those that
6 remained an MA from 2012 to 2019, this sub-cohort of
7 beneficiaries had spending that was 74 percent of fee-for-
8 service. Thus, enrollee that are most favorable to MA
9 plans tend to remain in MA.

10 The substantial favorable selection in the year
11 before MA enrollment coincides with historical data that
12 suggests favorable selection continues through all years in
13 MA. When examining the historical 2008-to-2019 fee-for-
14 service experience of 2020 MA entrants, we found favorable
15 selection that persisted, even for beneficiaries with at
16 least 13 years of MA eligibility.

17 Overall, we found approximately 11 percentage
18 points of MA favorable selection in 2019. Thus, even
19 assuming no coding differences, if the average MA bid was
20 89 percent of fee-for-service spending in 2019, after
21 accounting for favorable selection, the average MA bid
22 would be nearly equivalent to fee-for-service spending.

1 Because of favorable selection alone, Medicare
2 payments to plans for the Part A and B benefit should have
3 been about 11 percent lower in 2019, and this overpayment
4 would be even greater if we accounted for plan coding
5 intensity.

6 These findings raise concerns about the
7 appropriateness of basing MA benchmarks exclusively on fee-
8 for-service spending data. Future options for benchmarks
9 should consider the extent to which MA favorable selection
10 is addressed.

11 Now Eric will summarize the potential challenges
12 of declining fee-for-service enrollment.

13 MR. ROLLINS: Another concern about MA benchmarks
14 is that the share of Medicare beneficiaries enrolled in
15 fee-for-service is decreasing as more beneficiaries enroll
16 in MA. In absolute terms, total fee-for-service enrollment
17 peaked in 2017 at 38 million beneficiaries and has since
18 declined to about 34 million.

19 The fee-for-service spending for a county can
20 become unstable if the number of fee-for-service enrollees
21 becomes too small, and CMS now makes what's known as a
22 "credibility adjustment" to stabilize the estimates for

1 counties with fewer than 1,000 fee-for-service
2 beneficiaries. The number of counties that need this
3 adjustment will likely increase in the future as fee-for-
4 service enrollment declines.

5 In addition, we have observed that some
6 population characteristics, such as the share of
7 beneficiaries who are eligible for full Medicaid benefits
8 or the share who qualified for Medicare due to disability,
9 are higher in counties with low fee-for-service enrollment,
10 which raises concerns about the representativeness of the
11 fee-for-service-based benchmarks.

12 To be clear, apart from favorable selection, we
13 have not identified a problem with the way fee-for-service
14 spending data are used to calculate benchmarks at this
15 point in time, but problems could arise in the future if
16 fee-for-service enrollment continues to decline.

17 Given the potential weaknesses of using fee-for-
18 service spending data to set MA benchmarks, we're now going
19 to switch gears and look at three alternate ways of setting
20 benchmarks. Each option either reduces or eliminates the
21 use of fee-for-service spending data. The first option
22 would use plan bids to calculate benchmarks, also known as

1 "competitive bidding." The second option would use both
2 fee-for-service and MA spending data to calculate
3 benchmarks, and the third option would set benchmarks and
4 then update them using a fixed growth rate instead of fee-
5 for-service spending growth rates.

6 Under the first option, competitive bidding, the
7 MA benchmarks would be based on plan bids instead of fee-
8 for-service spending data. Over the years, there have been
9 several proposals to use competitive bidding in MA, and the
10 concept received serious consideration during the
11 development of the Affordable Care Act.

12 One thing I'd like to highlight is that
13 "competitive bidding," as we use the term, would differ
14 from premium support because it would only be used to
15 determine MA payment rates and would have no direct effect
16 on the fee-for-service program or fee-for-service premiums.
17 The use of bidding is appealing because it could
18 potentially generate more accurate payment rates relative
19 to MA costs and more program savings.

20 Here's an illustrative example of how MA plan
21 payments could change under competitive bidding. The
22 current benchmark system is shown in the three bars on the

1 left. Note that the vertical access has been truncated to
2 show more detail. Based on its per capita fee-for-service
3 spending of \$1,000, this county has a benchmark of \$1,075,
4 which CMS calculates before plans submit their bids.

5 Three MA plans submit bids ranging from \$900 to
6 \$800, shown in the purple bars. Remember that bids include
7 plan administrative costs and profits. Each plan gets a
8 rebate equal to 65 percent of the difference between its
9 bid and the benchmark, shown in the yellow bars. When
10 rebates are included, total Medicare payments to the plans
11 range from \$1,014 for Plan A to \$979 for Plan C.

12 With competitive bidding, shown in the three bars
13 on the right, the benchmark would be determined by plan
14 bids and would not be tied to the county's fee-for-service
15 costs. There are several ways you could use plan bids to
16 determine benchmarks, but the most common proposal has been
17 to use the enrollment-weighted average bid as the
18 benchmark.

19 In this illustrative example, the average bid is
20 \$850. As under the current system, plans that bid above
21 the benchmark must charge a premium equal to the difference
22 between the two. So Plan A's enrollees have a \$50 premium,

1 which is shown in blue. Plans that bid below the benchmark
2 receive rebates that are used to either lower enroll
3 enrollee premiums or provide extra benefits.

4 In many proposals, plans receive the full
5 difference between the benchmark and the bid, instead of
6 just part of the difference, to give them stronger
7 incentives to bid lower. So Plan C receives \$50 in
8 rebates. Since Plans B's bid happens to equal the
9 benchmark, the plan would not charge a premium or receive
10 rebates. As a result, unlike the current system, Medicare
11 would pay each plan the same amount, the \$850 benchmark
12 amount.

13 There are some design issues that policymakers
14 may want to consider for a competitive bidding system.
15 First, plans could be required to have standardized
16 benefits, which is an issue that the Commission examined in
17 some depth last fall.

18 The use of standardized plans would make it
19 easier to compare plans on an apples-to-apples basis and
20 promote price competition, because any differences in plan
21 bids would be reflected in plan premiums. The standardized
22 MA benefit package could also include a specific amount of

1 extra benefits to help ensure that MA remains an attractive
2 option relative to fee-for-service, even if competitive
3 bidding reduces payment rates.

4 Second, you would need to consider how to
5 calculate the benchmark. As I said, many bidding proposals
6 would use the enrollment-weighted average bid as the
7 benchmark, but other approaches, like using the median bid
8 or the second lowest bid, are also possible. Using the
9 average bid would give large insurers more influence over
10 the benchmark but could also be more stable over time,
11 since enrollment patterns tend to change slowly.

12 Third, the MA market is relatively concentrated,
13 which raises concerns that plans in some areas might use
14 their market power to generate benchmarks that are higher
15 than the ones we have now. Policymakers could address this
16 concern by putting caps on benchmarks that are based on
17 current benchmarks or plan payment rates, which would help
18 ensure that bidding generates program savings.

19 Fourth, one advantage of competitive bidding is
20 that it would reduce the impact of favorable selection and
21 coding intensity on program spending. Under a bidding
22 system, benchmarks would be based on standardized bids,

1 which is the plan's bid divided by its projected risk
2 score. Favorable selection and coding intensity push up a
3 plan's risk score, and as a result, they would decrease its
4 standardized bid and put downward pressure on benchmarks
5 and payment rates.

6 Finally, based on previous experience with other
7 MA payment changes, we anticipate that plans would change
8 their bidding behavior under a new system. So there is
9 some uncertainty about the overall impact of bidding on
10 payment rates and program spending.

11 DR. JOHNSON: A second option is to base
12 benchmarks on spending for the entire Medicare population.
13 This option would keep current bidding and benchmark
14 structure, but the benchmarks will be based on a blend of
15 spending for fee-for-service and MA enrollees in each local
16 area. If the fee-for-service population declines in a
17 local area, the benchmark would rely more on the spending
18 for the MA population in that area.

19 Similar to current policy, benchmarks based on
20 all Medicare spending would be empirically based, meaning
21 that they would automatically adjust for changes in prices
22 of services, new technologies and coverage decisions, or

1 fluctuations in care-seeking behavior.

2 Finally, the influence of favorable selection in
3 MA would be reduced because, as the share of MA enrollment
4 grows in the local area, the benchmark would rely less on
5 fee-for-service spending.

6 Under this option, spending for the fee-for-
7 service population in a local area would be calculated as
8 it is under current policy but would include adjustments to
9 reflect prior MedPAC recommendations to establish
10 benchmarks using beneficiaries who have both Parts A and B
11 and to use payment areas that are larger than counties.

12 Spending for the MA population in a local area
13 could be based on MA encounter data in the future.
14 However, we have found that encounter data do not include
15 records of all services provided to MA enrollees, and
16 encounter data do not currently contain complete spending
17 information.

18 For this presentation, MA spending is instead
19 estimated using plan bids. The MA spending estimate would
20 include spending for Part A and B services plus an add-on
21 to allow for plan rebates. This rebate add-on should be
22 large enough so that plans can attract beneficiaries but

1 low enough to produce savings for the program. One
2 possibility is an add-on of 10 percent of the national
3 average plan bid.

4 Finally, MA and fee-for-service spending
5 estimates would be projected forward to the payment year
6 using local fee-for-service growth rates and then combined
7 using the MA and fee-for-service share of enrollment in
8 each local area as weights.

9 Using the method described above -- on the
10 previous slide, we simulated benchmarks for 2022. The top
11 figure shows that simulated benchmarks would be very
12 similar to fee-for-service spending in many areas with
13 about half of areas between 99 and 101 percent of local
14 area fee-for-service spending.

15 Similar to benchmarks under current policy, the
16 simulated benchmarks are somewhat higher in areas with
17 lower fee-for-service spending, allowing for greater plan
18 participation, and lower in areas with higher fee-for-
19 service spending to generate some savings. Overall, the
20 simulated benchmarks are about 8 percentage points lower
21 than the benchmarks were under current policy for 2022.

22 Therefore, in the bottom figure, we calculated

1 actual plan bids as a percentage of the simulated
2 benchmarks for 2022. The average plan bid was 86 percent
3 of the simulated benchmarks, meaning that the average plan
4 had a relatively high rebate amount.

5 In the local areas, the enrollment-weighted
6 average plan bid in 2022 was lower than the simulated
7 benchmark for all areas, noted as 100 percent in the
8 figure.

9 These results indicate that benchmarks based on
10 all Medicare spending would likely provide a viable
11 alternative for Medicare for establishing benchmarks, and
12 more plans are likely to bid below their benchmark under
13 this approach.

14 One potential concern is that fee-for-service
15 spending is used to some extent to establish the
16 benchmarks, and therefore, these benchmarks would reflect
17 some favorable selection into MA. The fee-for-service
18 spending estimates could be based -- could be adjusted to
19 eliminate the effects of differential selection between
20 fee-for-service and MA.

21 On the other hand, highly concentrated local
22 areas are also a concern. An MA organization that

1 dominates in the local area could have a large influence on
2 the benchmark. Such concentration could be addressed by
3 capping the weight of an individual MA organization in a
4 market or by creating a minimum fee-for-service weight.

5 Alternatively, an overall cap on benchmarks could
6 be set using the Commission's June, 2021 recommendation to
7 rebalance MA benchmarks.

8 Finally, the amount of the rebate add-on to the
9 MA portion of the benchmark may need to be adjusted to
10 balance policy goals of plan access and program savings.

11 And now we turn to the third option, which would
12 use a fixed growth rate to set MA benchmarks. Under
13 current policy, benchmarks are updated each year based on
14 national fee-for-service spending growth rate. The
15 national growth rate can vary based on changes in fee-for-
16 service spending trends. Over the past six years, the
17 national growth rate has varied between 2.7 and 5.6
18 percent.

19 Under option 3, the current growth rate would be
20 replaced with a fixed rate. To do this, policymakers would
21 establish benchmarks in the initial year. These initial
22 benchmarks could be set using MedPAC's recommendation for

1 revised benchmarks from June 2021. However, these fee-for-
2 service spending-based benchmarks would need to be adjusted
3 to eliminate the effective favorable selection in MA.

4 The second step is to determine the fixed growth
5 rate, which we discuss on the next slide. The primary
6 benefit of determining benchmarks with a fixed growth rate
7 is that it establishes predictability in plan payment rates
8 several years in advance. Predictable benchmarks may
9 reduce a plan's effort to construct annual bids or
10 negotiate with providers and may help plans budget for
11 long-term projects.

12 One method to define the fixed growth rate is to
13 use the CMS Office of the Actuary's projected growth rates
14 for Medicare prices, volume and intensity, and demographic
15 mix. Considering prices, MA plan payments track fee-for-
16 service rates for most provider types, although there are a
17 few exceptions. So this method would incorporate the full
18 Medicare price growth rate.

19 MA plans are more likely to control volume and
20 intensity growth relative to fee-for-service. So this
21 growth rate could be reduced by a discount factor. A fixed
22 growth rate with a 50 percent discount on volume and

1 intensity would equate to a 3.5 percent growth rate
2 annually.

3 A second fixed growth rate method would be to use
4 the growth rate for the Medicare prices plus a growth rate
5 based on real U.S. gross domestic product. Real GDP is the
6 inflation-adjusted growth rate of the value of all goods
7 and services produced in the country over a specified
8 period of time. A fixed growth rate using Medicare prices
9 and real GDP growth minus an adjustment of 0.5 percentage
10 points would equate to a 2.9 percent growth rate annually.

11 Under current policy, benchmarks are empirically
12 based and automatically adjust for fluctuations in spending
13 trends. However, a preset fixed rate that is independent
14 of actual Medicare spending would require a method to
15 assess the adequacy of plan payments and determine whether
16 an adjustment to the fixed rate would be necessary.

17 MedPAC assesses fee-for-service Medicare's
18 empirically-based rate updates by considering provider
19 financial performance, the number of providers
20 participating in Medicare, providers' access to capital,
21 and other factors. Applying these metrics to MA may be
22 possible, but evaluating MA plan margins could be

1 particularly difficult due to the increasing number of
2 vertically integrated arrangements with providers. And the
3 Commission has concluded we do not have meaningful
4 information about plan quality and service use.

5 If indicators of payment adequacy are unclear,
6 policymakers' assessment of adequacy and any adjustments to
7 the rate could be vulnerable to stakeholder influence.

8 That brings us to the discussion. We'd like to
9 get your feedback about the implications of favorable risk
10 selection in MA and on the three alternative options for
11 setting MA benchmarks, competitive bidding, benchmarks
12 based on both fee-for-service and MA spending, and updating
13 benchmarks using a fixed growth rate.

14 To the extent that you have other ideas on
15 benchmark setting, you should also discuss those potential
16 alternatives.

17 We're going to include this material in an
18 informal chapter in June, and I'll turn it back to Mike.

19 DR. CHERNEW: So that was terrific. Every fiber
20 of my being wants to talk for the next half-hour, but I'm
21 going to not do that, as best I can, and instead we will go
22 to Round 1. And I think Round 1 questions are going to

1 start with Jaewon.

2 DR. RYU: Yeah, thanks. In the reading you talk
3 a little bit about the migration between MA and then, as
4 people might get sicker, a migration into something like
5 MedSupp. I may be remembering this wrong, but I thought
6 there were limitations or some sort of penalty around when
7 someone enters MedSupp. I may be totally wrong, but if you
8 could just clarify that, that would be helpful.

9 MR. SERNA: Yeah, that is correct. So there's
10 only four states where beneficiaries have guaranteed issue
11 if they've been in MA for longer than a year, I believe.
12 So if they wanted to go back to fee-for-service and then
13 purchase a Medigap supplemental insurance plan, then they
14 would not have guaranteed issue rights. Consequently,
15 their premiums would be much higher relative to if they had
16 stayed in fee-for-service.

17 MS. KELLEY: Amol?

18 DR. NAVATHE: Thanks. Great work, guys. I have
19 several questions that are generally truly intended to be
20 clarifying questions.

21 The first is something I've asked before, but I'm
22 sadly having a senior moment, and I can't remember the

1 answer exactly. But we talk about how the rebate can be
2 used largely for supplemental benefits, but then a portion
3 of it can be used for administrative costs and for profits.
4 I was wondering if you could remind us what that ratio is
5 that can be used for administrative costs and profits, and
6 in future versions of this, if we could just add a footnote
7 there and clarify that so people like me don't keep
8 forgetting it.

9 MR. SERNA: That is something we are reporting in
10 the March chapter, which is coming out in a couple weeks.
11 To my knowledge, there is no limitation on the amount that
12 is allocated towards administrative expenses and profit.
13 But typically, it's going to be generally 5 percent profit
14 on average, 10 percent administrative costs, similar to the
15 AB benefit.

16 DR. NAVATHE: By definition, then, or by
17 arithmetic, 85 percent ends up going to supplemental
18 benefits or premium reductions for Part B?

19 MR. SERNA: More or less, correct.

20 DR. CHERNEW: Depending on what you believe in
21 all the actuarial -- like, the enforcement of the --
22 there's like what is written is happening, and then what

1 you think is actually happening, and it's really hard to
2 tell. That's a Kenny question.

3 DR. NAVATHE: Right, so I'm just asking about --

4 MS. BARR: Hang on one second. I thought the
5 Affordable Care Act mandated a 15 percent maximum profit,
6 and the problem is there's a 15 percent mandate, but then
7 what that 15 percent contains is very squishy. Right? So
8 that's the problem -- right? -- is that the 15 percent
9 includes -- you know, you can get around that. Is that
10 right?

11 MR. SERNA: Right. There's some differences
12 between the medical loss ratio for the ACA requirement, and
13 we're talking about here there's some puts and takes for
14 quality improvement, for audit enforcement activities, but
15 that's correct. In general, medical expenses are supposed
16 to be 85 percent.

17 DR. NAVATHE: Great. So the second question I
18 have is a bit of a broad question, but the way that we're
19 looking at favorable selection -- and the next set of
20 questions I have are kind of about that analysis -- we're
21 looking at individuals, beneficiaries, who are first
22 enrolled in fee-for-service and then switch into MA. So we

1 have enough claims experience to understand something about
2 them. I was just wondering if you could remind us what
3 percent of enrollees are directly going into MA and if you
4 have any directional sense of whether we think the
5 favorable selection, if you will, is similar or different
6 for that cohort of individuals who are going right into MA.

7 MR. SERNA: Sure. So the proportion that had at
8 least two years of prior fee-for-service experience was 47
9 percent in 2019, so roughly half. The ones that are going
10 directly into MA, we have limited insight into their data,
11 but when we looked at those that had at least one year of
12 fee-for-service experience, our assumption based on looking
13 at that data for 2017, '18, and '19 is that the favorable
14 selection would have been a little bit bigger, at least in
15 that initial year, if that answers your question.

16 DR. NAVATHE: Okay, thanks. So with that being
17 said, obviously we don't know exactly how that would
18 extrapolate to the immediate [inaudible.]

19 MR. SERNA: That's correct. That's an assumption
20 of the analysis.

21 DR. NAVATHE: Okay, great. The next question I
22 have is: So now diving more deeply into the analysis that

1 we actually do, it sounds like we are risk-adjusting based
2 on what the HCC risk score, but that being said, there
3 could be distributional differences between those that are
4 joining -- switching into MA versus those that remain in
5 fee-for-service, and those distributional differences could
6 also relate not just to the quantitative risk score but
7 also -- and you guys hint at this in the context of the
8 networks for cancer centers and stuff, but also the
9 composition of the conditions that actually exist in those
10 beneficiaries, again, between those who decide to switch
11 into MA versus stay in fee-for-service.

12 So my two-parter question here is: One, if we
13 just think about this simply in the context of the
14 quantitative risk score, where do we have -- or I guess the
15 binary question would be: Do we have perfect overlap in
16 the risk score distributions? Or do we actually not have
17 perfect overlap in the sense that there may be greater
18 weighting, if you will, of fee-for-service enrollment
19 amongst those switching amongst those who have high risk
20 scores relative to MA? Is that question clear?

21 DR. JOHNSON: I think you're asking in the
22 individual cohorts where we compare an MA and fee-for-

1 service population are the distributions of the MA risk
2 scores overlapping with the distribution of fee-for-service
3 risk scores, or are we comparing two different
4 distributions?

5 DR. NAVATHE: Yeah. I guess the question is to
6 what extent are they overlapping, right.

7 DR. CHERNEW: Can I try another version that may
8 or may not be what you're saying, and if it's not, I
9 apologize.

10 DR. NAVATHE: Sure.

11 DR. CHERNEW: There's selection on observable and
12 unobservable things. In other words, you could look to see
13 -- if you just looked at the risk scores, are people with
14 more severe risk scores moving into MA versus people with -
15 - just observably what's the selection. And then there's
16 selection within the -- so two people with the exact same
17 risk scores, but you think more of them are moving into MA,
18 which you're basing off of spending and a switching
19 analysis.

20 One would expect that those two types of
21 selection would move together, that you would see -- if you
22 thought there was selection within risk score categories,

1 which is unobservable, you would also see selection just in
2 the risk score distributions. And I think Amol was asking
3 -- so if you look at just the -- ignore the unobservable
4 part -- just the observable part, you see huge amounts of
5 selection going on. I don't know if that --

6 DR. NAVATHE: Well, in other words, exactly as
7 you were saying, Andy. If you plotted the distribution of
8 risk scores for MA and if you plotted the distribution of
9 risk scores for fee-for-service amongst those in our
10 analysis, how much overlap is there under distribution and
11 is there -- are there areas where there's not overlap?

12 DR. JOHNSON: I don't think we looked at the
13 observed level of risk score differences, but I think in
14 general, these populations are large enough that there is a
15 lot of overlap. There might be small differences in the
16 average MA risk score over fee-for-service, but it is not
17 going to be a bimodal distribution or something.

18 DR. CHERNEW: If I understand a lot of what's
19 going on in this analysis, an enormous amount of what
20 you're talking about is selection on unobservables.

21 DR. JOHNSON: Yes.

22 DR. CHERNEW: Selection at the risk score is

1 simply not capturing, and you're inferring that based on
2 the spending of the people before they join.

3 DR. JOHNSON: Yeah.

4 DR. CHERNEW: Right? So essential risk score
5 adjusted, the people joining MA are healthier is basically
6 what you're saying.

7 DR. JOHNSON: Right.

8 MR. ROLLINS: Correct.

9 DR. CHERNEW: And the issue -- did I mention I
10 was going to talk for half an hour? I just -- the issue, I
11 think, that arises in this analysis is the serial
12 correlation people assume in spending and switching
13 analysis. It's not -- this is true of all switching
14 analysis. You look at people -- I could write down a
15 model, which I promise I won't, in which you get huge
16 amounts of selection based on the year before they join,
17 but if there's enough independence over time and spending,
18 it turns out there's no effect of it by the time you get a
19 few years out. It's all based on a strong assumption of
20 serial correlation, which is the way switching analysis
21 works.

22 I was hoping to get through MedPAC without

1 mentioning switching analysis issues, but I failed. So
2 keep going, Amol. I'm sorry.

3 DR. NAVATHE: Okay. The point that I was trying
4 to make was -- so I was going to kind of get to Mike's
5 point, but he jumped ahead. The point I was trying to get
6 at was a little bit more for the fiscal econometric nerds
7 in the audience and in the group here, kind of like common
8 support and propensity matching, right? So if we're making
9 these extrapolations and the distributions don't overlap
10 perfectly, essentially, then we are extrapolating a
11 relationship outside of -- and this usually happens at the
12 extremes of the risk scores. So that's why I think it
13 would actually just be helpful for us if we could see those
14 distributions. I totally suspect you're right, Andy, that
15 the vast majority of the density of these distributions is
16 overlapping. But if there are areas that are not
17 overlapping, just for the credibility of our analysis, it
18 might help to truncate on those ends where there's not
19 overlap, because then we are fully supported, if you will,
20 by the distribution. So that's kind of where I was...

21 DR. CHERNEW: I'm sorry. Keep going.

22 DR. NAVATHE: Okay.

1 DR. CHERNEW: I feel like we're in step.

2 DR. NAVATHE: Sorry, yes. The next question I
3 had is related to these potential conditions that interact
4 with things like the networks. In particular, I was
5 curious about cancer diagnoses, and I was curious to hear
6 if you could give us a little bit of -- so there's many --
7 just to elaborate a little bit, there's many different
8 aspects of how the MA program is currently designed, the
9 lack of a hospice benefit, for example, or having hospice
10 paid under MA is another one that's kind of tilting this
11 way.

12 So what I was curious about is have we done any
13 sensitivity checks just to look at how the distribution of
14 cancer -- members with cancer or beneficiaries with cancer
15 diagnoses might be shifting around this. And I think I'm
16 broadly aware of some literature around this, but I was
17 just curious. One, have we done some sensitivity checks or
18 have we looked at this issue? And if we hold out certain
19 groups where we do see a lot of this switching, it's -- I
20 don't want to say that it's not relevant to include them
21 because it's not irrelevant to include them, but I'm just
22 curious what would happen if there are these kind of

1 incomparable groups that people who always stay in fee-for-
2 service and kind of would never switch into MA, then they
3 may not be the perfect comparison group, but it might be
4 good to just see how much our estimates are sensitive to
5 that group. If they're not, then that would be double
6 confirming.

7 DR. JOHNSON: We haven't done that type of
8 analysis, and I think we might also be concerned about the
9 differences in coding of conditions of MA and fee-for-
10 service. So think about that, and I'm trying to assess
11 whether we can come up with a reliable analysis of that,
12 individual conditions and the types of facilities or
13 specialties that are more common in the network. That
14 might be beyond the scope of the June report, I think.

15 DR. NAVATHE: Okay. Fair point. And just to be
16 very clear, it's not that I don't find our analysis
17 credible. I do. I'm just trying to think about what are
18 the different dimensions so we can explore the contours and
19 be as confident as we can.

20 I have one question that is about the mailing
21 material itself. So we have -- this is switching gears a
22 little bit. On page 10 and 11, we have a point here that

1 says, "A plan's network can also contribute to favorable
2 selection by including clinicians whose practice patterns
3 tend to have lower overall medical spending." And I was a
4 little confused by that statement because if the clinicians
5 actually have more efficient practice patterns, is that --
6 I'm trying to understand why that would -- assuming that
7 that clinician is also taking fee-for-service patients, why
8 that would contribute to favorable selection specifically
9 in this way.

10 MR. SERNA: So I think the analog here is when we
11 talked about TIN selection for ACOs. If you have a group
12 that consistently have lower risk-adjusted spending, that
13 is one potential method of having favorable selection.

14 I think going back a little bit, one important
15 thing about it, before we parse out individual HCCs, is
16 that this analysis is meant to see what is assumed in
17 benchmarks. So we're not really trying to look at certain
18 HCCs or exclude certain HCCs. What is the overall effect
19 for benchmarks? And what are benchmarks assuming between
20 the fee-for-service and MA populations? And the reason why
21 we looked at what happened to MA entrants before they enter
22 MA, years before they enter MA, is to see how would their

1 favorable selection change in a world where they stayed in
2 fee-for-service? The short answer is it wouldn't change
3 very much.

4 DR. NAVATHE: Great. Okay. I think the
5 remaining questions I can -- they're trivial. Thanks.

6 MS. KELLEY: Scott?

7 DR. SARRAN: You mentioned that during the run-up
8 to the ACA there was consideration for incorporation of a
9 bidding process for MA. Any insights into why that didn't
10 make it into the final draft in terms of what were the
11 reasons that people backed off from it?

12 MR. ROLLINS: To be honest, I don't know
13 specifically why. We note this in the chapter.
14 Historically plans have very much preferred to have a
15 payment system where they have preset benchmarks, so I'm
16 sure -- I'm not sure, but I would suspect that there was
17 some discomfort in the plan community as well with moving
18 to this system. But, you know, I don't have a full answer
19 for you on that question.

20 DR. CHERNEW: One of the issues, Scott, that
21 arose was the role that fee-for-service was going to play
22 in the balance between fee-for-service. That was mentioned

1 in your talk about would you charge people more if they
2 stayed in fee-for-service, how would fee-for-service be
3 treated as a bid, and what would the actual out-of-pocket
4 have to be in the way the system was designed. There are a
5 lot of design issues -- actually, MedPAC spent a lot of
6 time on a version of this back in the day if Jim wants to
7 comment on it. Yes, on a version -- I don't know what we
8 called it. What were we calling it?

9 DR. MATHEWS: We called it "competitively
10 determined plan contributions," one of our less elegant
11 formulations.

12 DR. CHERNEW: As an aside, I actually prefer a
13 different term, which is "bidding-based benchmarks,"
14 because that's what's really going on here. The real
15 question is: To what extent do the bids feed into the
16 benchmarks versus not. That's the core philosophical
17 question.

18 MS. KELLEY: Larry?

19 DR. CASALINO: I have three questions that I
20 think are quite quick. One is: Do you have a sense over
21 any time period you want to name of the percentage of
22 people in MA who switch back to -- who switch to fee-for-

1 service?

2 MR. SERNA: So we referenced one study that
3 looked at everyone who switched between 2011 and 2019, and
4 those who had been alive for at least five years during
5 that period. So among those who had switched from MA to --
6 from fee-for-service to MA, 23 percent of those had
7 switched back to fee-for-service at some point during the
8 five years.

9 DR. CASALINO: But do we have a sense -- that's
10 helpful, but do we have a sense of people who start off in
11 MA, what percentage switch back within - or not switch
12 back, but what percent start in MA and then switch to fee-
13 for-service within two years or five years?

14 MR. SERNA: We haven't looked at that, but that's
15 something we could look at.

16 DR. CASALINO: Yeah, I think to me that would be
17 really important to know.

18 The second question is: Is there any data on the
19 percentage of beneficiaries who are in MA who don't
20 understand the penalty if they try to switch to fee-for-
21 service? That's something that actually I don't think
22 there's tremendous awareness of, even in academia, and yet

1 it's pretty important.

2 MR. SERNA: I'm not aware of any survey data,
3 which I think is where that would need to come from, that
4 actually looks at that specific question.

5 DR. JOHNSON: It is something we've encountered
6 in the focus groups we do with beneficiaries, though, that
7 it continues to be an issue that people don't understand.

8 DR. CASALINO: It is an issue in the focus
9 groups?

10 DR. JOHNSON: Yeah.

11 DR. CASALINO: I don't know if a question or two
12 could be added to our own survey of beneficiaries, but this
13 would be an interesting thing to know, seems like an
14 important data point.

15 Then the last question is -- could we go to Slide
16 14? The second big bullet point, empirically based
17 benchmarks adjust for changes in prices, technology, blah,
18 blah, blah. So this is for the second alternative, using
19 both fee-for-service and MA spending to set benchmarks.
20 But could you say that -- wouldn't this bullet also be true
21 in, just for shorthand, the competitive bidding
22 alternatives? Presumably plan bids are going to -- there

1 are many things that could factor into what plans bid, but
2 presumably they would be considering changes in prices,
3 technologies, coverage, and behavior. So is this advantage
4 unique to Alternative 2, or would it also be true for
5 Alternative 1 and -- well, I guess not for Alternative 3,
6 right?

7 MR. ROLLINS: I think that's the way to think
8 about it. It would also be -- that feature would also be
9 in our competitive bidding system. It's more of a concern
10 for the third option where you have sort of this fixed
11 growth rate over time.

12 DR. CASALINO: Good. Thanks. That's it.

13 MS. KELLEY: Marge.

14 MS. GINSBURG: My question is very much linked to
15 what Larry just said and that is the ability of people in
16 MAs to switch to OM. And it seems to me this is a gigantic
17 issue that has to affect the distribution of clients
18 between MA and OM, since it is my understanding that after
19 the first year that to get a Medigap plan you will likely
20 have to go through medical underwriting, and how often do
21 people do that and are rejected.

22 So as we are concerned with the greater number of

1 people moving into MA, but we know so little about those
2 who are trying to scamper back, if you will, to OM but are
3 unable to succeed, that, to me, is a gigantic issue. And
4 if, in fact, it exists -- and this is a topic for the
5 future -- is there anything we can do to squelch the
6 ability of Medigap plans to reject people?

7 So I don't know, and I don't remember that,
8 perhaps we have, looked more in depth about how often
9 Medigap plans reject applicants. That is, to me, a really
10 big part of all this, and I wonder whether you know a
11 little bit more about this than I am aware of or whether
12 this is something that we might look into further.

13 MR. ROLLINS: So I think some of what you're
14 talking about sort of requires data that we don't have, and
15 frankly, I'm not sure exists. I mean, you can use
16 administrative data to see how many people at MA do migrate
17 to fee-for-service over various periods of time, and I
18 think also there's probably data you could use to see how
19 many of those people do have a Medigap policy at some point
20 after they do go back to fee-for-service. But if you want
21 to look at how many people got back to fee-for-service and
22 then applied for Medigap but got rejected, I think that's a

1 group that we don't have data on specifically.

2 To your larger policy questions, we haven't done
3 -- and Jim can jump in; his memory goes back farther than
4 mine -- the specific rules about sort of Medigap and when
5 it's a guaranteed issue or when it's not is not something
6 that I think the Commission has looked at, at least for a
7 long time and possibly ever. Jim can provide more.

8 DR. CHERNEW: Yeah. To some extent I think -- go
9 ahead, Jim. No?

10 To some extent these issues are common across
11 actually all three of it. So there is a separate issue.
12 You join MA for whatever reason and now you don't like your
13 plan. In fact, your plan changes, that your doctor was in
14 a network and now your doctor is not in a network, and you
15 want out.

16 MS. GINSBURG: [Off microphone.]

17 DR. CHERNEW: Okay. All right. But the point is
18 there could be a whole bunch of other things that happen,
19 your condition changes or something, whatever. And that's
20 probably true in a whole bunch. Independent of how we set
21 up the bidding system or not, I think that issue is a
22 somewhat separate issue of the question about what extent

1 do we rely on bids to set the benchmarks. Because you're
2 always going to have the situation about the rules of going
3 back and forth and locking in selection, and they increased
4 the lock-in to avoid a lot of other broad -- there was this
5 notion where there could be a lot of adverse selection,
6 where originally you could just jump out whenever you
7 wanted, with no penalty. And they found the selection was
8 a lot worse. So by locking it in they've reduced some of
9 the selection.

10 Go on, Betty.

11 DR. RAMBUR: Briefly on this point, I'm curious
12 if anyone has looked at, is it possible, is it valuable to
13 look at the four states that do have guaranteed issue, and
14 is there anything that can be learned about similarities
15 and differences. Thanks.

16 MS. KELLEY: Scott, did you have another
17 question.

18 DR. SARRAN: A procedural one. Are we wanting to
19 or trying to firmly put our thumb on the scale and
20 recommend one of the three options or rank them?

21 DR. CHERNEW: So the answer is certainly at this
22 stage absolutely not. I'm not sure I'll call that a

1 clarifying question, but it is what I was about to say,
2 because I think Scott is the last one in Round 1. Dana,
3 right? So we're about to go to Round 2. So let me say a
4 little bit more about where we are.

5 There is an arc of work. There have been some
6 problems that have been identified. We have to decide two
7 things: to what extent do we want to continue along this
8 path or not -- so this is just a broad path we should keep
9 exploring in a bunch of ways -- and then if so, how we feel
10 about specific things.

11 And I'll tell you what I think the specific issue
12 that's most important to get -- if you have a view, if you
13 don't I understand -- is to what extent should we rely on
14 bids, or could we rely on bids, and the reason why that
15 comes up is in a world where MA is 70 percent, 80 percent,
16 90 percent, you have to rely more and more on these
17 credibility adjustments to make things work. You have to
18 deal with geographic variation and stuff. There's a whole
19 bunch of other things.

20 And so there was, since the beginning of when we
21 were doing this work, as was pointed out, there's been a
22 lot of interest in using bids. And I think for us to think

1 about work going forward, getting a sense of how people
2 feel about bids matters. So I am just going to make a very
3 hopefully quick comment on this.

4 If you go to Slide 12 -- you don't need to, but
5 if you did -- you would see there's a specific kind of
6 equilibrium that's implied of what happens. But, in fact,
7 if you asked a separate question, if there was a monopolist
8 plan and you let them bid, what would their equilibrium be,
9 recognizing that bid would enter. And what you would find
10 is, well, that's not good, and then you would see, as the
11 slide said, well, that could be a problem, as again the
12 staff said, and you might need some other system of capping
13 or doing a whole bunch of other things to guard against
14 that competitive issue.

15 And what matters intently is how people switch.
16 So even if there are five plans, but no one switches
17 amongst the plans, for whatever reason, any one plan has a
18 lot of inframarginal beneficiaries that they know are not
19 going to switch. And they can raise their bid, get a
20 higher benchmark, depending on the system that's set up,
21 and not lose beneficiaries in particular ways.

22 The other problem, which is almost the exact

1 opposite problem, which arises more in the mailing
2 materials, is imagine competition works perfectly. And
3 then if you look at Slide 12 you would see where that
4 works. You would see now they will compete away a lot of
5 the benefits, and so that's where the chapter outlines a
6 mechanism of how you might address that in a policy sense.
7 We are going to give you a certain amount of money to just
8 add on extra benefits, and, of course, depending on what
9 that costs the government depends a lot on how competitive
10 the bidding system is.

11 So there's a lot of underlying dynamics of how
12 this plays out, and I think the question on the table as we
13 go around broadly, in my mind, really hinges on how worried
14 are you about the selection issues as MA gets bigger and
15 bigger and bigger. How do we think about Medicare program
16 where MA is the dominant source of enrollment versus not,
17 and should we address that through the status quo approach
18 -- because we have a bunch of recommendations, cut at least
19 2 percent, et cetera -- or should we think about designing
20 a program that's more reflective of a dominant MA world,
21 and if we do, to what extent do we want to trust a bidding
22 system to set where the benchmarks are, which works great

1 in some models of competition and not so good in others, or
2 to what extent do we worry about a government version,
3 which says, all right, we're moving to a world where it's
4 just a much more kind of budgeted sort of world but make
5 the plans responsible. But, of course, in that world the
6 government can get it wrong, in a whole bunch of ways.

7 And so getting a sense of how people feel about
8 that tradeoff will, I think, be useful in how we think
9 about moving the work forward.

10 MS. BARR: Michael, can I just -- I'm confused,
11 because I thought we were given three options to consider
12 and we're asked to weigh in on the three options. Are you
13 saying that's not the case?

14 DR. CHERNEW: No. You can weigh in on the three
15 options, but we are a long way away from even having a
16 vote.

17 MS. BARR: I thought that was Scott's question,
18 though, is do you want us to weigh in on these options.

19 DR. CHERNEW: That's right. Yes. But there's
20 really two options, even though there's three. The first
21 two are versions of bidding. One of them is just pure
22 bidding. One of them is bidding but it dilutes it a little

1 bit by adding in fee-for-service, but it's still basically
2 a bidding thing. so the one is bidding matters, and it's
3 just a question of how much, and then third one is no,
4 bidding doesn't matter.

5 So when you weigh in on those three options you
6 are effectively going to be answering the question about
7 how you feel about bidding in the MA program for setting
8 benchmarks.

9 MS. BARR: Or how you feel about the government
10 setting the benchmarks. I just want to make clear that
11 there are two options here. I feel like we're being a
12 little bit driven, and so I just want to make sure.

13 DR. CHERNEW: No, actually not at all. In fact,
14 you could also say, "I don't think we should take this on
15 yet because we don't know." That's another reasonable
16 view.

17 What I was trying to say in response to Scott's
18 question is you are not being asked to weigh in on these
19 options the way we are on other things we've done. When
20 April comes there's going to be a bunch of votes. You're
21 going to see a chapter about wage index, a chapter about
22 Part D, where we're weighing in on things, that is really

1 coming close to a vote.

2 Here we are at a much, much, much, much earlier
3 stage. So you're being asked to weigh in on the broad
4 ideas about where we're going. The specific options are
5 much, much less tied down than they would be a year or two
6 down the road.

7 Oh, Jim is going to add another thing.

8 DR. MATHEWS: Yeah. Just to layer onto Mike's
9 comments here, first one minor clarification. The second
10 option does indeed invoke MA bids as a potential source of
11 spending for the MA population under that scenario, but I
12 think the chapter alludes to a potential future world where
13 MA encounter data might also be a source for estimating
14 Medicare Advantage spending. So there's a little bit of a
15 toggle there.

16 The second thing I want to say is very consistent
17 with what Mike said regarding where we are in the
18 development process of this work. So again, nowhere close
19 to recommendations, but it would be useful for the
20 Commissioners to signal where they think some additional
21 analytic work from the staff would be useful to help us
22 start to zero in on which, if any of these, policy options

1 will move towards recommendations in the next cycle.

2 MS. GINSBURG: May I ask a clarifying question
3 about the concept of the options for bidding? Maybe we
4 said it and maybe I missed it. Are we proposing or
5 suggesting, offering the idea that if MA plans are bidding
6 against each other that some will be rejected?

7 DR. CHERNEW: No one gets rejected in that sense.
8 Think of it more that the bids are being used to set the
9 benchmarks. So the benchmarks now, based on fee-for-
10 service spending, and you bid whatever you bid. So they're
11 bidding against each other already, but the rebate amount
12 is based on that. In this world, the benchmark would go up
13 if all the plans bid more. It would go down if all the
14 plans bid less. So the material shows if there was no
15 change in bidding behavior, with bids 15 percent below fee-
16 for-service, the bid would just drop a ton because the
17 benchmark would just be set where the bids are, not where
18 fee-for-service is, and the current bids are well below
19 fee-for-service.

20 MS. GINSBURG: And have we ever talked about the
21 option of, in fact, not approving every MA plan as a player
22 in the area, and is that off the table?

1 MR. KAN: No. I think that's too prescriptive,
2 Marge. I think the best way to think about it, for me
3 anyway, is on page 12. If you look at page 12, look at
4 Plan A. Plan A, currently under the current payment
5 system, the cost is \$1,014. In a competitive bidding
6 scenario, you know, basically the average of all the bids
7 is \$850. So then any member that's in Plan A will have to
8 pay \$50. So in the past the member did not have to pay
9 anything, but now they pay \$50. So this is where then that
10 member would have disruption. Then you may have to switch
11 back to fee-for-service. So that's where all the
12 disruption and switching analysis comes in.

13 DR. CHERNEW: That's right, but we have not
14 considered a situation where a plan bids and we decide
15 there's something wrong with that plan, "I'm sorry, no, you
16 can't serve." Right? It's almost like the exchanges.
17 Plans can be on the exchanges if they want to be on the
18 exchange. They can set the premiums they want. But we are
19 not doing a Department of Insurance oversight on rejecting
20 of a plan.

21 MR. ROLLINS: If I can add just one thing, Mike.
22 I agree that there's never been the discussion of limiting

1 the number of sort of insurers that can participate in the
2 MA market. I think one idea that was sort of, at least in
3 the background in our discussions of standardization in the
4 fall, was that you might not limit the number of insurers
5 that can participate in the MA market but you might limit
6 the number and types of plans that they could offer.

7 DR. MATHEWS: And there is also, Marge, an analog
8 for the idea that you've mentioned in durable medical
9 equipment competitive bidding, where DME suppliers or
10 manufacturers submit bids and then CMS estimates the
11 ability of a group of suppliers to serve a market and will
12 establish a cutoff point above which plans with bids higher
13 than that cutoff are not able to participate.

14 DR. CHERNEW: I hope it's clear the type of
15 things -- we don't need to go into a lot of detail, I
16 think, about this specifically or that specifically, or how
17 would you actually do the cap. It's really a bigger-
18 picture question of what role do you see bidding, or for
19 that matter MA encounter data, in the setting of benchmarks
20 versus not. That's the big-picture question, and if you
21 have a view on that. Some people may not.

22 Anyway, go on.

1 MS. KELLEY: Okay. I have Jonathan first.

2 DR. JAFFERY: Thanks, Dana. I'm not sure we
3 haven't been in Round 2 for about a half hour, but that's
4 okay.

5 [Laughter.]

6 DR. JAFFERY: So first off, this is great. Thank
7 you all so much for the chapter, the presentation. I think
8 it's really enlightening about some of the selection, which
9 is a bit different than some of the other issues we've
10 talked about in terms of how MA overall cost and
11 performance is or isn't compared to traditional Medicare.

12 You know, I do think it's crucial that this work
13 goes on. Kaiser Family Foundation had an article they
14 published, an analysis, just the other day, looking at
15 gross margins that big plans have across the country, and
16 they're \$650 or so or \$700 for Medicaid managed care group
17 and individual market, which, not incidentally, is a lot
18 more -- the people who are providing the actual care are
19 not making a lot of money off of Medicaid managed care, for
20 example. But in MA it was \$1,750. I mean, it's 2.5 times
21 what it is in these other markets. So there's a lot of
22 opportunity here.

1 Thinking about these three options, the middle
2 one, the second one, I definitely have concerns given what
3 we continue to see with the trends. I mean, you mentioned
4 a couple of problems about the encounter data that
5 continues to be an issue for a number of reasons, but
6 certainly the fact that more and more we're seeing Medicare
7 Advantage be the dominant, and in some markets very
8 dominant. It's hard to understand how this would work in
9 every market even today. Puerto Rico comes to mind.
10 That's a place where it's almost all Medicare Advantage.
11 So that could be tricky.

12 But of the other two, when I think about
13 competitive bidding, Mike mentioned how if you had a
14 monopolistic plan, they could drive prices up. I also
15 think that you could get the situation where a large plan
16 actually drives prices down as they enter a market to try
17 and eliminate the competition and the ability of small
18 plans to compete and drive them out of the market and then
19 subsequently raise benchmarks.

20 I think if we do have a competitive bidding
21 process, I agree that a standardized plan, which I know
22 we've already started to talk about a little bit this

1 cycle, would be very important.

2 And I do wonder, actually, if there's an
3 opportunity to pilot something like competitive bidding, so
4 it would have to be a program that rolls out across the
5 country.

6 And then finally, talking about the third option,
7 using a fixed growth rate, I mean, you certainly talked
8 about all the different things appropriately that we'd have
9 to think through and the policy questions. You know, I
10 guess I worried less about is the government going to get
11 it right setting those rates, because, you know, certainly
12 they're not going to get it exactly right and we'll have to
13 adjust. I worry more about the political influence that
14 folks might have on impacting those things.

15 But that said, it feels like there's an
16 opportunity to explore policies in something, and forget
17 about a fixed growth rate language and thinking about it in
18 terms of an administratively set benchmark that gets it
19 closer to what we've been proposing for population-based
20 payments in traditional fee-for-service and ACOs.

21 And so to me the more we align how those programs
22 work in areas like this, where you're talking about how we

1 set benchmarks and not make it difficult to continue to
2 propagate either program and allow them to actually compete
3 in individual markets I think is appealing.

4 So again, it's pretty early, I know, but to me
5 that third option has some potential to think about
6 administratively set benchmarks in a similar way that could
7 be very appealing. So thanks so much.

8 DR. JOHNSON: If I could add, on the encounter
9 data since it's come up a couple of times, we say that
10 there are issues now. I think this future world,
11 envisioning, where I would say that benchmarks are going to
12 be set on encounter data and that plans would then have, by
13 far, the biggest incentive to submit anything bigger than
14 currently now to submit complete and accurate encounter
15 data. So we're assuming that issue would resolve itself as
16 the incentives were increased.

17 DR. JAFFERY: Yeah, that's a great addition. I
18 mean, obviously, as you know, that would help with all
19 sorts of other things. So to the degree that that would be
20 a strong lever for us is a nice idea.

21 MS. KELLEY: Kenny.

22 MR. KAN: Thank you very much for a very thought-

1 provoking analysis.

2 Regarding the three alternate benchmark options,
3 my comments for future cycle analysis are as follows.

4 Option 1. competitive bidding. In addition to the
5 administrative complexity, I'm not supportive of this, as I
6 believe that it will result in a race to the bottom, which
7 will likely result in greater MA consolidation and
8 significant beneficiary access disruption. Currently, the
9 top three MA national players hold 55 percent. Under
10 competitive bidding scenario, maybe that could be 80
11 percent like Part B.

12 Option 2, a plan of fee-for-service in MA. This
13 may have some merit and would suggest that we spend the
14 next one or two cycles understanding the various dynamics
15 and scenarios with a few key assumptions, possibly being,
16 number one, what is the ultimate level of MA penetration,
17 say, 10 years from now?

18 Number two, how do we get comfortable with the
19 credibility adjustment of fee-for-service benchmarks when
20 we reach that level of MA penetration, similar to what Mike
21 mentioned earlier?

22 Number three, how do we think about competitive

1 game theory behavior of MA players under those equilibrium
2 scenarios, and what are guardrails against undesirable
3 behaviors?

4 Number four, potential beneficiary access issues,
5 and is this a technical term, switching analysis in
6 counties with low, medium, and high MA penetration.

7 And after we are able to think through these
8 various assumptions and scenarios and after we have a
9 better understanding of these issues, I would suggest then
10 we look at the totality of it. How do we evaluate the pros
11 and cons of an alternate benchmark redesign and overhaul
12 versus incremental tweaking at the edges? So that would be
13 my comments for Option 2.

14 Option 30 a fixed growth rate benchmark. I don't
15 favor this, as I believe that such a benchmark is more
16 susceptible to political intervention and governed by
17 politics, potentially leading to unsustainable and actually
18 unsound benchmarks. I understand that such a fixed growth
19 rate benchmark may have worked for Medicaid rates in
20 perhaps a fiscally responsible state like Utah. I believe
21 those fiscally responsible states are a small percentage of
22 the union and would suggest that we be very careful about

1 extrapolating that to the broader Medicare program, given
2 the \$32 trillion federal debt.

3 Thank you.

4 MS. KELLEY: Greg.

5 MR. POULSEN: Thanks.

6 So leaping from the fiscally responsible but
7 unusual state of Utah --

8 [Laughter.]

9 MR. POULSEN: I guess just to get this out of the
10 way, because I actually lean a little bit towards the three
11 different approaches may not be our highest and most
12 important focus right now. But because I think that is
13 what we're bringing up, I am biased towards a combination
14 of 2 and 3. I think there's a way to do that in a way that
15 would be clever to prevent what Kenny just talked about and
16 yet would be less amenable to gamesmanship than I think
17 competitive bidding currently is and is likely to be. But
18 I really wouldn't like to jump into that for the focus of
19 my brief remarks.

20 What I would like to say is that there's MA, the
21 way it basically exists today, broadly speaking, which I
22 think is way, way, way under what it ought to be. And then

1 there's MA, the way it was envisioned back when
2 Medicare+Choice was brought into being a couple of decades
3 ago, more than three decades ago-ish.

4 And there are examples of real achievement in
5 that area, both historical and current, and it seems to me
6 that the ideal situation would be to come up with a
7 mechanism that makes those rare examples common examples.

8 Something that is true in the chapter as well as
9 the slides is the perception, which is today accurate, that
10 favorable selection exists whenever MA costs are lower than
11 the risk scores would predict. That's probably true today,
12 by and large. On the other hand, that is really what we
13 should achieve. What we'd like to do is to say here's a
14 population that has this level of underlying illness burden
15 and other situations, and here's what we would expect, but
16 oh, by the way, what we'd love is to find ways to keep
17 those people healthier than they're expected to be,
18 spending less money than they are expected to spend. And
19 that's what we should aspire to in MA. Anything else than
20 that, then all we're really doing is transferring the
21 administrative burden from CMS to private organizations,
22 and CMS has demonstrated it's very capable of doing

1 administrative stuff. I think if that's our -- if that's
2 all we hope for from MA, there's no reason to pursue it.

3 But I think there is a reason to pursue it. I
4 think we have some really good evidence from organizations
5 both that exist today and have existed historically that
6 it's not -- it's not silly to expect that we can change the
7 trajectory of people's health, that we can help them to
8 live healthier and happier lives at less expense to the
9 government and to themselves.

10 I do agree that the current risk scoring is
11 deeply flawed, and I know you all have heard me say this,
12 but I feel like it can't be repeated too much. No other
13 insurance mechanism uses this basic approach, not large or
14 small group commercial plans, not individual coverage, not
15 the ACA exchange plans. None of them use the kind of risk
16 scoring that we use in MA, and I think it's deeply flawed
17 because it leads plans to put their primary focus -- the
18 easiest way to be successful in MA is to maximize your risk
19 scoring, and we see that if we compare -- it's in the
20 chapter -- if we look at a population and the risk scoring
21 in traditional Medicare versus their scoring when they're
22 in MA. They don't bear a strong resemblance to each other,

1 and it always goes one direction, no surprise.

2 So I think that to come up with a different and
3 better way of scoring risk or identifying what the risk of
4 a population of Medicare Advantage enrollees is is job one,
5 and I think it's doable. And we've got examples in the
6 other insurance mechanisms that already exist in the United
7 States today and including in some government programs.

8 If we look at other ways of identifying risk
9 profiles in a group, we can follow the principles that are
10 already in place, as I mentioned. I would point that when
11 -- that there's good reason to be optimistic that this can
12 really be -- achieve
13 great results. I think that there's demonstrations over
14 the years of places where populations of the same people
15 have been cared for in a way that reduces spending by
16 meaningful and -- meaningful amounts, enough that would
17 really catch people's attention, while simultaneously
18 having enrollees that are both happier and healthier. And
19 isn't that the ideal that we're really after?

20 I would just one point to one thing. I know we
21 all agree -- I think we all do at least that stars ratings
22 are far from perfect, but they're not also completely

1 without some validity in terms of mentioning some
2 difference between the way plans are meeting the needs of
3 their enrollees. If we accept that as even true to an even
4 minimal extent, I think it's just really interesting.

5 If you go back to 2019 -- and I'm just going pre-
6 pandemic because it's clean and you don't have a whole
7 bunch of other chaff in the air. So the last year that was
8 pre-pandemic, the roughly 3,500 MA plans in the country, 20
9 of those, just 20, or five-star rated in that year.
10 That's a pretty small percent. Duh. But if you look at
11 those, 13 of those 20 were in plans that had prepaid or
12 provided value-based incentives to their providers, 13 of
13 the 20, and yet there were only 221 plans that were -- that
14 we're paying that way. So 13 out of 221 versus the
15 remaining 7 out of 3,350, that's roughly 30 times more
16 likely to get a five-star rating for those plans that
17 incentivized correctly the providers that they were working
18 with.

19 Why isn't everybody doing that? Because that's
20 not what's rewarded today. You can make more money by
21 doing the easy lift of increasing the risk score than you
22 can by doing the hard lift of actually getting providers to

1 change the way care is delivered and put more -- give them
2 the incentive so that they're rewarded when people are
3 healthier.

4 Today everybody in almost every aspect except
5 those 220 plans, everywhere else everybody makes more money
6 when people are sicker. And those 221 people make more
7 money when people are healthier, and it makes a huge
8 difference. And I think if we could move down that
9 pathway, we would be enormously benefitted.

10 I commend you all for your chapter because I
11 think the points you make are right on, and I think that we
12 have a pathway out of this if we will pursue it. It will
13 take some hard work on our part, though.

14 MS. KELLEY: Stacie.

15 DR. DUSETZINA: Thank you so much, and then thank
16 you for a great chapter.

17 I guess I'm a little bit torn here. One of the
18 things that I think Amol brought up really nicely was this
19 issue of the analysis presented of those switchers, and I'm
20 not exactly sure how to get to the right spot with that.
21 But I do worry that there is some bias in there for the
22 people who aren't moving versus who are moving between

1 traditional to MA. And I guess the way I would think about
2 this is kind of a "don't rock the boat" if you are healthy
3 and doing fine. Well -- or if you're healthy and doing
4 fine, you may actually be willing to rock the boat because
5 you're like, you know, maybe I can save more money or I
6 want to go and get some vision or dental benefits or
7 something like that. But if you're not well and you're
8 interacting with the health care system, you might just be
9 like I know what my plan is, and I don't want to move. So
10 I just worry a little bit about that analysis and who's
11 represented and who's not.

12 So I think the comments early on about trying to
13 get a little bit more of a big picture, who's in which plan
14 from the start and who's moving around would be really
15 helpful just contextually. I know that's hard to get, and
16 I know you can't replicate the same analysis that you did
17 because of the lack of the same data on the MA population
18 in the pre-period.

19 I guess for the options, Kenny has made me second
20 guess my actually liking the cap -- or the competitive
21 bidding with the cap. I really appreciated the way that
22 you all described the potential for gaming there, and I

1 completely agree. I think that sounds like why Kenny also
2 doesn't really like this is that there's so much
3 consolidation within the MA market that you could imagine
4 gaming in either direction, like gaming it to get all the
5 way back up to the same fee-for-service level or gaming it
6 to race down to the bottom. So I guess that was
7 conceptually the one I liked the most, but I also
8 appreciated the additional comments from Greg about -- and
9 Kenny about the fee-for-service and MA and trying to use
10 all of that information.

11 So I guess I'd say least interested in No. 3, but
12 I would like the idea of exploring a little bit more the
13 competitive bidding, and going all the way back to Scott's
14 Round 1, that was the first thing I wrote down is like,
15 "What was the fatal flaw of this for the ACA?" Is there
16 something, some sort of landmine we don't -- we want to
17 avoid around the competitive bidding to not go too far down
18 that path because maybe it's really contentious in a way
19 that would make it unproductive for us to spend a lot of
20 time trying to go down that route?

21 But excellent work, and thank you all very much.

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

1 wouldn't characterize what Kenny described or what you
2 described as "gaming." That's just the way competition
3 works. So if you looked at the prices that are set in
4 consolidated markets for hospital services and they're
5 charging high prices, right, that's not gaming. It's that
6 they have -- you've set up a system where they get to set
7 the price, and they compete with other hospitals that set
8 the price. And if there aren't a lot of other hospitals,
9 the price goes up.

10 So you've fundamentally set a model where you
11 have created a competitive dynamic to set the price. If
12 The competition isn't working, the prices are really high,
13 and if you set the prices in the government system like you
14 do in, say, Medicare, the prices turn out to be
15 substantially lower. Are the prices too low? I don't
16 know. We had a whole chapter that's going to come out on
17 whether the prices are too low, but at least you don't have
18 to worry about the competitive model that's working for
19 setting hospital prices.

20 So, again, this conversation can go on. My only
21 point is if you think of the -- if we were having this
22 exact same analysis, should we have competitively bid

1 hospital prices or should the government set fee schedules
2 for hospital prices, this discussion would probably go
3 something like, well, it really works well for competition
4 for setting hospital prices if competition works, but if
5 competition doesn't work, we get commercial prices that are
6 extraordinarily higher. And the government actually sets a
7 better rate, albeit too low in some -- potentially too low;
8 hence, what we do. And so I'm not arguing which is right,
9 but I think that's the analogy. If you were thinking about
10 this exact same question, do you want competition to set
11 hospital prices or do you want the government to set
12 hospital prices, and you ask how that plays out, you have
13 to work through the equilibrium of what you think will
14 happen.

15 And that' where I think this core tension is, and
16 so the competitive bidding models, if you were to write
17 them down on how they work and you believe people switch,
18 say, in most hospitals, you would get really low hospital
19 prices. It would be very competitive, and it -- so that's
20 not how competition in the hospital sector, for example,
21 has largely been working.

22 Boy, I'm waiting for -- you can reach us at

1 meetingcomments@MedPAC.com or via Twitter to complain. But
2 I think that's --

3 UNIDENTIFIED SPEAKER: It's dot-gov.

4 DR. CHERNEW: Dot-gov, whatever.

5 Anyway, sorry. I think that's -- my only comment
6 -- I'm sorry for being so ranty -- is I think fundamentally
7 it's not a gaming issue. It's fundamentally an equilibrium
8 issue when you're allowing different organizations to
9 basically determine through competition what they're paid
10 and how well you think that will or will not lead to the
11 outcomes that you want, and again, I both am relatively
12 speaking pro-market and then relatively concerned that it
13 doesn't work well in health care. And that's the tension.

14 Anyway, that was also --

15 MR. SERNA: I wanted to respond to Stacie's --

16 DR. CHERNEW: Oh, please.

17 MR. SERNA: -- concern about people who weren't
18 included the analysis. So the available data that we had
19 on the people that we weren't able to include suggests that
20 favorable selection would actually be greater, and those in
21 the sensitivity analysis that we did, they're actually in
22 the footnotes. So we looked at those who were nearly newly

1 eligible, right? And so their initial favorable selection
2 was actually greater. It was when they initially would
3 have entered MA. It would have been 85 percent as opposed
4 to 95 percent for the cohort that we were actually able to
5 include. So just -- I just wanted to set that straight.

6 MS. KELLEY: Amol.

7 DR. NAVATHE: Andy, Luis, Eric, this is really
8 terrific work and I think really fundamentally important
9 and really commend and thank you for it.

10 I have a few high-level comments and then kind of
11 a hit list of nice features, features to worry about as we
12 can go forward.

13 So my first comment is kind of very generally
14 about framing. I think I have a decent sense of what we're
15 empirically trying to uncover here with the favorable
16 selection analysis, and I think we then use that as kind of
17 a launching pad to go into why we might consider
18 alternative ways to set benchmarks.

19 My concern here is that I think there's a lot of
20 complexity in this market. There's a lot of complexity in
21 terms of what plans are doing, in terms of what
22 beneficiaries are doing, et cetera, et cetera. And I think

1 while your analysis obviously contributes to what we
2 understand of what's happening, I don't know that we
3 necessarily need to, quote/unquote, prove the point on
4 exactly specifying the level of favorable selection and
5 generalize it. Of course, we want to do as credible
6 analysis as possible, because I think there's a whole
7 number of other reasons that we might think that there's
8 opportunities to put some -- or gain some efficiencies in
9 the MA program.

10 We know there's a number of program design
11 issues. There's stars. There's how the quality program
12 works and adding dollars. There's the way that plans that
13 work -- national plans that work in multiple markets have
14 some advantages in terms of how they group sub-plans or
15 counties and states and such together. So I think there's
16 a whole number of reasons, including where we see the bids
17 currently are, relative to the benchmarks that suggest that
18 there is great opportunity here for the federal government,
19 the Medicare program, taxpayers, and beneficiaries to get
20 some more efficiency while accomplishing the types of aims
21 that Greg is pointing out in terms of better value, better
22 quality, changing the trajectory of clinical care.

1 And so I feel to some extent that we should
2 broaden our motivation here and include this selection
3 analysis as part of it, but I think take some pressure off
4 of it, to some extent, because I don't think we need it as
5 much as -- currently, I think it's sort of implied in the
6 paper, and I think that will actually help a lot.

7 Second thing I wanted to say is that I won't
8 restate all the empirical suggestions that I made in Round
9 1, but I think those would be generally helpful to do
10 because I think it will help us understand the contours of
11 what's happening here on the observables. Of course, on
12 un-observables, it's harder to know.

13 Andy, I think it was either you or Luis. I can't
14 remember. I think it was you, Andy, who mentioned
15 something about differential coding as being a challenge in
16 looking at things like cancer diagnosis. I think, if I
17 understand correctly, we're using fee-for-service data to
18 identify diagnoses. I don't think differential coding
19 specifically is confounding that type of analysis, although
20 I understand your general point about differential coding.
21 So I just wanted to make sure to make that point.

22 Okay. Now moving to the kind of transition of

1 the policy option pieces. So I'm struck here that there's
2 a tremendous amount of complexity. Mike has alluded to it
3 in many of his comments. Ken, you brought it up. I would
4 find it helpful -- and I think MedPAC has done this. We
5 did it as part of our APM work. I think we've done it as
6 part of other work, the prescription drug space --
7 otherwise, where we've outlined some principles that we're
8 trying to get at in terms of how we can make the MA program
9 work better and more efficiently. And I think without that
10 as kind of a scaffolding from which to jump, it's hard, to
11 some extent, to understand where we might be making
12 tradeoffs. Inherently, we're going to be making tradeoffs,
13 and the question is, are those tradeoffs worth it? Is what
14 we're giving smaller than what we're getting? And I think
15 it's hard to know that unless we have some kind of
16 organizing frame.

17 So if I take a step into that, for example --
18 Mike has outlined that, you know, how competition works may
19 vary. It may vary it may well. It may well vary
20 tremendously geographically, because we know that MA
21 penetration, MA competition in markets, also in terms of
22 number of plans available, varies a lot.

1 But I think if we take a step back and say what
2 are we trying to accomplish, I think we're trying to
3 accomplish a more efficient MA program.

4 I think, generally speaking, this notion of an
5 empirical-based benchmark where using what is actually
6 happening in terms of prices, technology utilization, as a
7 way to inform a system that is kind of able to adjust
8 itself over time relative to something like an
9 administrative benchmark, where we would need policymakers
10 to come together and decide what that growth rate is or
11 something like that, I think that's a tension. We could
12 identify some kind of principle around that, that would
13 help guide our ideas.

14 I think the standardized benefit is something
15 that I strongly support. I think it would help
16 beneficiaries a lot. Again, we could define whether that's
17 something that the Commission supports in terms of our
18 principle going forward and how that would then fit into
19 the system as we think about it going forward.

20 Another element is supplementary benefits and how
21 we want the supplementary benefits to work. So a concern
22 around a competitive bidding type solution would be

1 potentially that you could compete away all the
2 supplemental benefits. And we as a Commission and
3 certainly the beneficiaries as they seem to be voting may
4 suggest that that's not really what the beneficiaries want.
5 That may not be actually what's right for our system. And
6 so preserving some element, some degree of supplementary
7 benefits, while also counterbalancing that with getting
8 value out of those benefits. But right now I think there
9 are concerns that we may be in a situation where the
10 government is paying for supplementary benefits that either
11 don't provide much value or in some cases may not even be
12 used by many of the beneficiaries. And so having some
13 rationalization, if you will, or some approach to get value
14 out of those while preserving that might be another
15 principle.

16 So I'm just stepping through several of these
17 ideas because I think it might be helpful for us to codify
18 them, particularly since we're not at the point where we're
19 trying to vote on recommendations but really kind of lead
20 us to the right policy options. I think this might be very
21 -- particularly helpful.

22 The last point I'll make is I think to the extent

1 that we were to take on -- actually, sorry. One other
2 principle to note was around the encounter data as well, so
3 I think Jonathan brought that up. I think you all did that
4 principle of creating incentives to get better encounter
5 data, improve transparency of the program writ large.

6 The last point I wanted to make is I wanted to
7 support Jonathan's idea, which is that to the extent that
8 we were to suggest a larger shift where there might be a
9 lot more in terms of unknowns of how plans might respond
10 and how beneficiaries may be helped or harmed, the idea of
11 potentially, to the extent that it would be possible, to do
12 a pilot under CMMI or something like that might be a very
13 attractive way to address some of the uncertainties that
14 could then serve as a basis for more confident, if you
15 will, policymaking.

16 Thanks. Great work.

17 MS. KELLEY: Lynn.

18 MS. BARR: Thank you, guys. Terrific chapter.
19 You know, I'm going to counter Amol's comment about the
20 favorable selection issue that you raised. I thought it
21 drove the point home to me that things are actually worse
22 than I think, and the more data we can put in front of

1 policymakers, you know, we've got to get them to move. And
2 so I think it was very powerful data, so I certainly
3 continue in the future.

4 And, you know, as a general comment about the
5 whole program, we need to fix HCC coding because that is
6 the fundamental issue that, you know, is underlying a lot
7 of this craziness that we're dealing with.

8 As I looked at the options, I had -- my framework
9 for looking at them were four things. One of them is
10 accuracy. You know, what's going to give us the right
11 answer. What's the fair price, you know, that we should
12 pay for these services?

13 And when I think about the next three, I think
14 about them across the stakeholders. So we have patients,
15 providers, and plans -- right? -- and all of them need
16 different -- you know, have needs that we need to address.
17 And what I think about what they need is stability,
18 simplicity, and trust -- right? -- and that we need to
19 think about those three things for all three of the
20 stakeholders and think how these different options fit in.

21 I feel like when we talk about stability, Option
22 1, you know, feels to me like a patient might have a co-pay

1 one year and not a co-pay the next year and might have a
2 co-pay the -- you know, and they've got to stay in a plan.
3 It feels like that's going to be a very unstable system for
4 the patients, and I worry about that, and for the providers
5 and plans as well.

6 When I think about simplicity, what I liked, what
7 you mention in the paper as Option 2 is the most current --
8 similar to what we're doing today, you know, with the least
9 amount of disruption. Isn't that right? And I think that
10 disruption is important. We are disrupting everything for
11 people, and the least we can disrupt and get a good
12 outcome, we should lean towards that, you know, because of
13 the burden that we put on both the plans and the providers,
14 and the patients, to try to figure out what the heck we're
15 doing now.

16 You know, and so simplicity is very important, I
17 think, but also trust. And I don't know if we think enough
18 about how much providers don't trust payers, right? And
19 we're a payer. So if Medicare is setting the rates or if
20 we are -- you know, in Option 3 we're doing administrative
21 benchmarks, there's going to be a -- there is a huge trust
22 issue, which is worse in some parts of the country than

1 others. I would say that, you know, in the rural parts of
2 the country there's more of a trust issue. And it is very,
3 very uncomfortable for them to be -- that these are numbers
4 that could be potentially driven by politics.

5 So I strongly support looking -- hopefully
6 getting the data and looking at a blend on Option 2, and in
7 your analysis trying to understand, you know, stability and
8 doing some modeling on stability and simplicity in terms of
9 what is the burden that we're asking for with these
10 different options.

11 Thank you.

12 MS. KELLEY: Betty?

13 DR. RAMBUR: Thank you very much. I really
14 appreciate this work and the comments. I think it was at
15 my very first MedPAC meeting I sort of slammed my fist down
16 saying, "We need to do something about this," and, of
17 course, I had no idea how complicated it was. So I just
18 want to say how much I appreciate all the work you've done.
19 It's really impressive.

20 So in reading the materials -- perhaps I'm
21 channeling Stacie a little bit here -- my immediate
22 instinct was that the comparative bidding with the caps was

1 the way to go. If Medicare Advantage is supposed to be
2 putting some market forces into Medicare, that seems
3 logical to me. And I understand, and, Kenny, you really
4 have made me now rethink this, but is there a way the
5 guardrails can be in there so that that can work. That was
6 appealing to me.

7 I initially was very not excited about number 2
8 because keeping the fee-for-service benchmark as a part of
9 it seems inherently flawed to me. But I also heard that
10 that should be explored more. And I just wasn't excited at
11 all about number 3 for whatever reason. But I think that
12 there is -- you know, it's worthwhile to continue to look.

13 I think the last thing I want to say is, Greg, I
14 really appreciate what you said about what are we really
15 trying to do, so I agree with the what. What I don't see
16 at all -- and probably somebody else can or we could craft
17 it -- is the how. What is the how to that? What's the
18 specific policy recommendation we could make?

19 So I agree with -- is there a way, you know, to
20 really take this on so it really impacts people's health
21 and well-being? But I can't trace that through these
22 different options or other options. But thank you very

1 much for really excellent work. It will teach me not to
2 pound my fist, right?

3 MS. KELLEY: Robert?

4 DR. CHERRY: First, I want to thank the staff for
5 really a well-articulated document because it clearly tees
6 up the problem and the robust discussion that we're
7 currently having. To answer Mike's overriding question, I
8 do favor continuing with this work.

9 Among the choices, I don't think there's any bad
10 choices. They're probably all an improvement related to
11 the current state. It's a series of compromises and what
12 we're most comfortable with, and it's likely at the end of
13 the day it will be a blended approach among these and maybe
14 some other ideas as well.

15 So just, you know, looking at the three options,
16 the first one, which is the bidding option, does seem
17 rather straightforward, but there's no real, you know,
18 pricing control here. I think there does need to be some
19 sort of minimum floor to make sure that the plan operates
20 safely in terms of the case that it's delivering and
21 probably some sort of cap to make sure things don't really
22 get out of control. So, you know, having that in place

1 would be helpful.

2 In terms of the second option, the idea of using
3 MA and fee-for-service together intuitively makes sense,
4 and it seems relatively straightforward. And so you start
5 thinking about MA encounter data, and it seems like every
6 meeting I've been here -- I'm a new Commissioner -- this
7 comes up at every meeting in terms of data integrity with
8 regards to MA encounter data and the limitations associated
9 with that. So the idea of using that data does make me a
10 little bit apprehensive in terms of the second option.

11 And then in terms of the third option, you know,
12 with a fixed growth rate with administrative adjustments,
13 may seem reasonable as well, but I'm concerned that the
14 administrative adjustments are rather resource-intensive
15 and it doesn't allow for long-term planning for the various
16 MA plans that are out there. You know, if you don't know
17 what next year is going to look like, it's hard to have a
18 normal three-year business cycle and forward-looking
19 planning.

20 I do agree that there should be some overriding
21 principles that, you know, for me I did drop down, you
22 know, a few of them. One is that I think some of these

1 plans do a good job of using their rebates and cost savings
2 to invest in other services, like dental and vision and
3 hearing, and I think probably some beneficiaries actually
4 find that attractive.

5 I think also that there's probably other back-
6 office operations that MA plans need to invest in for their
7 beneficiaries, and that includes case management,
8 navigators, patient educational materials, things that
9 really provide for, you know, targeted care for complex
10 patients, and that would avoid, you know, flights to fee-
11 for-service, which has been articulated as a problem.

12 Then that translates into sort of a third
13 principle, which is making sure that these MA plans in some
14 ways are incentivized for population health and improving
15 the overall health and quality of their beneficiaries.

16 So I'm looking forward to further discussions on
17 this. I don't have any -- you know, right now any
18 predetermined conclusions about, you know, which of these
19 options is best, and am just waiting for more iterations to
20 come in future discussions.

21 Thank you.

22 MS. KELLEY: David.

1 DR. GRABOWSKI: Thanks. So, first, I really
2 appreciate the staff's work on this issue. I wanted to
3 start, similar to Amol, with the issue of framing. The
4 first part of the chapter really focuses on favorable
5 selection in MA. There's a huge academic literature on
6 this topic, and I'm a little bit concerned about how much
7 value our work adds on top of this really well-developed --
8 I can't think of too many areas in the academic literature,
9 in the health economics academic literature, that have been
10 sort of more developed.

11 I'm not typically a big fan of the sort of
12 switching analyses that are presented in the chapter.
13 Given the amount of work that's been done on this, I just
14 don't know how much value we're going to add on top of
15 that. And I think the more important point that Amol made
16 was that I don't know that it's necessary to sort of
17 connect the dots and prove the point. We know that the MA
18 benchmarks are flawed. We've been saying that since I came
19 on the Commission in 2017. We have lots and lots of work
20 on that issue. I don't think we -- to once again use
21 Amol's great sort of phrase there, we don't need to prove
22 that point. I think that's well established. And so I

1 really like Amol's point about reframing the chapter. We
2 don't need to connect those two dots between, you know,
3 that we have favorable -- or that we have selection issues
4 in MA and that we need to reform the benchmarks.

5 Going to the second part of the chapter in terms
6 of options for reform, I agree with Robert. All three of
7 the options I think would be an improvement on the current
8 system. I tend to favor, like Stacie and others, the
9 competitive bidding. I appreciate Kenny's point. That's
10 why you need those guardrails and caps that were put
11 forward in the chapter. This is not unconstrained.
12 There's going to be kind of checks and balances there. And
13 if those are put in place, I'd love to see us kind of
14 continue to work on that particular option.

15 Thanks.

16 MS. KELLEY: Scott?

17 DR. SARRAN: Four very brief points.

18 First, I'd reinforce the importance of continuing
19 the work. The favorable selection issue, you know, is a
20 huge one and the issue of being able to deal more
21 effectively with high MA penetration counties as fee-for-
22 service dwindles. So I think we, you know, just have to

1 keep going down this road.

2 Second, I would reinforce what Jonathan and Amol
3 already did, which is we've got to have accurate and
4 complete encounter data from MA plans. So I think anytime
5 we have the ability or the opportunity to reinforce that in
6 our public statements, we need to and should do that
7 because more and more that's foundational.

8 Third, in terms of the three options that are
9 laid out, in a much more gut-driven, less rigorous and
10 quantitative way than Kenny and Michael and others did, I
11 came up with fairly similar take-homes, which is the Option
12 1, the pure bidding option, whether you call it gaming or
13 you just call it, Michael, an appropriate reaction in a
14 compliant fashion of smart players in an imperfect market
15 that will always be imperfect, it's just -- there's just
16 too much chance that we race to the top or bottom and have
17 unintended consequences. So I just -- I'm not sure there's
18 value in continuing to develop that.

19 Option 3 -- and I'm a little bit like Goldilocks
20 or Gandalf choosing the passageway in Moria, but just --
21 you know, the ability to be whipsawed year to year or
22 administration to administration on political grounds just

1 feels wrong for something we are trying to get to behave
2 like a market, to the extent possible. And so Option 2
3 just feels right, so I would like to see Option 2 to
4 continue -- more work to be done to continue to develop
5 that.

6 Fourth and last comment, I'd certainly reinforce
7 Lynn and Greg's points about the HCC system. I more and
8 more over time just believe it's fundamentally broken and
9 should be replaced. Rather than, you know, trying to rehab
10 a house, it just should be torn down.

11 And the last point of my last comment is that
12 it's around Greg's -- your comment that we really need to
13 try to hold MA to be what -- make MA be what we wanted it
14 to be when Medicare+Choice was first put in place multiple
15 years ago. And I'd suggest that the best marker of MA
16 becoming what we want it to be may well be if we're sitting
17 here, whatever, three years from now, looking at truly
18 widespread documented adverse selection in MA, because if
19 MA works the way we want it to work and beneficiaries
20 behave reasonably rationally, which, you know, most
21 beneficiaries reasonably do most of the time, then the
22 sicker you are, the more you would want to be in an MA

1 plan, because you've got somebody who is helping you
2 navigate, you've got a provider who's paid on a value-based
3 mechanism, you've got a network that's appropriately
4 curated, and you've got a plan that is chasing well-
5 thought-out, outcomes-based incentives.

6 So, you know, at the end of the day, I think
7 anything we can do to kind of keep that as -- you know, MA
8 being what we want it to be as our North Star is very
9 important.

10 MS. KELLEY: Larry?

11 DR. CASALINO: Yeah, I'm very glad that we're
12 doing this work, and I hope we will move forward quickly.
13 I don't want to lose sight of the big picture while talking
14 about technical details. The big picture is that, you
15 know, by MedPAC's own analysis, and other people's as well,
16 we're giving right now I think about \$20 to \$30 billion
17 extra a year to MA pans, and from 2007 to 2023 MedPAC's
18 letter to CMS the other day, just for coding alone, \$124
19 billion of extra money given to MA plans. This is really
20 not the time to be doing that now with the Medicare budget
21 and the federal budget more generally.

22 Also, you know, this money is being used to

1 reshape the health care system rapidly in ways that may or
2 may not be desirable, but are probably not reversible. So
3 we give \$120 billion to large health insurers, basically,
4 and they use it to buy medical groups around the country,
5 and there's various ways that that can increase their
6 profits.

7 So I do lean toward Option 1. It doesn't involve
8 the government pretty strongly. It doesn't involve the
9 government in setting prices or growth rates. I'll talk
10 about Option 2 in a moment. It completely deals with
11 favorable selection, which Option 2 doesn't really do very
12 well at all, in my opinion. It keeps us from having to try
13 to play Whac-A-Mole with HCC scoring, which CMS is trying
14 to do a little bit right now.

15 I am worried about the impact of plan market
16 power in a lot of markets with Option 1 and how the
17 competitive dynamic might play out. I'm not an expert on
18 this by any means. Mike has referred to it a few times.
19 But I think there's pretty big literature on what happens
20 when there's a potentially small number of bidders in a
21 competitive situation. And I'd like to see more explicit
22 attention to that, hopefully, you know, well-informed

1 attention.

2 There are ways to deal with possible undesirable
3 effects in that situation, I think, and actually a couple
4 are mentioned in the chapter, but very briefly. So I'd
5 like to see a lot more on that.

6 One idea that wasn't mentioned -- and this is off
7 the top of my head, it may be naive -- would be -- we're
8 worried about market power -- not to weight bids by
9 enrollment when we're using the bids to calculate a
10 benchmark. So that's it for Option 1.

11 Option 2 I think is a non-starter. There's
12 declining fee-for-service enrollment. The selection issues
13 would still be huge. I think any option -- and Greg keeps
14 talking about this. Any option that depends on HCC scores
15 is fundamentally flawed, and it's just going to be forever
16 a losing game of Whac-A-Mole.

17 Then the last point on Option 3, you know, I
18 would have picked that myself over Option 2, but I think
19 it's inferior to Option 1. It's just too hard to predict
20 growth on this scale in any accurate way, and I think also
21 setting the benchmark to start with would also be difficult
22 politically, very fraught but also difficult to do well.

1 So I would lean toward Option 1. I hope we can, in any
2 case, move the work forward as quickly as possible.

3 MS. KELLEY: Jaewon?

4 DR. RYU: Yeah, thanks. I agree with many of the
5 comments that were already made, but I gravitate, actually,
6 to Option 2 for some of the comments that Scott and Kenny
7 and others have made. I think if you think about the two
8 challenges that at least the chapter laid out, one being
9 the declining fee-for-service enrollment and some of the
10 challenges related to that or the credibility issues of the
11 current approach related to that, and then also the
12 favorable selection, the movement between MA and fee-for-
13 service, that option actually seems to address both, the
14 favorable selection being address because now you have both
15 fee-for-service and MA in the pool of data that you're
16 using to calculate the benchmark, and then the declining
17 fee-for-service because, again, everybody is in the pool of
18 what you're factoring in to assess the benchmark.

19 I think Option 1, I think the big thing that
20 concerns me there is it seems to propagate and maybe even
21 further reinforce a fairly concentrated market, and I think
22 longer term if you play that out, I think it has the

1 potential to backfire, leading to less competition, not
2 more, which is kind of ironic.

3 And then Option 3, I was just trying to play out
4 in my mind what that would look like, and it seems
5 administratively cumbersome, and it also seems like it
6 would lead to even more kind of lagging dynamics to create
7 these adjustments that have to factor in what's going on in
8 the market.

9 So for those reasons I landed at number 2.

10 MS. KELLEY: That's all I have in Round 2 except
11 for Cheryl.

12 DR. CHERNEW: I think Kenny wanted to say
13 something.

14 MS. KELLEY: Okay.

15 MR. KAN: I understand the concern about HCCs.
16 One thing to be mindful of is that in the latest CMS
17 advanced notice, CMS, by updating the risk adjustment
18 model, will help allay a lot of the comments on HCCs. So
19 just one thing to be mindful of, so I just wanted to make
20 sure I pointed that out.

21 And number 2, regarding competitive bidding,
22 maybe we should take a look at situations outside of MA.

1 I'm a plus-one on Jaewon. I remember 10 to 20 years ago
2 when generic drugs -- this was the game, basically, when a
3 drug went generic a lot of competitors came in and they
4 drove the price of generic drugs to under 10 cents on the
5 dollar, even 5 cents on the dollar. Then all the small
6 players get squeezed out, you have a few larger players
7 left, and then it went back. And it's concentrated, and
8 it's like 20 cents on the dollar.

9 So we just need to be mindful of that. So it's a
10 similar dynamic as playing out right now in the EV space.
11 Tesla has the first mobile advantage. I mean, we were just
12 talking at dinner last night that they're dropping the
13 prices. They hope to squeeze out a lot of players, and
14 when the market gets bigger guess who wins?

15 So we may want to think about all of those
16 dynamics and what [inaudible].

17 DR. CHERNEW: Cheryl, and then I'm going to make
18 --

19 MS. KELLEY: Okay. Cheryl. She says, "This is a
20 terrific chapter and I thank the team for the excellent
21 work." She supports the Commission continuing to explore
22 alternative approaches for setting benchmarks given the

1 continued growth in MA, if the current approach to setting
2 benchmarks is not viable in the long run.

3 A key issue she continues to struggle with is the
4 tension between achieving savings for the Medicare program
5 versus continuing to make MA an attractive option via
6 provision of supplemental benefits that are paid for by the
7 taxpayers, which is problematic.

8 She favors continuing to play out the competitive
9 bidding with some tweaks to deal with issues like market
10 concentration. She likes the idea of standardizing
11 benefits to promote competition and to make comparisons
12 easier as this market is so difficult for any consumer to
13 navigate, which hinders plan switching.

14 Mike?

15 DR. CHERNEW: I don't know. I need a drink, and
16 for me that means soda.

17 Anyway, so this has been a great discussion. I
18 have an enormous number of reactions that I think we're
19 going to have to regroup on, so let me start by first
20 thanking you all for your comments.

21 I am not sure where this is going to go. I'm
22 going to make one big-picture comment. I hear the

1 enthusiasm for going forward and I share it. That's why we
2 got here. I also understand there's a big opportunity cost
3 in going forward, and I only want to go forward in some of
4 these things if we can solve them.

5 I'll just lay my cards on the table and give my
6 personal view. In most markets where we have relied on
7 competition in a range of ways in health care, a whole
8 series of dysfunctions have arose in ways that we then say,
9 well, we've yet to find a tweak or a cap or a regulatory
10 thing, and it goes back and forth, and you end up in
11 something that is often -- Kenny gave one example. I think
12 you could think about this.

13 Larry, so much of your work is around private
14 equity and how competition works for health care services.
15 The notion that if you let plans do the bidding you would
16 not find situations where -- the first part of this chapter
17 is on selection. Imagine a world in which they selected
18 high SES or low demand patients. They'd lower or drove out
19 other prices. Because you get it. You're serving a sick
20 population, gets driven down. If a deep-pocketed plan or a
21 plan that selected better than you bids lower than you.

22 And so we get put in this very complicated

1 dynamic of how that plays out. And so what I hear, I hear
2 a lot of enthusiasm for going forward with competitive
3 bidding, and again, just so you know, I was asked by Jim,
4 should we have competitive bidding in this thing, and you
5 can probably tell I'm skeptical of it. I said yes, because
6 we should have this discussion. I'm glad we had this
7 discussion.

8 But I will I think the reaction of, well, there
9 are these problems but may be if we put guardrails we'll
10 fix them, is kind of a level of optimism that's well beyond
11 at least where I am. But I'm not opposed to trying to find
12 what they are, so we will continue that process.

13 But what I hear is you really need to think
14 through what you think the longer-run equilibrium of the
15 process will be as opposed to not, and that is a -- I think
16 it was where Scott was -- that's risky in a lot of
17 settings, depending on how it plays out.

18 DR. CASALINO: If I may, we could really use help
19 with this as Commissioners. I take what you're saying and
20 what Kenny said and what Jaewon just said really seriously.
21 But it's really a specialized area in which I think there
22 is experience and literature. And it would help if we

1 could be more informed.

2 DR. CHERNEW: Myself too, by the way, and I think
3 that's right. So I think that's the type of work we need
4 to do.

5 The other problems which I think is just true --
6 and I'll just make a general comment -- I 100 percent
7 appreciate the concern that if you give too much authority
8 the government to set the rates you worry that they're
9 going to be -- I don't know if words were used in the
10 session -- whipsawed, you know, subject to political
11 manipulation. I could think of a number of other words
12 that all would capture a very legitimate concern that what
13 happens if the government gets it wrong, and that is
14 really, really, really, I think, an important thing to say
15 in this meeting, and I think it is a really genuine
16 concern.

17 On the other hand, almost every aspect of what
18 we've done, even in the selection about how to get the
19 right amount of benefits, you end up in a world of the
20 government is now picking how much supplemental benefits
21 there are. Because if the competitive bidding works the
22 way it worked in the say Slide 12 shows, basically

1 supplemental benefits average zero, people have to switch
2 around their plans, so that doesn't become problematic, so
3 the government now has to pick how much supplemental
4 benefits are getting in MA, which might be a better thing
5 to pick. I'm not arguing. I'm just saying this is a
6 really complicated area.

7 So, one, I will regroup with Jim, Amol, and the
8 staff to decide what we take from this very rich and wide-
9 ranging discussion. Once we have a course forward, I think
10 it will be a reasonable -- there's a lot of competing
11 things -- to have a discussion about this at the retreat,
12 to try and do a little bit of what you've said, Larry.
13 Because I think it is very hard to have this play out in,
14 here's this bunch of materials. Okay, this isn't really
15 what you guys don't study competition. Let's go around and
16 say what you all say. That's a challenging thing to do. I
17 agree completely.

18 So I think we will probably try and go there.

19 I actually have to say, in closing, as I said at
20 the beginning, I'm really enthusiastic about this work and
21 this topic. I do believe that the Medicare program was not
22 designed for 70, 80 percent, some places more Medicare

1 Advantage, and giving some thought to that early. You
2 don't want it to be 80 percent enrollment -- what do we do
3 now? So getting ahead of that, I think, is actually a
4 valuable thing for MedPAC to do.

5 On the other hand, I very much take the point
6 that there are a lot of other issues going on in the
7 Medicare Advantage program that we also have to pay
8 attention to.

9 So we have a lot to chew on. The last thing I
10 will say is this was an hour-and-a-half session, and Jim
11 changed it to two hours on the theory that we might need
12 the two hours. I said, "I don't know if we're going to
13 need more than an hour and a half, but it's better to have
14 it if we need it." So we're 5 minutes over, probably
15 surely my fault.

16 But anyway, for those at home that haven't read
17 the material that came out I will echo that the staff did
18 an outstanding job of outlining a range of very complicated
19 issues, both conceptually and empirically, and I really do
20 appreciate it. I don't know if Jim conveyed to you what I
21 said to him. I hope you did, Jim, but if you didn't, I'll
22 say it now in public.

1 What I like best is when I read the chapters and
2 my opinion changes or I learn something, and that bar was
3 met with this chapter. I'm not sure where I come down on
4 it now, which I think is useful, but I do really
5 appreciate, just personally, the opportunity to actually
6 expand my thinking about important issues. So that's a
7 thank-you to you three for what you've done. I really
8 genuinely appreciate it and mean that.

9 So with that we're now going to take a five-
10 minute break, and please let's keep it close to five
11 minutes because we're going to finish up with our
12 discussion of site neutral. So again, we'll be back in a
13 minute.

14 [Recess.]

15 DR. CHERNEW: Welcome back. After that last
16 session, I think we needed a little bit of a break. So now
17 this is like a cleanse your pallet and jump in. This is a
18 long-standing and really important topic that MedPAC is
19 focused on, again, for over a decade, the issue of site
20 neutral.

21 And so. Dan, why don't you take it away.

22 DR. ZABINSKI: All right. Thanks, Mike.

1 To start, the audience can download a PDF version
2 of the slides for this presentation in the handout section
3 of the control panel that's on the right-hand side of your
4 screen.

5 All right. From 2012 to 2014, the Commission
6 evaluated the effects of aligning payment rates for
7 services provided in hospital outpatient departments with
8 payment rates for services provided in freestanding
9 physician offices.

10 In the June 2022 report to the Congress, we
11 published an analysis that built on the previous Commission
12 work in which we evaluated the effects of aligning payment
13 rates across all ambulatory settings.

14 At the November 2022 meeting, we discussed three
15 options for the savings that occur under the aligned
16 payment rate options. One option would be the current law
17 requirement in which CMS would apply budget-neutral
18 increases to the payment rates for the services for which
19 payment rates would not be aligned. A second option was
20 that Medicare would keep the savings from payment rate
21 alignment, and finally, the final option was to use some of
22 the savings to support safety-net providers that would have

1 been adversely affected. This option is no longer germane
2 based on the Commissioners' vote in January on hospital
3 safety-net policy.

4 Today we'll summarize the work that we've
5 completed on payment rate alignment, and we'll also present
6 a Chair's draft recommendation on aligning payment rates
7 across ambulatory settings.

8 All right. In fee-for-service Medicare, there
9 are distinct payment systems for the three ambulatory
10 settings: physician offices; hospital outpatient
11 apartments, or HOPDs; and ambulatory surgical centers, or
12 ASCs.

13 Payment rates can often differ for the same
14 service among these three settings. In particular, the
15 outpatient prospective payment system, the OPPS, which is
16 the payment system for most HOPD services, has higher
17 payment rates than the physician fee schedule and the ASCE
18 payment system for most services.

19 The primary concern about these differences in
20 payment rates among the ambulatory settings is that they
21 result in the providers in higher cost settings acquiring
22 providers in lower cost settings, then billing at higher

1 rates. For example, hospitals can consolidate with
2 physician practices and convert them to provider-based
3 apartments. Hospitals can then bill for the physician
4 services at the usually higher OPPS rates with little or no
5 change in the site of care.

6 In recent years, hospital acquisition of
7 physician practices has led to an increase in the share of
8 office visits, echocardiography services, cardiac imaging
9 services, and chemotherapy administration being billed
10 under the OPPS with an analogous decrease in the shared
11 billed under the physician fee schedule, and this shift of
12 billing increased Medicare program outlays and beneficiary
13 cost sharing.

14 On this table, we show how hospital acquisition
15 of physician practices has led to the billing of two
16 important services, shifting from the physician fee
17 schedule to the OPPS. From 2012 to 2021, the share of
18 office visits billed under the OPPS increased from 9.6
19 percent to 12.8 percent, and the share of chemotherapy
20 administration services increased from 35.2 percent to 51.9
21 percent.

22 Note that these are just a subset of the services

1 that that have shifted from the physician fee schedule to
2 the OPPS. Also, this shift of services illustrates the
3 need to align payment rates across settings.

4 It would be easy to simply align all OPPS and ASC
5 payment rates through the physician fee schedule rates.
6 However, these sites of care have important differences
7 that we first must consider. One issue is that some
8 services that are provided in HOPDs can't be provided in
9 offices or ASCs because they're not covered under the
10 physician fee schedule or the ASC system. The most obvious
11 of these are ED visits, but there's also relatively complex
12 services, such as some joint replacement procedures, that
13 are covered under only the OPPS. These services must
14 continue to be paid at standard OPPS rates.

15 Another issue is that the OPPS and the ASC system
16 have more packaging of ancillary items in their payment
17 units than does the physician fee schedule. We must
18 account for these differences in packaging when aligning
19 payment rates.

20 Also, we should align payment rates across
21 settings only if it's safe and reasonable to provide the
22 service in the lower cost settings for most beneficiaries.

1 Now, you've seen this slide before. So I'll
2 review it quickly. To identify the services for which it's
3 reasonable to align the payment rates across settings, we
4 collected services into ambulatory payment classifications,
5 or APCs, which is the payment classification system in the
6 OPPS. If offices had the highest volume for APC during the
7 2016 through 2021 period, we aligned the OPPS and the ASC
8 rates with the physician fee schedule rates with an
9 addition for greater packaging under the OPPS and the ASC
10 payment system.

11 But if ASCs had the highest volume for an APC, we
12 align the OPPS rates with the ASC payment rates, but we
13 kept the physician fee schedule rates unchanged.

14 And finally, if HOPDs had the highest volume for
15 an APC, we do not believe it would be reasonable to align
16 the payment rates for those APC, and payment rates were
17 unchanged in each setting in those situations.

18 And once again, you've seen this slide before, so
19 I'll cover it relatively quickly. This table is an example
20 of why Medicare payments are usually higher when a service
21 is provided in an HOPD than in an office and how we align
22 the payment rates across the ambulatory settings.

1 The service in this example is from the Level 2
2 nerve injection APC. The first column shows the payments
3 that Medicare makes if the service is provided in office.
4 When we sum the three components of the payment to the
5 physician, we obtain a total Medicare payment of \$256.

6 The second column shows the payment if the
7 service is provided in an HOPD. In this case, the payment
8 to the physician has three components plus Medicare makes a
9 payment under the OPPS to the hospital. The total of the
10 payments to the physician and the HOPD combined is \$741.

11 And the third column is the same as the second
12 column, except we apply our method of aligning payment
13 rates between offices and HOPDs by adjusting the OPPS
14 payment downward so that the total payment is equal across
15 the two settings. That is, the total Medicare payment in
16 the third column becomes \$256, which is the same as a total
17 payment in the first column when the service is provided in
18 an office.

19 We used this method of aligning payment rates on
20 this slide as a basis for aligning payment rates across the
21 three ambulatory settings.

22 Right now, the OPPS has 169 APCs for services,

1 and we've determined that it's appropriate to align their
2 payment rates for 66 of those APCs. Specifically, we
3 identified 57 APCs for which we aligned OPPS and ASC rates
4 with the physician fee schedule rates. We also identified
5 nine APCs for which we align OPPS rates with ASC rates and
6 left the physician fee schedule rates unchanged. And
7 finally, we did not align payment rates for the 103
8 remaining service APCs.

9 And for the 57 APCs for which we align the OPPS
10 and the ASC payment rates with the physician fee schedule
11 rates, beneficiary cost sharing and program outlays would
12 be lower for the services in those APCs. Under the OPPS,
13 cost sharing in these APCs would be lowered by \$1.2
14 billion, and program outlays would be lowered by \$4.9
15 billion. Under the ASC payment system, cost sharing would
16 be lower in these APCs by \$50 million, and program outlays
17 would be lowered by \$200 million.

18 However, under current law, CMS would proceed by
19 applying a budget neutrality adjustment by increasing the
20 OPPS payment rates in the 103 APCs for which we have not
21 aligned payment rates, which includes payment rates for ED
22 visits to fully offset the lower payment rates in the 57

1 aligned APCs.

2 In the end, aggregate beneficiary cost sharing
3 and program payments would not change, and because this
4 policy would increase payment rates for ED visits, it would
5 help hospitals maintain access to emergency care and
6 standby capacity.

7 Then for the nine APCs for which we align OPPS
8 payment rates with the ASC payment rates, all represent
9 surgical procedures, including ophthalmologic,
10 gastrointestinal, and musculoskeletal procedures. Aligning
11 the OPPS payment rates with these APCs would reduce the
12 cost sharing in these APCs by \$300 million and program
13 outlays by an even \$1 billion. Once again, under current
14 law, CMS would apply a budget neutrality adjustment by
15 increasing the OPPS payment rates in the 103 APCs for which
16 we have not aligned payment rates, which again includes ED
17 visits to fully offset the lower payment rates in the nine
18 aligned APCs. Therefore, aggregate OPPS spending would not
19 change. However, the payment alignment policies coupled
20 with the budget neutrality adjustment would shift Medicare
21 payments among hospital categories.

22 On this table, we show the percent change in

1 total Medicare revenue for various hospital groups. By
2 definition, the net effect on total Medicare revenue for
3 all hospitals would be zero, as indicated in the top row,
4 but rural hospitals would have to decrease in total revenue
5 of 2.5 percent, while urban hospitals would experience a
6 lower Medicare revenue of -- sorry -- more Medicare revenue
7 of 0.2 percent.

8 Also, government hospitals would have a total
9 revenue decrease of 0.8 percent, while for-profit hospitals
10 would have an increase of 1 percent, and non-profit
11 hospitals would have no change in their total Medicare
12 revenue.

13 These decreases in revenue occur for the rural
14 and government hospitals because the services in the 66
15 aligned APCs constitute a disproportionately high share of
16 the total Medicare revenue for those hospitals.

17 And the concern raised by the Commissioners at
18 the November meeting was whether to align -- was whether
19 aligned payment rates should be adjusted for differences in
20 health status between settings. We acknowledged that on
21 average, HOPD patients do have slightly higher CMS-HCC risk
22 scores than do office patients. However, we do not believe

1 that an adjustment for patient severity is needed, and we
2 base this assertion on four points.

3 One is that the services in the aligned APCs are
4 generally low complexity, like office visits and simple x-
5 rays. For example, the average relative weight in the OPPS
6 for the aligned services is 1.9, while the average OPPS
7 relative weight for all APCs is 2.5 times higher at 5.0.

8 Also under the OPPS, providers can bill
9 separately for additional services if a patient needs more
10 intensive care. This contrasts with the inpatient PPS,
11 which has a fixed rate for specific diagnoses.

12 Third, using regression analysis, we found that
13 hospital charges for the services in the aligned APCs are
14 largely unaffected by patient health status.

15 And fourth, in response to Commissioner concerns,
16 we did an analysis of the risk scores for the patients
17 treated in HOPDs and offices. We found that only 8 percent
18 of the risk scores for the HOPD patients were above the
19 95th percentile of the distribution of office in HOPD
20 patients combined.

21 I'll also note that the OPPS has a system of
22 outlier payments that provides additional payments to

1 hospitals for unusually costly cases treated in HOPDs.

2 And for the Commission's consideration today, the
3 Chairman has this draft recommendation: "The Congress
4 should more closely align payment rates across ambulatory
5 settings for selected services that are safe to provide in
6 all settings." And note that CMS would select the specific
7 services for site-neutral payments based on clinical input
8 and existing utilization pattern.

9 In terms of implications, we expect that over the
10 first year that the draft recommendation would have no
11 effect on total Medicare spending, but we do expect lower
12 spending over the longer term as hospitals would have less
13 incentive to acquire physician practices, which will
14 mitigate the shift of billing of services from the
15 physician fee schedule to the OPDS.

16 For beneficiaries, they will have lower cost
17 sharing, and we expect that under the draft recommendation,
18 beneficiaries will maintain access to the services in the
19 aligned APCs.

20 For providers, we have shown that payment
21 alignment policies will have differing effects on Medicare
22 revenue for different hospital categories, and to the

1 extent there is a concern about the effect of the
2 recommendation on specific providers, we emphasize that
3 these concerns should be addressed through policies
4 targeted to those providers.

5 Finally, overall, this draft recommendation is
6 not expected to affect providers' willingness or ability to
7 furnish ambulatory services.

8 That concludes the presentation, and I turn it
9 back to Mike.

10 DR. CHERNEW: Dan, thank you tons for that. I'm
11 looking forward to this discussion.

12 I will say that it's important to understand that
13 the option of what we've done and what we've modeled, which
14 has been very important, that is sort of an option of
15 what's going on. The recommendation is kind of stepped
16 back a little bit to be simply CMS should select services,
17 and then there's some criteria in which they should pick.
18 But the recommendation is not necessarily the specific
19 services that we've outlined to do our policy option.
20 We've picked ones that we think are reasonable, because
21 obviously, the recommendation is not explicitly do these or
22 don't do others or some version of that.

1 Anyway, that said, we should start with --

2 [Pause.]

3 UNIDENTIFIED SPEAKER: So please put the
4 recommendation on the screen as opposed to the implication.

5 MS. KELLEY: I think Lynn has a first Round 1
6 question.

7 MS. BARR: Sorry, Larry. Got it. Thank you.

8 My concern is around obviously access, right?
9 And so in your comment about that you didn't feel that this
10 would harm access in, for example, rural settings, what was
11 your thinking behind that?

12 DR. ZABINSKI: Generally that, number one, we
13 have the new recommendation on safety-net hospitals from
14 January, and also that rural hospitals as of right now,
15 they have better financial status in terms of margins than
16 do most other hospital categories.

17 MS. BARR: Okay. When the -- by the way, I think
18 this is great work, and I think you're on to something
19 here, and that there is a framework where we can look at
20 services that are being offered and say should we or
21 shouldn't we, you know, what should we pay for.

22 But when you're thinking about that, I just --

1 I'm curious as to how you thought about access, because
2 what I believe you're saying here -- and I think is correct
3 -- if you Medicare could get this service in a physician's
4 office or a hospital, why should we pay? That's fair,
5 right?

6 But what if there is no access other than the
7 hospital in that local area? So it doesn't really consider
8 that access piece. It seems like there's an assumption
9 that access is a given.

10 DR. ZABINSKI: Well, just based on what you see
11 in terms of what services are being applied, how they move
12 around from the physician office to the hospital -- and
13 it's clear, at least to me, that what the hospitals are
14 doing when they -- they're moving a lot of these services
15 into provider-based apartments, which are paid at physician
16 fee schedule rates, and they don't seem to have an issue
17 with providing more of them in that setting.

18 MS. BARR: In that setting.

19 Okay. But the assumption is this is a commodity,
20 right? And you should be able to get it, and that there
21 should be -- is there an assumption that you should be able
22 to get this service in a physician office in order for this

1 formula to apply?

2 DR. CHERNEW: Can I try and take a -- do you want
3 to take a stab, Dan, or otherwise --

4 DR. ZABINSKI: No, go ahead, Mike.

5 DR. CHERNEW: The assumption is not so much that
6 you could go somewhere else to get it. The assumption is
7 that the cost of it being provided in any setting is
8 basically you're worried about commodities, that the cost
9 is basically the same.

10 So the concern that you have, which is a
11 completely legitimate concern, is that if there's no office
12 setting and you lower the price to the hospital, even
13 though we think that the hospital should be able to produce
14 it at that lower price, because other places they can, that
15 they really can't. And they will then drop it, and then
16 there will be an access problem because there's not another
17 place to go. That has to be taken into account in the
18 selection of services.

19 I think what Dan would say is through some
20 combination of what the marginal cost of producing the
21 services are, the connection of the services to other
22 things that are obviously going to happen in the hospital,

1 and then broader programs we've made to support those types
2 of hospitals that might lose revenue in general, we are
3 trying to cover those bases.

4 But the notion, I think, generally speaking, that
5 you would pay dramatically different for very similar
6 services, vastly, because you're just trying to -- because
7 there's a few places where you can't -- is I think where we
8 would push back.

9 MS. BARR: Okay. I just want to -- I don't want
10 to dominate this, but just to clarify, that the services
11 that you selected were services that you could get
12 elsewhere, and that there was an assumption of access in
13 that, in the selection of those services. And so I just
14 don't think that that's a reasonable assumption.

15 DR. CHERNEW: It wasn't an assumption about
16 access as much as an assumption about cost differentials.

17 MS. BARR: I thought it was an assumption that if
18 you could safely do this here or there, right?

19 DR. CHERNEW: Yes, that's right, but --

20 MS. BARR: But that means access here or there.

21 DR. CHERNEW: No. That just means that if you
22 could safely do it in the physician's office, even if there

1 was not -- that's loosely the cost of doing it. It's not
2 about the --

3 MS. BARR: But you allow some things to stay in
4 hospitals because it's more complex but not to stay in
5 hospitals because it's the only access point. I'm just
6 kind of clarifying that.

7 DR. CHERNEW: Okay.

8 DR. SARRAN: It's only the payment that's
9 changing here.

10 DR. CHERNEW: Yeah.

11 DR. SARRAN: It's not where the procedures
12 happen.

13 MS. BARR: I get it, but I'm just -- the criteria
14 seemed to me around this is a commodity, and I'm not sure
15 it's a commodity if there's no access, right?

16 At any rate, I'm not going to dominate the
17 conversation, but that's my comment.

18 MS. KELLEY: Larry.

19 DR. CASALINO: So Dan and I have had, to me, a
20 very satisfactory communication about this in this past
21 week, but it is something I want the whole Commission to
22 hear.

1 I think the idea of using volume as a criterion
2 for which site's payment rate to use is a good one. In
3 other words, if the volume is high in physician offices
4 than the assumption is that it's safe enough to do in
5 physician offices and therefore should be paid the
6 physician office rate. I think that's good.

7 The problem is, as Dan readily acknowledged, that
8 as hospitals acquire more practices this could become
9 problematic. And so, for example, if you look at
10 transthoracic echoes, which are discussed in the paper we
11 were given, in 2012, 32 percent of them were done in
12 hospital OPDs, and now with the acquisition of more
13 practices it's 43 percent, and it probably won't be too
14 long before it's about 50 percent, and you could imagine
15 that that would happen with some other services as well.
16 So that's a problem for the volume criterion.

17 I think there might be a solution to that, and
18 Dan, I'm saying this partly because I think it is a Round 1
19 and people should hear it, but then I'd like your response.
20 You could, for example, and Dan suggested this, set a point
21 in time, like now, when you would decide which site to use
22 for the payment rate and then that would be true forever

1 after. Otherwise, every year you could get more and more
2 services in an ASC or in a physician office now being
3 dominated in volume in a hospital and then you'd be paying
4 hospital rates.

5 So Dan, your comments?

6 DR. ZABINSKI: Yeah. I mean, that's clearly an
7 issue. I think one idea would be to, okay, you set some
8 group that you think are viable candidates and you don't
9 allow any to be taken out over time, and if any come up
10 that seem to be viable candidates in the future you can add
11 to them. That's one possibility.

12 DR. CHERNEW: I think the recommendation is
13 trying to get to more of a multifactorial selection
14 process. But to deal with that issue, for example, you
15 could treat freestanding hospital outpatient departments
16 like they were offices to pick the services. In other
17 words, you could differentiate between how CMS would do it.

18 But again, there is a level of detail about how
19 CMS would go through the process of selecting that's a
20 little bit beyond this. That's why we've moved it to, you
21 know, how clinical input matters. Volume is just a way of
22 identifying sort of a quick way of getting candidate

1 services, I think to use a Dan phrase, to say what are
2 things that we think could be produced at the cost that
3 we're currently seeing outside of the hospital. And then
4 once you get this, so it might be you have to go through a
5 whole bunch of other screens, somewhat related to Lynn's
6 concern, would hospitals drop and would we lose access, and
7 related things.

8 DR. CASALINO: I'm sorry. I just would like to
9 see this specifically mentioned in the chapter, the
10 potential problems with the volume criterion and how to
11 deal with it. Transthoracic echo is not a dangerous
12 procedure, to put it mildly. It's safer than getting your
13 blood drawn really, and probably doesn't need to be done in
14 an HOPD to be safe.

15 MS. KELLEY: Robert.

16 DR. CHERRY: Yes, thank you. I was wondering if
17 you can clarify for me how we're defining physician
18 offices. And to provide some context, increasingly
19 physician offices are in atypical locations these days. So
20 you have health plans buying physician practices. You have
21 retail pharmacies, big box stores, telehealth companies, et
22 cetera. And so how broad is this in terms of how we're

1 defining physician offices in this context?

2 DR. ZABINSKI: It's defined in the sense of how
3 it's billed more than anything. Kind of why I emphasized
4 that's probably the better way to think about it is how
5 it's billed. It might look like a physician office but if
6 it's billed under the OPPS, it's not. If it's billed under
7 the physician fee schedule then it's classified as a
8 physician office. It's more a billing technique rather
9 than a location type thing.

10 DR. CHERRY: Okay. So that's clear. Thank you.

11 MS. KELLEY: Kenny.

12 MR. KAN: Great work, Dan, on the site neutral
13 analysis. I'm very supportive of the Chair's draft
14 recommendation.

15 On page 13, I found the finding that hospital
16 charges for the services in the aligned APCs are largely
17 unaffected by patient health status reviewing, and having
18 done this in a prior commercial setting, because in trying
19 to implement something like that the one complaint or
20 pushback is that hospitals will say that they have the
21 higher acuity patients.

22 So I'm curious as to what do you think drove that

1 finding on this slide?

2 DR. ZABINSKI: Yeah, that's a good question. I
3 think it's sort of a combination of two things. One key
4 factor here is just the type of services that we're
5 including. They're generally pretty basic, like I said,
6 office visit, x-rays, that type of thing.

7 The second is the nature of the OPPS. You have a
8 patient, one who is in really very good health and one that
9 is in very poor health, and under the OPPS if the patient
10 in very poor health needs some additional things that the
11 one in very good health doesn't, they can bill separately
12 for additional things under the OPPS. It's not like the
13 inpatient PPS, where you have kind of a set rate or
14 whatever the patient is in the hospital for, where you
15 don't get additional payment for doing more, but under the
16 OPPS you can.

17 MS. KELLEY: Amol.

18 DR. NAVATHE: Dan, great work. I just had a very
19 quick question of clarification, which is that with respect
20 to the rural hospitals, critical access hospitals would not
21 be affected by this because they're not paid by OPPS. Is
22 that correct?

1 DR. ZABINSKI: That's correct. Yes.

2 DR. NAVATHE: Thanks.

3 MS. KELLEY: That is all I have for Round 1,
4 unless I've missed someone.

5 DR. CHERNEW: Let's go to Round 2.

6 MS. KELLEY: All right. I have Jonathan first.

7 DR. JAFFERY: Thanks. Yeah, Dan, this is great,
8 and I really appreciate how you've sort of continued to
9 give this more nuanced, sort of elegant, targeted approach
10 to this concept. And I think it's very timely and
11 commercial payers are starting to push on this concept
12 more. So the more that we can get ahead of that, to add
13 that nuance, I think is important.

14 With that said I think there are two or three
15 things I want to mention where I think there still may be
16 some disconnect between the analysis, the policy proposals
17 and goals, and sort of what happens on the ground.

18 The first one may have some similarities to what
19 Lynn was saying, but I'm thinking more specifically about
20 the ASCs and the nine APCs that are done most commonly
21 there. So while conceptually I agree that if it's done
22 most commonly there it's safe to do there, and effective.

1 But the analysis around it is really national level, right,
2 and as you know, ASCs are not available everywhere. And
3 even if they are, they may not provide all those services
4 because some of them are very specialized.

5 So I think that's a potential concern, and I
6 wonder if there's an opportunity to think about
7 incorporating something like what we had proposed in the
8 past around isolated dialysis centers, if there's some sort
9 of modifier if they're some distance from the nearest ASC
10 that provides those services. So that's one thing.

11 You talk about some categories, trauma and
12 emergency medicine, that might have some modifiers and I
13 think that makes sense. I wonder if there are some other
14 things, other categories that are things that beneficiaries
15 might need or choose to go to a place where there are more
16 services readily available, and that might be based on some
17 other characteristics like transplant, cancer, some other
18 immunocompromised state.

19 And I guess that sort of gets into my last
20 thought. This gets into the complexity, and I appreciate
21 that that complexity doesn't necessarily translate to
22 whether or not something could be done safely, needs to be

1 done in a hospital safely all the time. But I'm not sure
2 that always totally captures the complexity and what that
3 means for beneficiary choice or provider preference or
4 advice around where somebody gets something done.

5 So even if the presence of diabetes or a history
6 of transplant or whatnot does not change the outcome
7 whether it's in the hospital or in a physician office, and
8 even if you don't end up needing additional services or
9 needing additional things, as you said, that there may be
10 some subjectivity to where something needs to be done. And
11 that's important because, I mean, I think that's what we're
12 getting at with some of the basics is that the hospitals
13 need to have greater capabilities to do things in certain
14 circumstances, and that's very costly to maintain that kind
15 of capacity and capability.

16 And so it may be a very appropriate decision for
17 a beneficiary to go one place versus another, even if they
18 don't end up needing those services. So I think that's a
19 potential distortion that we should think about that goes
20 beyond just what their HCC scores or diagnosis codes
21 include.

22 Thank you.

1 MS. KELLEY: Greg.

2 MR. POULSEN: Thanks very much. I'm really
3 piggybacking very much on what Jonathan just said, so thank
4 you. I'm grateful for the hard work that's gone into this,
5 Dan, and I realize this is an incredibly difficult and
6 challenging topic in some meaningful ways.

7 I've really, really wrestled with this, this last
8 week, and I'm supportive of the way this is phrased, and I
9 understand that that's likely to go with wording that
10 essentially mentions that these services are those that
11 could be effectively treated in freestanding settings
12 except for an occasional emergency situation, something
13 like that.

14 And the reason I think that it's really important
15 that we understand that is that there are often things that
16 end up looking exactly the same in terms of the way you
17 bill it and code it and so forth, and yet are very, very
18 different.

19 Let me just give you an example. I'm going to
20 pick one that I intentionally didn't determine whether it
21 was on our list of possible examples or not because it is
22 irrelevant whether it is or not. Examples like this could

1 be used for a whole bunch of things, including
2 transthoracic echocardiograms. And I got real examples
3 from real people that happened in the last week.

4 Consider one that's a 76-year-old who has
5 developed difficulty swallowing, occasionally feels like
6 her airway is partially blocked. This trouble is gradually
7 growing, and after an examination her internist decides
8 that an MRI of the neck and thorax is appropriate to look
9 for what's going on and see if there's a tumor or something
10 else.

11 So it's scheduled at the imaging center within
12 the same clinic. She shows up. She goes to the changing
13 room. She gets changed. She goes in, sits down on the
14 table, lies down on the table, they give her a headset, and
15 say, "Okay. This is going to make some loud thumps and so
16 forth. Don't be concerned. Relax."

17 So she's zoomed into the MRI machine. She's
18 asked to breathe deeply and then hold still. Boom, boom,
19 boom. This happens three times. Out she comes. She sits
20 up and she goes back and gets changed and leaves. End of
21 story.

22 Okay. Now imagine an 82-year-old living in a

1 care center, moderate dementia, losing some cognitive
2 skills. And Sunday morning this actually happened. Sunday
3 morning this gentleman throws up. They're worried that
4 something is going on. There is a little concern that he
5 may have swallowed something that's lodged but there are
6 other concerns too. They decide that an MRI would be very
7 helpful. And so they call the hospital because, by the
8 way, that's where patients from these centers go. They
9 don't go to the freestanding imaging centers, even if it
10 wasn't a Sunday.

11 So off he comes there. He's disoriented. He's
12 now in a place he's not used to. Two technicians assist
13 him in getting changed. They have to call back to the care
14 center to make sure that he doesn't have any metal implants
15 that would be dangerous in an MRI setting. They double-
16 check his mouth.

17 Also, because he's disoriented, they really have
18 two choices. They can either basically knock him out or
19 they can sedate him a little bit and provide assistance in
20 the MRI. Doing the latter requires an open MRI as opposed
21 to the normal closed tube MRI that some of us are familiar
22 with. And it's a more expensive machine, by the way.

1 So on he goes to that. Because it's an open MRI
2 it doesn't have the strength of magnetic fields for the
3 patient so they need to have him hold still longer than he
4 would in the closed tube, which, oh, by the way, is very
5 difficult because he doesn't understand the hold still
6 parts of this. So they go in, they try it out, and they
7 can't get a sharp image because her keeps moving around,
8 especially when the loud bangs start. It startles him --
9 no surprise.

10 So they move in with a second tech, so you're
11 going to have two techs in holding each hand and reassuring
12 him, trying to help him to be calm, which they ultimately
13 do. They ultimately get the images that they need. At
14 this point the two techs now go and help him to dress, and
15 off he goes back to the care center. Elapsed time, about
16 four times as long as the first patient took in the
17 freestanding center. And oh, by the way, rather than
18 having one technician they had three technicians involved
19 during that time.

20 So at the end of the day it's still coded the
21 same procedure. And there really aren't additional
22 services. There's not additional things that happened to

1 that patient. They didn't suture him. They didn't give
2 him anesthesia and so forth. So this ends up being really
3 expensive.

4 Now that's a rare example in the scope of all the
5 MRIs. It's not a rare example in a tertiary referral
6 center hospital. That's not uncommon at all, because
7 people who can go in, lie down, get the exam, get up, and
8 go out are going to go to the freestanding center. So the
9 costs are significantly higher at those hospitals,
10 historically, when those have happened.

11 Let me just give a quick example that you'll all
12 recognize. OB ultrasounds, which we don't do a whole lot
13 of for Medicare patients, I get that, but nevertheless
14 those are basically not done in most hospitals anymore as
15 an independent service because they're so readily available
16 elsewhere, and by the way, they cost a lot more in the
17 hospital. We all know that.

18 So if you want an OB ultrasound the only way that
19 you get it in a hospital is through the emergency
20 department, if you show up with pain that requires that.
21 My concern is if we start to have patients like our second
22 one that really only get access to the hospital setting via

1 the emergency department that's a huge challenge because
2 the clinicians in here know you'll never have a patient
3 show up at the emergency department and say, "We need an
4 MRI of the upper chest." Ain't going to happen. The ED
5 physicians are going to say, "Well, we've got something in
6 the upper chest. Let's take a look and see what's going
7 on."

8 They may go straight to the MRI but they may
9 determine that an endoscope would be the appropriate way to
10 approach this, at which point you've got general
11 anesthesia, you've got endoscopy, you've got minutes in the
12 OR, and suddenly what started out as an imaging test just
13 became a full-blown intervention that could become
14 incredibly expensive, and spending many, many thousands of
15 dollars.

16 So I think the downside if we don't limit this to
17 the appropriate cases -- and I think the wording here does
18 that, so I am supportive. But I really want it on the
19 record that we need to be very careful that what we don't
20 do is unintentionally push this into something where people
21 who are, for their own situation, able to get this service
22 in a freestanding center and those who don't, end up going

1 down an emergency room pathway. Because a lot of hospitals
2 already are in this situation. My hospitals are in this
3 situation because we have freestanding imaging centers, and
4 the people who should go there do go there. And I'm proud
5 to say they're not licensed as hospital outpatient
6 departments. They are freestanding centers.

7 But for those people who actually need the
8 hospital service, the payments that they are getting to
9 date don't cover their costs, and to push them further, I
10 think, is likely to see some institutions simply unwilling
11 to take those as an independent outpatient service. It
12 rather would be, "Great. Call the emergency department.
13 We'll get him in and we'll take care of it." And they'll
14 do a good job but it's going to cost multiples of what this
15 outpatient service --

16 DR. CASALINO: Greg, do you have a proposed
17 solution?

18 MR. POULSEN: Yeah, absolutely. I have two
19 proposed solutions. The one is part of this, which is
20 let's make sure that we constrain this to those services
21 which really can be done in a freestanding setting, with
22 only occasional ones that go through the ED, which a lot

1 these are. I mean, we've got a huge number here in the
2 list that are things like chemotherapy. That's appropriate
3 to be done --

4 DR. CASALINO: But you wouldn't include MRIs.

5 MR. POULSEN: I would be thoughtful about which
6 MRIs I did include.

7 DR. CHERNEW: Just to make sure that we move
8 along -- I don't mean to belabor this point --

9 MR. POULSEN: No, I understand.

10 DR. CHERNEW: The actual details -- and Greg
11 knows this because he's talked about it a lot. The actual
12 details of what will be chosen and the exceptions or not or
13 whatever happens is the recommendation assigns that to CMS.
14 I think the way that I read or listen to Greg's comment is
15 getting on the record the notion for the text to make sure
16 that CMS does that thoughtfully.

17 MR. POULSEN: That's it. That's the entire
18 point.

19 DR. CHERNEW: Right.

20 MR. POULSEN: And the other point is the one that
21 Jonathan made, which is I don't think it would also be
22 unreasonable to contemplate -- although I don't think this

1 is in the recommendation. I'm supportive of the
2 recommendation irrespective of this -- is were there an
3 additional code that allowed you to have some sort of a
4 multiplier for cases that justified a differential level of
5 care without necessarily getting some different procedure.
6 It would be the same procedure. So I think there are a
7 couple of mechanisms that could be used and either one of
8 which, I think, or in combination.

9 So, again, sorry, long way to say I appreciate
10 what's been done. I know there's been a lot of work here,
11 and I just wanted it to be on the record that CMS has a
12 responsibility to be thoughtful about this or there could
13 be adverse consequences.

14 MS. KELLEY: Okay. Lynn has -- oh, sorry, did
15 someone want to jump in?

16 [No response.]

17 MS. KELLEY: Yeah, Lynn had a Round 2 comment
18 that she sent before she had to leave. She thinks this is
19 important work and supports the approach of identifying
20 instances where beneficiaries can get a similar service in
21 alternative settings and reducing pricing in those
22 instances. Her concern is that the current formula assumes

1 that access is equal in urban versus rural areas. In rural
2 settings, the only reasonable access to these services may
3 be the hospital. She thinks the formula needs to be
4 modified so that areas that do not have access to
5 alternatives should not have a reduction in payment.

6 Rural and sole community hospitals may reduce or
7 eliminate unprofitable services and access under this
8 policy like they have eliminated maternity services due to
9 poor Medicaid reimbursement. This doesn't seem like a good
10 policy if it only punishes rural and government hospitals,
11 threatens access for the underserved, and doesn't actually
12 save Medicare any money.

13 I have Robert next.

14 DR. CHERRY: Thank you. I appreciate all the
15 hard work that has been done around this. I have to say
16 I'm very much on the fence regarding this proposal, mainly
17 because there are several potential, you know, unintended
18 consequences associated with this.

19 One is the fact that, you know, hospital
20 outpatient departments are licensed facilities associated
21 with their hospital, and I'm a little concerned that it
22 might drive the de-licensing of these outpatient areas.

1 Now, there are pros and cons to doing that, but
2 there are also, you know, significant cons as well, and I
3 don't think that's really been considered. So it may drive
4 behaviors among hospitals that have not really been fully
5 considered.

6 The other thing I was concerned about -- and Greg
7 articulated this very nicely -- is the level of difficulty
8 in using coded data and trying to figure out how to select
9 services across all settings, and particularly among
10 academic health systems or health systems that deal with a
11 lot of tertiary and quaternary patients because of the
12 complexity of care, the co-morbidities that they have, and
13 the clinical judgment that's necessary to determine which
14 is the most appropriate setting. And so I'm a bit
15 concerned that there could be unintended consequences that
16 Greg mentioned in terms of providing an optimal location
17 that coded data may not be able to fully adjudicate for.

18 Then, finally, the other concern is just the
19 unintended consequences or optics around, you know, rural
20 hospitals, you know, losing 2.5 percent under this model
21 and for-profit hospitals gaining 1 percent. I'm not quite
22 sure that that is what we're trying to drive here in terms

1 of equitable care and access to services.

2 So these three concerns are major concerns for
3 me, and there would be a lot more work involved, I think,
4 to make this a viable solution, at least in my opinion.

5 Thank you.

6 MS. KELLEY: Stacie.

7 DR. DUSETZINA: Thank you. Dan, I think the
8 lucky socks maybe are working, hopefully. So I am very
9 much in spirit in favor of this recommendation and getting
10 payments to align more closely. Could you go to Slide 8?
11 I think it's where you demonstrate the breakdown of the
12 payments and how this would shift.

13 [Pause.]

14 DR. DUSETZINA: Okay. Yeah, that's the one. So
15 I guess one of the overarching things when I look at this
16 and when I'm thinking back through the issue of, you know,
17 that savings here mean that we just repay for services
18 within the OPPS at higher amounts, so there's not like a
19 huge savings.

20 The other thing that seemed glaring to me is: Is
21 this the right amount for those services in the office
22 setting? And part of this, I think, goes to the issues,

1 you know, looking at the list of proposed services, you
2 know, in the top, a lot of drug administration codes, and
3 some of the work we're talking about separately on the
4 payment redesign changes how much, you know, the drug
5 payment is, but the administration codes and fees are
6 different.

7 So I guess I'm just kind of thinking about those
8 two separate work streams and this concept of is the office
9 setting -- is that the right price there before you do that
10 adjustment to match them and then redistribute that money
11 across other OPSS services.

12 So I realize that that's probably not something
13 we could specifically do, but it's just maybe a point of
14 Jaewon's dreaming yesterday, like if I could think about
15 are these the right amounts, then match the prices, and
16 then, you know, reshuffle the dollars within the OPSS for
17 the other services because of the neutrality.

18 That is probably dreaming, but it did strike me
19 as something that even if we're not saying what services
20 necessarily will be included, those seem like low-hanging
21 fruit, especially given the amount of spending on those
22 services, the frequency of spending for those services,

1 and, you know, that they can be safely provided in both
2 settings.

3 Also to Robert's point, I completely agree the
4 redistribution that looks like the government hospitals and
5 rural hospitals are harmed is really concerning. And I
6 really appreciate Lynn's comment about like what do you do
7 when that's your only site of care, like the hospital is
8 your only site of care to get those services. Do you pay
9 them more? But then I worry that would also reward like an
10 incredibly consolidated area where, you know, maybe you
11 don't have systems because everything is under the hospital
12 outpatient umbrella, so then we're accidentally overpaying
13 both the places that are treating patients who have no
14 other real options, and we're also maybe accidentally
15 rewarding consolidation, which I think we don't want to do.

16 So I am in spirit very much in favor of this, and
17 I also really appreciate the analytic approach and all the
18 detailed work that you've done there. I think it makes a
19 lot of sense from a logical perspective of how to select
20 services this way. So I very much applaud the work, but do
21 think there are some of these big-picture considerations
22 that I'm still wrestling with.

1 MS. KELLEY: Okay. Now I have a comment from
2 Cheryl. She is very supportive of the approach outlined in
3 this chapter and the Chair's draft recommendation. She's
4 concerned, given budget neutrality under current law, that
5 there are no net savings in the near term when ideally the
6 Medicare program and taxpayers would be able to benefit
7 from the proposed changes.

8 She does wonder how much will be accrued in
9 savings over a longer time period as a function of reduced
10 incentives for provider consolidation. While this may tamp
11 down on future consolidation, a great deal of provider
12 consolidation has already occurred, which will limit the
13 potential savings.

14 And now I have Betty.

15 DR. RAMBUR: Thank you very much. Just to start
16 off by saying I'm a very big supporter of site-neutral. I
17 can tell you that perhaps as a nurse I have somewhat of a
18 different experience, but it's very, very hard to respond
19 and feel like it's honorable to a patient who says, "I had
20 this done in this setting just this little bit ago, and now
21 again the exact same thing, the exact same office, and this
22 was more expensive. Why?"

1 It is very hard to feel like it's an honorable
2 response, so I'm very supportive of the language.

3 A couple of things about specific things that
4 were raised. The issue of government and rural I think,
5 you know, gives me pause. At the same time, I'd be
6 reluctant for us to pay more to rural, for example, because
7 I've seen a lot of mission drift in rural hospitals who
8 actually figure out how they can get the revenue. So they
9 start doing, you know, complicated surgeries when there's a
10 place not that far away. So I don't have a solution to
11 that, but I think we should pay attention.

12 I was questioning on page 16, 15, it says there
13 wouldn't be any cost savings in the short run. I wasn't
14 clear on that because the example I gave of Person X who
15 now has this much bigger bill, isn't their savings in their
16 cost sharing, you know, even in the short run?

17 DR. ZABINSKI: Well, yeah, you know, on specific
18 services, yeah. What we're talking about is, okay, you
19 have the savings on the services for which we align payment
20 rates, there's savings there. But then they do -- CMS
21 would step in. This is in law, in statute, that they'd
22 have to increase the payment rates for all the non-aligned

1 services.

2 I'm finding myself that there is potential
3 eventually for some pretty big savings as the consolidation
4 -- to the extent it -- it all depends on how much the
5 consolidation slows down.

6 DR. CASALINO: And the budget neutrality rule for
7 this could be changed as well, potentially.

8 DR. RAMBUR: But we'd want that to go in the
9 right direction.

10 DR. ZABINSKI: Right.

11 DR. RAMBUR: Anyway, it seems to me that
12 individual people would feel a difference in their cost
13 sharing.

14 And then the last thing, the issue of using
15 volume as one of the drivers, I'm not able to critique
16 that, so I really have to, you know, look to some of you in
17 terms of getting that right. So I appreciated the comments
18 on that. But I am very supportive of this overall
19 direction.

20 MS. KELLEY: Mike, before we end, I wanted to
21 note that before he had to leave, Scott said he was
22 extremely supportive of the recommendation and he thinks

1 this is solid and important work.

2 DR. CHERNEW: Great.

3 MS. KELLEY: Amol has something as well.

4 DR. NAVATHE: [Off microphone.]

5 DR. CHERNEW: I'm going to go around. Say your
6 piece, I guess Larry and then Amol, and then I will say my
7 piece, and then we'll go around quickly.

8 DR. CASALINO: Really my piece is just go around
9 saying --

10 DR. CHERNEW: Okay. Amol.

11 DR. NAVATHE: [Off microphone.]

12 DR. CHERNEW: Okay. So, first of all, this is a
13 very helpful discussion, and I mean it when I say I've
14 heard a lot of the concerns. I think one of the challenges
15 that we face in general -- and I would say this is a broad
16 problem with fee-for-service, writ large -- is we just
17 don't get the prices right in a gazillion different ways.
18 And so I have to say personally I'm very skeptical of using
19 site of care as a proxy for illness or severity, but I also
20 am quite aware that in some ways site of care is a proxy
21 for severity. And certainly when we get our post-acute
22 stuff, we struggle with exactly that issue of how to play

1 out.

2 I think we need to separate out our desire to
3 support organizations like rural or government, or whatever
4 it is, in ways that don't involve mispricing services. And
5 so there's a balance in how this is played out. This is
6 intentionally crafted in a way that the recommendation does
7 not explicitly say, you know, this is what the volume
8 criteria should be for when you're doing it. The volume is
9 being used mostly to identify services -- if there was a
10 service that was always done in one site or 90 percent done
11 in one site, you wouldn't want to worry about should we --
12 you wouldn't really worry about exactly how to manage it
13 when you see services that are done broadly across
14 different sites, you would then look at them, to Greg's
15 point. That is just -- you have to look at them, right?
16 And then CMS is going to have to make decisions about what
17 service is going to be paid where, as they do for a whole
18 bunch of other things, and sometimes the services are right
19 and sometimes they're not. And we had a lot of discussions
20 on that.

21 So that's sort broadly where I am on thinking
22 about how to implement our principles of paying similar for

1 similar care, understanding that you can never say the same
2 and they're going to get it wrong in some cases, and you
3 have to worry to the point about if some -- you're the only
4 provider in an area and you drop the services, that's
5 clearly a problem in a range of ways, so that has to be
6 taken into account. But it has to be taken account, in my
7 view, by CMS in the selection of the services and what they
8 do as opposed to the principle that we're recommending.

9 But that's my view, and so now maybe we'll go
10 around, and I guess we'll start -- we started with Jonathan
11 last time, so we'll start with Kenny, if you want, and
12 we'll just go around just quickly.

13 MR. KAN: I'm supportive.

14 DR. DUSETZINA: I'm also supportive.

15 DR. RILEY: I'm on the fence. I'm with Robert.
16 I'm really worries about the effect on governmental
17 hospitals and rural hospitals.

18 DR. GRABOWSKI: I'm supportive.

19 DR. NAVATHE: I'm supportive as well. I want to
20 make a couple of really quick comments.

21 One, I agree with Mike that the implementation
22 pieces are really important, and that what we're doing here

1 I take to be illustrative, and so CMS would put a lot of
2 effort hopefully in trying to implement this appropriately.

3 Second, I think Greg made a number of fantastic
4 points. I think importantly we have to differentiate
5 whether something costs more to deliver versus a lot of
6 these services, like having MRI, open MRI, are not created
7 for the purpose of this OPPS service. They're for a much
8 bigger issue, and so what is the marginal difference, in
9 economist-speak, you know, that little difference. And
10 we're not stopping to pay for these services. We're just
11 paying an increment less. And so I think they're -- this
12 is something to think about there.

13 The third point, Betty pointed out the cost-
14 sharing piece. I think that's really important.
15 Essentially, as part of this, we're saying a lot of people
16 who are getting the identical service in a different site
17 are paying more cost sharing, which seems unfair.

18 And the fourth point is I agree with concerns
19 that Wayne and others are raising. I think we have to also
20 keep in mind that we did do the safety-net work that I
21 think is in part really just to try to help some of these
22 issues.

1 Thanks.

2 DR. RAMBUR: I will say again I'm very supportive
3 and consider it to be a matter of fairness and ethics as
4 well. Thank you.

5 DR. CASALINO: And I am very supportive. Look,
6 I'm a clinician, and I get what Greg described, real-life
7 cases, and Robert in a more abstract way also brought up
8 some problems. But I just want to put things in
9 perspective here.

10 I think that -- what's the most common thing
11 where this is a problem? It's office visits, right? So by
12 way, way, way overpaying hospital-based physicians for
13 office visits, we've driven consolidation. We've cost CMS
14 a lot of money. So I don't want to let the exceptions
15 drive the policy. If we just did exactly what's in this
16 report, nothing else, I think the country would be so much
17 better off now than it is if we don't do anything.

18 That doesn't mean that CMS, as Mike keeps saying,
19 couldn't try to do something to deal with exceptional
20 cases. You know, rural is so often a problem, but there
21 would be ways of dealing with that. I don't want to let
22 the exceptions drive the recommendation here. So I think

1 it would be great, and then CMS would have to try to deal
2 with some of the concerns that have been brought up, and I
3 think they could be dealt with. But, again, these are not
4 -- as Greg said, these are not necessarily rare, but
5 they're very uncommon in relation to high-volume things
6 like office visits, which we are way overpaying for now in
7 hospitals.

8 MS. GINSBURG: I'm with Larry.

9 DR. CHERRY: I'm on the fence, but, you know,
10 less supportive in the current format.

11 MR. POULSEN: And as I said, I'm supportive as
12 written, with an understanding that the text will identify
13 that there are services -- that CMS should examine the
14 services to make sure that we're not doing harm and driving
15 things to the ED, which I think is an absolute possibility
16 -- not for office visits. I agree with that. Not for the
17 services that I think have inappropriately been created by
18 the definition of a hospital outpatient department when, in
19 fact, it is a freestanding area. I agree with all those
20 points. I just want to make sure that we don't take what I
21 think could become a major, major inflator of costs by
22 driving people to the emergency department as the only way

1 for people with distinctive illnesses to end up getting
2 their car. Ditto kind of for the rural issue.

3 DR. JAFFERY: It strikes me that sometimes when
4 we drive towards fairness in everything, you get unintended
5 consequences. So, Mike, you were very thoughtful to say
6 let's start over there because we started here, but now I
7 get the first and last word.

8 [Laughter.]

9 DR. JAFFERY: So, you know, I think I said most
10 of what I've said, and as Greg just said, I'm very
11 supportive of this overall approach of trying to align
12 payments so they're safe to provide in the appropriate
13 settings, and, you know, just with some of those same
14 caveats. You know, Larry, totally agree, if the bulk of
15 these are office visits, you know, office visits absolutely
16 should be on that list. It sort of gets down to what's on
17 what list, and I'm not sure we -- there may be still some
18 nuances to work out. I mentioned the thing about the
19 availability of ASCs and so how do we modify for that. But
20 there may be some things that are on the biggest list now,
21 on physician offices, that maybe we need to think about and
22 if there are other modifiers. That may be a select few,

1 and I think, Greg, you had made this point earlier. There
2 may be -- even if those -- though those things may be in
3 the scheme of things very rare for individual institutions,
4 they may be relatively common.

5 Thank you.

6 DR. CHERNEW: Apart from my microphone, I also
7 don't know if anyone can see me, but that's besides the
8 point. I am here, just so you know.

9 Thank you all for these comments. It really was
10 a good discussion. It was a rich discussion. I think it
11 shows the level of deliberations that we can do, so we will
12 regroup and think about all of this and make sure that the
13 text reflects these concerns, and then we'll ponder where
14 we are, and I'll be continuing to work with Amol, Jim, and
15 the staff on this.

16 So, with that, it concludes our March meeting.
17 For those of you at home, thank you for joining us. Please
18 don't hesitate to reach out at meetingcomments@medpac.gov.
19 We do want to hear what you say. Or you can go to the
20 website and leave us comments there.

21 But, again, Dan, terrific job. We really do
22 appreciate it. There's a lot of analytic work and thought

1 that goes behind this, and I think it's really quite a good
2 job. So, again, thank you. Thanks to all the other staff
3 for their presentations today and yesterday, and we will
4 see all of you again in April.

5 Everybody, travel safe.

6 [Whereupon, at 11:42 a.m., the meeting was
7 adjourned.]

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