MEDICARE PAYMENT ADVISORY COMMISSION

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AGENDA PAGE

P R O C E E D I N G S

[11:02 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to the October MedPAC meeting. We are thrilled that you are here. We're going to start today with a discussion of the Medicare's payment rates for clinician, and I want to emphasize that the discussion we're going to have today is about long-term issue related to the fee schedule. But we will separately be having our normal discussion of the update, the sort of annual update as we do every cycle in December and January. This is sort of a broader discussion about the PFS.

So, with that said, I think -- am I turning it over to you, Geoff? I can't see you now. Yep. All right.

So I'm going to turn it over to Geoff. Take it away.

MR. GERHARDT: Okay, great. Good morning, everybody.

So this morning, Brian O'Donnell, Rachel Barton, and I are going to present issues related to current law updates to Medicare's payment rates for clinician services. Viewers can find a copy of this presentation on the control

panel on the right-hand side of the screen.

Every year, the Commission considers whether payment rates for services paid under the physician fee schedule are adequate and makes recommendations about whether current law updates should be carried out or if Congress should enact a different update.

For many years, this process has indicated that Medicare's beneficiaries' access to care is similar to the commercially insured population, and the Commission has generally recommended sticking with current law updates.

Those modest updates have helped restrain growth in Medicare spending, beneficiary premiums, and cost-sharing payments. However, some observers maintain that the current law approach to updating fee schedule payment rates is flawed and needs to be overhauled. Specifically, they point to the fact that inflation has been higher than recent historical trends and argue that the gap between future statutory updates and projected inflation will cause problems with clinician participation and beneficiary access.

Some stakeholders have also drawn attention to the fact that bonus payments to clinicians who participate

in advanced alternative payment models, known as advanced APMs, are scheduled to expire at the end of 2025, which could negatively affect participation in those models. In response to these concerns, today MedPAC begins to examine issues related to updating fee schedule payment rates as well as APM participation incentives.

As Mike pointed out, it's important to say that the work we embark on today is related to, but separate from, the assessment of payment adequacy that the Commission does each year, which will be performed as usual starting in December.

We'll begin today by presenting background information about how Medicare has approached fee schedule updates over the years and MedPAC's assessment of updates prescribed by current law.

Next, we will discuss how inflation affects the adequacy of payment rates and trends in the growth of volume and intensity of clinician services.

We'll then look at how Medicare payments vary based on what setting a clinician's service is delivered in as well as the issue of overvaluation of certain clinician services.

Finally, we'll examine how incentives for clinicians to participate in advanced APMs are structured under current law and how they relate to the merit-based incentive payment system, known as MIPS.

I'll kick things off by walking through the evolution of Medicare's approach to paying for clinician services. Since the Medicare program launched in the mid-1960s, policymakers have struggled with how to set payment rates for clinician services and how those rates should be updated over time.

Initially, the program based payment rates largely on the charges submitted by clinicians themselves. That meant payment rates increased as clinicians increased what they charged Medicare, a feature which helped drive payment rates upward.

The charge-based approach to determining payments was eventually replaced with a method that based payment rates on the relative value of resources needed to furnish each service. Payment rates were then updated each year by the volume performance standard, or VPS.

The VPS formula determined a target growth rate for spending and compared it to the growth of actual

spending during a given year. If actual spending growth was above the target growth rate, the inflation-based default update would be reduced. If actual spending was lower than the target rate, the default update would be increased. This mechanism was set up in order to slow spending growth driven by increases in service volume.

The VPS was replaced by the sustainable growth rate. The SGR didn't repeal VPS so much as it refined the spending target approach. The SGR made changes to the way spending targets were calculated, but more importantly, spending targets were not reset each year but were compiled cumulatively over time. This feature created problems when cumulative spending got so much larger than cumulative targets, and the SGR formula called for years of annual rate reductions.

In 2015, the SGR approach was replaced by updates specified by the Medicare Access and CHIP Reauthorization Act, or MACRA, which I'll discuss on the next slide.

MACRA contains three main provisions that affect payments to clinicians. In contrast to VPS and SGR, which use national spending target mechanisms to encourage clinicians to furnish care efficiently, MACRA looks to

alternative payment models and clinician-level value-based payment adjustments to encourage efficiency.

As shown in the top row of this figure, the law replaced the SGR's target approach with statutorily specified updates. One important feature of MACRA is that starting in 2026, rates for services furnished by clinicians and advanced APMs will be updated at a higher rate than services furnished by clinicians not participating in an APM.

Congress has made a number of adjustments to the updates specified by MACRA, as shown in orange. Notably, Congress replaced the flat update schedule for 2021 to 2024 with temporary one-year increases in payment rates that will not carry through to subsequent years.

As shown in the second row, MACRA provides annual bonus payments to clinicians who participate in advanced APMs equal to 5 percent and then 3.5 percent of their fee schedule revenue. The bonuses are set to expire at the end of 2025.

The law also creates MIPS, which is not scheduled to expire, and is a value-based payment adjustment for clinicians who do not participate in an advanced APM.

MedPAC has concluded that the MIPS program is ineffective and recommended that it be repealed.

This nearly 60 years of experience has provided a number of lessons that are worth mentioning. First, it's become clear that the fee-for-service approach we use to pay clinicians has built in incentives to increase volume and intensity because doing so generates more revenue. However, the VPS and SGR systems demonstrated that the prospect of across-the-board payment adjustments based on national spending trends provides weak incentives for individual clinicians to furnish care more efficiently.

At the same time, the way the spending target mechanisms worked in VPS and SGR can lead to highly variable and unpredictable updates, but with MACRA, we have seen how efforts to provide a high level of predictability by specifying updates years into the future means rates can't automatically adjust when conditions change, like unexpectedly high inflation.

Now that we've reviewed the history of the fee schedule and current law updates, I want to touch on MedPAC's assessment of payment adequacy.

As you know, each year we review various measures

that help indicate whether Medicare's fee-for-service payment rates are adequate. For our assessment of the physician fee schedule, we place a high premium on beneficiary access to care. One way we measure this is to survey Medicare beneficiaries about their experiences accessing clinician services. We also survey enrollees in commercial insurance plans to see how their experiences compare. Through these surveys, we found that Medicare beneficiaries' access to care is similar to and by some measures better than those in private plans. Comparable experiences between the two groups indicates that Medicare's somewhat lower payment rates are not negatively affecting access to care.

We also look at how many clinicians are billing the program. This part of our assessment indicates that the overall number of clinicians who are billing the fee schedule -- and that includes both physician and nonphysicians -- has grown steadily over time. What's more, the vast majority of clinicians accept Medicare's rates as payment in full.

Other indicators point in the same direction. The number of clinician encounters per beneficiaries

continue to grow. The number of people applying to medical schools and enrolling at schools has increased steadily over the last several decades, and studies indicate that clinician income has been growing faster than inflation.

With one exception, since MACRA was enacted, the Commission has recommended that updates specified by the law should go into effect. The one exception was earlier this year, when MedPAC recommended that fee schedule rates receive an increase equal to half of the Medicare Economic Index in 2024.

The recommended update, equivalent to 1.45 percent, was made in response to higher than normal increases and inflation and, unlike temporary increases, would be included in rates beyond 2024.

Given that our measures have consistently indicated payment rates for clinicians services are adequate, the Commission could take a watchful waiting approach to future fee schedule updates. In other words, instead of recommending structural changes to MACRA's update approach, it could continue to monitor payment adequacy data and respond to any deterioration in the measures, if or when that occurs.

I'll now turn things over to Brian, who will lay out some of the issues the Commission might consider when thinking about possible changes to the current law approach.

MR. O'DONNELL: Our first issue to discuss is the impact of inflation on the adequacy of payment rates in the physician fee schedule.

The Medicare Economic Index, or MEI, measures the weighted average price change for various inputs involved in furnishing clinician services. The index is made up of two broad categories, clinician compensation and practice expenses. Clinician compensation accounts for 47.5 percent of the cost of furnishing clinician services and includes the wages of physicians and other clinicians who bill the fee schedule directly, such as nurse practitioners and physician assistants.

Practice expenses account for the remaining 52.5 percent and account for items such as staff wages, medical equipment, supplies, and rent. For this work, we analyzed how MEI growth has compared with past fee schedule updates and how projected MEI growth compares with projected payment updates.

The next slide focuses on historic differences between cumulative MEI growth and payment updates. Over more than two decades, MEI growth consistently exceeded fee schedule updates. From 2000 to 2022, the cumulative increase in fee schedule updates, the light blue line, totaled 12 percent compared with MEI growth of 45 percent, the orange line. However, as the dark blue line on the figure shows, Medicare fee schedule spending per fee-for-service beneficiary grew by 94 percent over the same period, far outpacing MEI growth. This suggests volume and intensity growth has helped offset the gap between MEI growth and annual updates.

And as Geoff noted earlier, the Commission's full set of access measures over this time period suggest that beneficiary access to care has remained stable and similar to or better than individuals with commercial insurance.

The fact that our beneficiary access measures remain good while fee schedule payment rates have not kept up with MEI growth suggests that increasing fee schedule rates to closely reflect inflation has not been necessary to ensure beneficiary access to care. Instead of hindering access, relatively low payment rate updates appear to have

been a tool to slow the rapid increase in spending on clinician services, which benefits both the taxpayers and beneficiaries.

Switching from cumulative MEI growth to an annual view, we see that MEI growth was relatively low for the two decades preceding the COVID-19 pandemic, averaging 1.7 percent growth per year. Beginning in late 2021, MEI growth accelerated, reaching an annual rate of 4.5 percent. MEI growth is projected to moderate but remain slightly above the levels experienced during much of the past two decades.

For example, OACT currently projects that MEI growth will average about 2.5 percent per year from 2025 through 2030. Because updates are set at zero percent in 2025 and 0.25 percent or 0.75 percent per year thereafter, the gap between projected MEI growth and fee schedule updates is projected to be slightly larger from 2025 to 2030 than in the past.

As the Commission considers whether future fee schedule updates should be indexed to some measure of inflation, our review of the data on beneficiary access to care, annual fee schedule updates, and MEI growth over

multiple decades suggests that full MEI updates have not been necessary to maintain beneficiary access to care.

The gap between projected MEI growth and current law fee schedule updates is projected to be slightly larger in the future than in the past, and payment rate increases that are specified in law can become disconnected from the growth in the cost of running a clinician practice. These facts suggest that the Commission could consider exploring a policy to update the fee schedule rates based on some portion of input cost inflation. However, we note that higher updates will increase Medicare spending, beneficiary premiums, and cost sharing.

Our second issue to discuss is the growth in volume and intensity of services clinicians deliver. Relative to other types of providers, clinicians have a larger degree of control over the volume and intensity of services they furnish. The structure of the physician fee schedule, under which gross revenues increase when more services and more intense services are furnished, creates an incentive to increase the volume and intensity of services. Consistent with that incentive, the volume and intensity of fee schedule services has increased over time.

For example, from 2000 to 2017, the cumulative per-beneficiary growth in volume and intensity of imaging services was 75 percent. Importantly, such growth in volume and intensity and the additional examples included in your mailing materials could represent increases in patient complexity and/or other factors, such as changes in coding behavior.

Since the inception of the fee schedule, policymakers have used two main strategies to control volume and intensity growth. The first strategy employs explicit mechanisms to lower payment rate updates if spending growth exceeds certain targets. Such mechanisms were employed as part of VPS and SGR and were tools to limit national Medicare expenditures.

However, such mechanisms don't provide individual clinicians with an incentive to practice efficiently because they still benefit from increasing the volume and intensity of services they furnish, and all clinicians in the aggregate are penalized through lower payment updates.

The second strategy is the MACRA framework of modest fee schedule updates paired with value-based payment arrangements, such as A-APMs. Such strategies limit

Medicare expenditures through modest payment updates and, in theory, promote efficient provision of care because value-based purchasing rewards or penalizes individual clinicians. In practice, the evidence on the effectiveness of many value-based purchasing programs is mixed.

Our third issue to discuss is the wide variation in payment rates based on where a service is delivered. Medicare often pays more when services are paid under the OPPS. Different updates can increase payment differences across payment systems.

From 2001 to 2023, the average annual hospital market basket increase was 2.7 percent compared with 0.5 percent the fee schedule. Widening payment differentials across settings may contribute to vertical consolidation in care being billed under the higher-paid OPPS.

In your mailing materials, we discussed two options to address payment differentials across sites of service. The first is to implement the Commission's standing site-neutral recommendations. Under this option, Medicare would reduce OPPS rates for certain services to ensure Medicare sets rates based on the resources needed to treat patients in the most efficient setting.

Commissioners also could consider updates that promote site-neutral payments. For example, the practice expenses paid under the fee schedule could be updated by the growth in the hospital market basket. Such a policy would promote parity in how practice expenses are updated under the OPPS and fee schedule.

I'll now turn things over to Rachel.

MS. BURTON: Our fourth issue is that some of the fee schedule's billing codes are overvalued relative to other codes. We mention this because when Medicare's payment rates are updated, the payment increase applies to all codes in the fee schedule, including these already overvalued services.

There is particularly strong evidence of the overvaluation of surgical services relative to other services.

A recent study of 1,350 surgical procedures that involve the use of anesthesia found they took 27 percent less time to conduct than Medicare's billing codes assumed. This type of overvaluation could be addressed through policies MedPAC previously recommended that would improve the process and data used to set billing code values.

But there's another problem with surgical services.

A study of 10- and 90-day global surgical codes found that the number of post-operative visits provided by the clinicians using these codes is lower than Medicare's billing codes assume: only 4 percent of the post-operative visits assumed in 10-day global surgical codes are actually being provided, and only 38 percent of the post-operative visits assumed in 90-day global codes are being provided.

Given the fact that these codes make up half the codes in the fee schedule, the Commission could supplement our prior comment letters on this topic with further action on this issue.

The fifth and final issue we will raise has to do with incentives for clinicians to participate in advanced alternative payment models.

As Geoff showed in a prior graphic, MACRA incentivizes A-APM participation through a bonus and then higher updates to payment rates.

Clinicians who qualify for the bonus or higher updates are also exempt from MIPS' performance-based adjustments to their payment rates, which can be positive,

neutral, or negative.

To date, the A-APM participation bonus has always been larger than the highest MIPS adjustment; this year, the median bonus is worth 5 percent of a clinician's fee schedule payments, while the top MIPS adjustment is worth less than 2 percent of a clinician's fee schedule payments.

It is unclear whether the A-APM participation bonus has actually influenced clinicians' A-APM participation decisions, since the size of the bonus is relatively small, and a number of other costs and benefits must also be weighed when deciding whether to participate in an A-APM.

Nevertheless, some stakeholders claim that the expiration of the A-APM participation bonus after 2025 could result in a scenario in the late 2020s where some top-performing clinicians might receive larger Medicare payments by exiting A-APMs to participate in MIPS.

The type of clinicians for whom this would apply are those who don't expect to qualify for shared savings or other performance-based bonuses in their A-APM, but do expect to be able to earn a near-perfect MIPS score.

For example, this graph shows that in 2027,

payment rates for clinicians in A-APMs, shown by the orange line, will be 1 percent higher than other clinicians' rates, shown by the blue line.

Yet the clinicians shown in the blue line will also be eligible for MIPS adjustments, which could increase their payment rates by an additional 2 percent, if past trends continue.

Although only a small share of clinicians will likely find themselves in this situation, A-APMs have had such a hard time generating net savings that if even a small number of top-scoring clinicians exit A-APMs, it could have a negative impact on A-APMs' ability to succeed.

By the early 2030s, the differential updates shown in this graph will create a financial advantage for clinicians in A-APMs comparable to that experienced by clinicians today.

But a new problem will emerge in the 2040s: the difference in payment rates will become so large that it may be untenable, especially if clinicians continue to not always have access to an A-APM, due to their geography or medical specialty or other circumstances.

Due to differential updates' weak incentives in

the 2020s and then overly strong incentives starting in the 2040s, Commissioners may wish to consider eliminating these differential updates.

A separate question for Commissioners is whether the A-APM participation bonus should be extended after 2025.

To some extent, the rationale for keeping this bonus depends on whether MIPS is retained or not.

If MIPS is retained, extending the bonus could prevent certain clinicians from exiting A-APMs for MIPS. But if MIPS is eliminated, as MedPAC previously recommended in 2018, then the bonus may not be needed since it's unclear that the bonus, worth $1,500 to the median clinician, is the deciding factor in A-APM participation decisions, it's not available to clinicians in some geographic areas, in some medical specialties, or in some situations, and it increases Medicare spending by about $650 million a year.

Yet retaining the participation bonus might keep some clinicians in A-APMs, especially if they fail to earn performance-based bonuses such as shared savings.

If there's interest in retaining the bonus, we

can come back to you with options for restructuring it to have less expenditure-maximizing incentives.

This brings us to your discussion.

We've raised a lot of issues in this presentation, but the key questions we are looking for your input on are shown on this slide.

Our first and most basic question is: Are changes needed to Medicare's default fee schedule updates to ensure adequate payments to clinicians, or should we continue our "watchful waiting" approach -- meaning we'll monitor our payment adequacy indicators each year and only recommend an overhaul of current law if we see deterioration in our indicators?

If Commissioners are interested in reforming current law now, some more specific questions arise:

Would you want to incorporate some portion of inflation into the default updates to payment rates?

Would you want to incorporate some limit on spending growth?

Would you want to consider using payment updates to try to promote site-neutral payments?

And in terms of incentivizing A-APMs, would you

want to restructure or eliminate the A-APM participation bonus? And would you want to eliminate differential updates for clinicians in and out of A-APMs?

Your input will help us identify topics to explore in greater depth later this cycle.

With that, I'll turn things back to Mike.

[Pause.]

MS. KELLEY: Mike, we can't hear you.

Mike, I'm sorry. We can't hear you -- there we go.

DR. CHERNEW: Now you can hear -- I know. You can't see me. But I am, in fact, here, as my voice illustrates. I will hopefully be back on camera if I can get my cursor back.

My technical difficulties masked what was really a spectacularly, spectacularly good chapter and really, really exceptional presentation. So I won't say more about that, and I think we should go through the queue, starting with Round 1 questions. And if I followed this right, Cheryl is going to have the first Round 1 question. Is that right, Dana?

MS. KELLEY: Yes.

DR. CHERNEW: And then I'll let you manage the queue.

DR. DAMBERG: Thanks, Mike. And kudos to the staff for an excellent chapter. Amazing work.

I had a quick question related to A-APMs. Do we have any information or might this be something that could be included in the chapter in terms of what percent of eligible physicians are actually participating in A-APMs? And has participation been waning or is it still growing? I don't really have a sense of that space.

MS. BURTON: We can look into those stats, but I can tell you off the bat that one in four clinicians receive the A-APM bonus.

DR. DAMBERG: Thank you.

MS. KELLEY: Betty.

DR. RAMBUR: Yes, thank you. Absolutely fabulous. Very interesting. I have a quick question for Geoff.

Geoff, you talked about MIPS having been repealed when you entered the slides, and on page 22 it says that the -- or not that it was repealed, but the recommendation was that it be repealed. And then on page 22 that the

previous group of MedPAC Commissioners recommended elimination.

But is it more precise to say that it was recommended to be revised? Is that correct?

MR. GERHARDT: Yeah, so that's sort of a two-part recommendation. One, the first part was to repeal MIPS, just kind of rip it out by the roots. And the second recommendation that went along with it was to replace it with a value-based system that would work better than MIPS. And I believe the chapter that that was included in in 2018 gave some possible examples of how that could look, but didn't get at all specific about how sort of a new and improved value-based system would work.

MS. BURTON: I should mention that it would be voluntary and that it would be designed to always be smaller in size compared to like an A-APM bonus or any kind of incentive, because our clear goal was to incentivize people to go into A-APMs in that chapter.

DR. RAMBUR: So it was a recommendation --

DR. CHERNEW: Can I ask --

DR. RAMBUR: I'm sorry.

DR. CHERNEW: No, go on -- I'm going to ask a

clarifying question on your clarifying question, Betty, but first you should finish your second clarifying question.

DR. RAMBUR: Okay. I was just going to say I think it's important that that's sort of clearly laid out, and I'll stop there because the rest would be a Round 2 comment.

DR. CHERNEW: So the follow-up clarifying question I want to ask is: The timing of those two recommendations -- I wasn't on the Commission -- is a little unclear. My interpretation was always some version of we should get rid of MIPS and -- it's fine to replace it -- revise it, but it wasn't actually tied in time. It would be consistent with our recommendation to get rid of MIPS while we developed the complicated replacement approach. Is that the correct interpretation of that, or is it really that they happen simultaneously -- like, how would you interpret that generally, that recommendation, in terms of the timing of those two parts?

MR. GERHARDT: I think that's generally accurate. I think the priority was removing MIPS and then -- the goal was to replace it, but the timing, along with all the other sort of particulars, was left up to sort of CMS and other

stakeholders to develop. Obviously, you'd want that transition to happen as quickly as possible, but one wasn't sort of hooked to the other directly time-wise.

DR. CHERNEW: Thank you.

MR. MASI: I agree with everything Geoff said, and we can work to make sure the chapter is clear in this area. I would emphasize what Geoff said, that there was urgency to eliminate MIPS reflected in that recommendation. I think that was kind of the headline message that I took away.

MS. KELLEY: Okay. I have Lynn next with a Round 1 question.

MS. BARR: Okay. Good morning, everybody. I have a number of Round 1 questions.

So I'm curious about, you know, the movement from 99213 to 99214, and I'm -- you know, one of the things we hear all the time from clinicians is, you know, do more, pay me less. Are we kind of mischaracterizing this a little bit? I mean, it was about that time when everybody started having this extensive amount of quality reporting they had to do. We had to do depression screening. We have to do, you know, substance abuse screening. I mean,

we have regulated a more complex E&M visit, you know, particularly primary care physicians. So I'm just wondering, like that just strikes me as kind of a, "look, they're coding" more without sort of taking into account what we might be doing around -- what they might be doing with that extra time.

My next Round 1 question is that, you know, there was a discussion about, you know, now it's -- the matriculation of physicians, right? And what we didn't mention in that matriculation of physicians was that we went from, you know, one-third PCPs, two-thirds specialists, to one-quarter PCPs, three-quarters specialists. So are we really creating an adequate workforce? And the fact that this has really been pretty flat yet we have this huge aging population, you know, it seems like we're paying them enough and we have all these applicants but not enough slots potentially. But are our payment policies actually driving people to more specialists? I just felt like there was an awful lot missing in that that says, oh, it's adequate, but I don't think that supply could possibly continue to be adequate given the aging of the population and also the shift from

PCPs, which are the lowest paid, to more specialists. Is that also a result of what we're doing. These are just questions I have.

When we calculate -- I'm a little concerned about in the paper how we lump PCPs and specialists together. So we have an average practice expense of 50 percent -- right? -- and an average compensation of 50 percent. Is that true for specialists and PCPs? You know, because maybe if we're going to make a differential update on the practice expense, yet their practice expense is much lower, then we're actually going to be hurting the constituents we care about the most. So I was curious if you could break that out or if you've already found whether they're actually the same. And that is the end of my Round 1 questions. Thank you.

MR. O'DONNELL: So, Lynn, this is Brian. I can take a shot at a few of them, and then my colleagues can jump in.

On the shift from coding from 99213 to 99214 over time, the process of increasing the intensity has happened over the last two decades, and so, you know, I think we -- I think we did not mischaracterize it, particularly because

we didn't characterize it, in the sense that we said this could be due to kind of increasing complexity, and one of the things you mentioned is that they could be doing more services during the visit. I think that's a fair thing.

I think the thing to note -- and we can give you more data points -- is that it has not been a kind of last-few-years thing. It's been happening kind of slowly over the last 20 years, and a lot of that had preceded these new codes that you are talking about.

So I would just state up front we didn't say that it's all just coding, but we can make that as clear as possible.

I think on the second point on the matriculation of physicians, I think, you know, we hear you in terms of the share of PCP versus specialist, and I think when we presented this data, we were kind of looking for problems on, you know, does the pie need to get bigger in terms of clinician payments. And I think when we think of the distribution of specialists versus PCPs, we tend to think of that as kind of a relativity problem in terms of PCP kind of salaries relative to specialists. And so we can hammer that point home that the relativity issue, which we

have a long body of work in, is really probably the primary driver, not the size of the pie. But we hear you on that point.

And then on the practice expense point, when you said kind of, we mentioned about half practice expenses is for -- or kind of MEI is for practice expenses. And certainly when you break it out by specialty, you'll see that a lot of specialties, although not all of them, have higher practice expenses. You know, primary care kind of lives in the middle of the distribution, so you can think right around half, but we can spell it out in the spring paper. And then you have other specialties like, you know, behavioral health or mental health counselors which have very, very low shares of practice expenses. So you're talking in maybe the 30 percent range.

And so you're right that there's a distribution there and kind of as we think about how we might update rates, that definitely is something that we can put in the paper in the future.

MS. BARR: Great, because then --

DR. CHERNEW: Can I ask --

MS. BARR: -- said if we did something, you know,

more global, then the specialists would get more.

DR. CHERNEW: Well, so can I jump in for a second?

MS. BARR: Yeah.

DR. CHERNEW: So this issue of primary care -- and I would add, while we're having this discussion, the issue of behavioral health specialists is really, really central to a lot of what we do. The challenge in these recommendations is we do a lot of different things and we approach then in different places, so we unnecessarily -- I won't say un -- we necessarily end up dividing up certain things. So, for example, the E&M rule, which I think reflected a longstanding MedPAC view that we need to pay more for E&M services to a bunch of people, including behavioral health, a version of that has been implemented. We've been very strong there. A lot of our -- like our physician safety network, we've been very clear to try to direct more money in that rule to primary care.

So the challenge we have is when we weave the threads of all the different objectives through specific things. So I'm going to paraphrase Brian's answer. Correct me if I'm wrong, Brian. We care an enormous amount

about the relative payment of different specialty, be that primary care to specialists, behavioral health and others. We've done a number of things in those spaces that we will continue to do and echo.

It is true that if we give a general across-the-board increase dollar-wise, it helps the higher-paid groups more than the lower-paid, because that's just the way percentages work. The extent to which we target things is probably -- and this is the part I want to hear your thinking of, Geoff, Brian, and Rachel. The extent to which we target things, maybe that would come up here in the overpriced code portion where, say, we thought some things were overpriced, but for the most part the targeting is coming in other recommendations, and this is a bit of a broader update recommendation, and now it gets to how we do our March work as opposed to how we do some of the other things. So that's sort of how I see this, but I interrupted and rambled to explicitly make the point that the spirit of the concerns you're raising, Lynn, are not lost, I think, certainly on me, and I would say on the staff, that the primary care, specialists, behavioral health supply, those are really first-order concerns. How

that plays into this is a slightly different question, but I will repeat, first-order concerns.

Did I mischaracterize anything, team?

MS. BARR: Can I just ask a clarifying question? I know that last year, we talked a lot about we've got the new E&M rules and everything's -- you know, this is really going to help PCPs, but I read, I believe, just in the last couple of days, that it ended up not really helping the PCPs. And I'm very confused by that, because all of that work was really to help primary care, and then it didn't really give it much of a bump. So I'm still worried. These policies, to your point, are very hard to implement, but I don't think we've solved primary care payment unless other people disagree.

MR. O'DONNELL: Yeah. And, Mike, I would just say that I think that there was a two-part question, and I probably answered the first part and you answered the second one. Lynn asked about the distribution of practice expenses, and then I said, of course, we can provide that data to you. And then the bigger, larger, harder question, which falls on you all, is how do you deal with that? Is it a relativity thing? Is it a targeting thing, or is it a

general update thing? And that's for you all to discuss.

MS. BARR: Thanks.

MS. KELLEY: Okay. I have Scott next for Round 1.

DR. SARRAN: Can you hear me?

MS. KELLEY: Yes, we can.

DR. SARRAN: Okay, great.

Yeah, so two questions. First, Mike, can you help us collectively understand how we think about the disconnect between the consistent rise in physician incomes versus the discrepancy between MEI and the physician fee schedule? And my question is meaning, is the rise in physician income something we should consider in this discussion, or is that essentially out of bounds for our work?

And the second question is really on this issue of whether the shift in coding patterns as well as the overall increase in both volume and intensity of services is something that is physician-driven without being driven by either new value creation, new standards of care, new quality requirements increasing severity of illness, et cetera. And the question there is, is there any reasonable

way we can try to parse out the causalities of that observed rise in volume and intensity of service? Is there any research out there that we haven't yet pulled? Are there any data sets that we could incorporate to help us parse that out? Because it is an important question.

DR. CHERNEW: Brian, let me -- or Geoff or Rachel, let me answer the inbounds question, and you can answer the technical questions. I have my thoughts on them, but for the inbound question, Scott, it is certainly inbound to consider what the trajectory of physician incomes are broadly, the same way we would think about that across other sectors. Our goal is not to make that the determining factor of what we recommend. We would like the Medicare rates to be adequate, whatever that means. So that's my general sense is it's certainly inbounds, but it's not definitive in terms of what we should do.

In terms of parsing it out, I think it's a combination of things that are happening outside of Medicare -- consolidation would be the main one -- and things that are happening inside Medicare, some of the volume and intensity things that was mentioned. And I'm going to save the answer to how we parsed out the volume

intensity stuff, which I do think is quite important to the staff.

MR. O'DONNELL: So I don't have a great answer on the volume/intensity thing. I think we can double back and look at what research is out there.

It's often -- and we gave you multiple examples in the paper, and so it's going to be example-specific, so the disaggregation for CTs might be different -- CT scans, rather, might be different than E&M office visits. So I wouldn't think of it as one global bucket needs to be sussed out. It's probably lots of little buckets.

But I do think that one of the points that we were making on the volume and intensity bit is that the fee schedule relative to other payment systems is kind of uniquely susceptible to volume and intensity. So, within a hospital DRG, there could be lots of things happening or increasing over time, but the payment system doesn't reward that necessarily. And so I think that's one of the points we were trying to make.

DR. CHERNEW: And, in fact, what I think they've done is they had a system for volume and performance, which was called "volume performance." Then they had a system

called "sustainable growth." It was called "volume performance." Those had a bunch of design flaws because of their aggregate nature, which was pointed out in the presentation, and what seems to have happened going forward -- and I think the staff said this, so I'm reiterating it -- there's less concern on volume and intensity. There's addressing it by having very low fee uptake, and that's sort of been the tradeoff. And a lot of this discussion is what are the limits to that, essentially, and that's basically the discussion we're now having.

MS. KELLEY: Okay. I have Larry next.

DR. CASALINO: Really outstanding written materials. I really, really, really -- I didn't know we were going to be getting a packet like this, and I was really delighted. I think it was outstanding. The historical discussion of evolution of physician payment was terrific, and I like the five policy areas that you divided things out. It was wonderful throughout, really. Great work, even by the Commission's high standards.

I have two Round 1 questions. One is in terms of the more intense coding, moving from 99213 to 99214 and 99215, Brian and Scott have addressed some of the reasons

why that might be happening, and I agree some of it probably is increased complexity of what physicians are supposed to do. I think there is some target income efforts on physicians that has led to increased coding.

But the question I have is, how much of this increase -- this should be a relatively easy thing to do -- comes from -- how much increase nationally comes from physicians who almost always code 99214 or 99215 or in some cases almost always code 99215?

We published a paper some years back -- and I'm sorry I don't have it at my fingertips now -- where we show there's not an insignificant number of physicians who do that. It's unlikely that they could have a rolling business fee 99215, for example, without working about 24 hours in the day.

So the question I have, really, is this a significant enough phenomenon if one matched what these physicians are doing against the overall increase in 99214, 99215? Would there be a significant impact if there was more of an effort to go after that kind of fraud and abuse? Because I don't think there is much effort now.

I guess that's not much a question as asking you

if there's something that you could do to look into that. I'm happy to share the paper with you if you like.

And then I do have one more question, but if you want to comment on what I just said?

MR. O'DONNELL: Yeah. I can comment on that. So I think directly answering your question, we did not do that. It is something we could do, but taking a step back and thinking about it globally, the shift has been so substantial in terms of maybe 20, 30 percentage points, something like that, such that I don't think it's simply a tail effect or a very, very small number of clinicians that's driving it. It's largely a broader spectrum change, and we did see across both PCPs, specialists, and then APRNs and PAs.

So, at a first kind of blush, it looks relatively broad based, but that's not to say that there aren't some folks who are doing it more aggressively than others or they had a disproportionate impact. So we can look at that in the future.

DR. CASALINO: I agree with what you're saying, Brian. I guess another way to frame the question would be, is this tail, even though it's only a small fraction of the

overall increase, is it still a large enough absolute sum of money that it would be worth CMS looking at it more carefully, I guess, would be the question. And that is something you probably could look at pretty easily, and I'm happy to share the data with you.

The second question is, you know, on page 22 of what you all sent to us -- and this isn't the only time that we've seen this -- you point out that the Commission's criteria for thinking about payment adequacy, there are three principles. One is ensuring beneficiary access to care. Second is promoting high quality, and third is making sure payments are adequate to meet the cost of relatively efficient providers.

But really the materials you sent to us -- and I think this is generally true -- and it's not your fault. It's just the nature of what's available, but I think the third point about relatively efficient providers, my understanding is for physician practices, we don't really have data on that. So you kind of ignored it, I think, in the written materials.

But the second one, quality, also really didn't come up much in this chapter. So what we've really gotten

rid of materials is one out of three principles.

The third one probably can't be gotten at for physicians that are relatively efficient providers.

Second one, quality, I just wanted to hear what you guys have to say about that.

MR. GERHARDT: So, Larry --

DR. CASALINO: Let me just put it one other way. I can imagine a situation -- and I think we may even be in a situation -- where access is -- where measures of access are good, but quality is still not good. But we might not know that.

MR. GERHARDT: Yes.

MR. MASI: Can I jump in? Maybe I'll jump in to take the first pass, and then you should certainly jump in because you know more.

So I really appreciate you surfacing this, Larry. On quality, we can see what we can do to bring more information on quality into this discussion. As Geoff said at the beginning, this line of work, while it's related to our payment adequacy work, it is also a distinct block of work that we're pursuing here. And so there is some judgment involved about how much work from this other line

of work do we copy over to here, but we can see what else we can bring with respect to quality.

On cost, I agree with you that there are data limitations here, and so we are somewhat limited in terms of what we can bring to that conversation. But, in my mind, I do think of the entire MEI conversation as somewhat related -- as a cost consideration, thinking about how growth and input costs for physicians has trended over time. And we did try to emphasize that both in the written materials and the presentation, but we're happy to look more closely at that to see if there's some additional information we can bring to bear.

But, Geoff, you should certainly jump in here as well.

MR. GERHARDT: No, I think what you said is fine.

I think, Larry, since you've been part of this process for many years, you'll probably remember that when we do the annual assessment as part of the December-January process, we admit that it's much more difficult to measure quality and costs in the clinician world. We take what data we can get, and we use it, but it's just -- it's either not there or not very reliable for those two sort of

areas. And so we end up focusing more on access than we might with some of the other payment systems.

But I think, as Paul said, we'll see what we can do to bring in more on those other two issues going forward.

DR. CASALINO: Great.

MS. KELLEY: Okay. I have Brian with a Round 1 question.

DR. MILLER: Thank you.

And I want to echo various comments that I enjoyed. The historical journey down physician payment policy was a fun trip, and we don't get to take it very often. So that was very well done.

Two questions. I guess two big ones and a few small ones. The big ones are, we talked about physician compensation as being a measure that payment levels are accurate, yet over the last 20 years, physician payment has changed at a very low rate, while hospital IPPS, OPPS rates have gone up a lot, and physician employment has become a huge trend. So physicians were previously in independent practice, now many are corporate employees.

So when we are measuring physician compensation,

are we taking that into account? And if not, when we say physician compensation is adequate and increasing, are we really saying that the lack of site-neutral payment has made up for the decline in physician fee schedule and encouraged consolidation? So that's one big question.

The second question is around the measures of beneficiary access and sort of bene satisfaction. If we're comparing commercial private insurance to the Medicare population, those are very different populations, and frankly, they have different expectations and a different schedule.

So when they self-rate, like if you're working 8:00 to 6:00 p.m. and someone offers you a Tuesday 11:00 a.m. appointment, your answer is that's not adequate access for me. If you're retired and have activities and things you do, that may be considered adequate access for you. So are we considering these sort of differentiations between those two populations?

MS. BURTON: Well, I think at the end of the day, we're trying to assess whether beneficiaries' access needs are being met, and when large shares say they are, I think that is somewhat reassuring to us.

On your first point, when we've looked at the compensation of physicians in hospital practices versus independent practices, we don't find that hospital practices consistently pay more than independent practices. So I just wanted to mention that on that point.

DR. MILLER: So we should probably include data and parse the physician compensation question down into more detail if we're going to make that assertion.

Another couple of other questions about figures. Going to Figure 3, which I know one of my colleagues had asked about, the per capita physicians and noted appropriately the differentiation between primary care and specialty care, wouldn't a more appropriate measure be per capita applicants and matriculants, noting that the domestic population has grown significantly over the past 40 years? So it's actually unclear if an absolute number adequately reflects supply.

MR. O'DONNELL: Oh, yeah. I can take that one. I think we can think about that. The per capita makes sense.

I do think that looking at it over the last 20 years when physician updates were quite low, you're still

going to see that upward slope. So applicants per capita will still be increasing at a time when fee schedule rates are low, but we can look at putting it on a per capita level.

DR. MILLER: And then the question about Figure 2, which I enjoy --

DR. CHERNEW: Wait. Can I just jump in and say something in response to that, Brian?

DR. MILLER: Sure.

DR. CHERNEW: I think the point broadly to take away is, regardless of per capita or not, I think it's pretty clear that there's excess demand to be physicians relative to excess supply. People want it. I think that's because there's constraints on the number of slots. So if you just looked at the number of people coming into the physician labor market versus the number that want to, there's fewer, because of other constraints in the system.

DR. MILLER: Thank you.

One of the other questions I want to ask about was in Figure 2. We note the MIPS max adjustment, but the actual adjustments are often much lower due to budget neutrality. And perhaps we should just figure to account

for that. It might more accurately display the effective max. I looked it up. I think that the max performance bonus in 2018, for example, was 1.68 percent, which is a very different message than saying that you could get a 9 percent for exceptional performance.

And then a final question about the volume intensity response, building off others, even if there are multiple components -- maybe there's a component of increasing patient complexity; there's a component of income targeting -- isn't there also a component or potential alternative explanation that the volume and intensity modulation suggests that payment levels are too low, and that that is a response to that?

MR. O'DONNELL: So I do think there are two broad -- and we have a text box on this, but two broad theories about how payment rates reflect kind of volume and intensity. I think one school of thought says the lower payment goes -- payment rates go, the higher the volume and intensity. That's one school of thought. And then the other school of thought says the exact opposite, which is the sense that the lower payment rates go, the lower volume and intensity goes. And people can have their equities on

which side of the fence they are on, but I do think the last decade, we've had very, very low fee schedule updates and quite low -- and relatively low volume and intensity growth. So I do think that there's been new research coming out on that front, which we can try to incorporate.

DR. MILLER: Thank you.

DR. CHERNEW: I just want to do a time check. We need to get to Round 2. So I want to just emphasize as we go through this is, this is Round 1, clarifying questions. I didn't mean that to sound aggressive.

MS. KELLEY: Okay. We have Gina next.

MS. UPCHURCH: Great. Thanks. This will be quick.

Yes, it was a great chapter, and it's -- I've tried to wrap my head around Medicare Advantage and the Part D benefit for years and how complex it is. I will say how we pay providers is equally complex and lots of revenue streams, so thanks for trying. Especially giving the history of it was very helpful.

Just a quick question. So these payments that come for A-APMs, whether it's the bonus payment or trying to get at the quality of the A-APMs as well as the MIPS

payments, are they directly for provider compensation, or can they be spread across practice? I mean, does it go to the practice to spread the funds however they wish to, or is it directly tied to compensation? It wasn't clear in the writing, and I'm just not clear. Thanks.

MS. BURTON: You know, I'm not sure if it's to the TIN or the NPI either, so we can look into that and add that.

MS. UPCHURCH: Great. Thank you.

DR. CASALINO: I can respond to that. It goes to the practices, and the practices decide what to do with the money. Unless you're a solo practitioner, it doesn't go directly into your pocket.

MS. UPCHURCH: Thanks, Larry.

DR. CHERNEW: Josh Gottlieb does a paper on the passthrough, and I'll try and get you the numbers to how much seems to be passed through.

MS. KELLEY: Tamara.

DR. KONETZKA: Great. This can be quick because my original question was really the exact same as Scott's second question, and that's come up a few times. And that is about the increases in volume and intensity over the

years. Is there any way to parse out what part of that is due to coding, what part of that is due to changes in technology, underlying health versus just making up income?

And I think I had some similar thoughts to Brian as well that this could be a reaction to rates. It could be something they would do anyway, but to the extent that this is a strategy pursued by physicians to compensate for lower rates, I think it would be interesting to see. And I'm curious if you ever did the analysis of volume and intensity increases by a type of physician, right? And this goes back to the primary care versus specialist too, because I think to the extent it's a way to compensate for lower rates, it's much easier for procedure-based specialties to make up for those rates through volume and intensity and probably much less so for primary care.

I realize it's quantitatively actually quite challenging, but if we can get to the point where we have a sense of how much this is to make up for rates, we may want to consider the unintended consequences of that for different types of specialties.

So I guess the question was, have you looked at it by types of physicians?

MR. O'DONNELL: So I can answer that. I don't know that we've looked at it specifically by types of physicians, but we have looked at by type of service. And so your intuition is probably correct, at least in part.

So when we looked at the number I cited for imaging, it was 75 percent. You also saw more rapid growth for test and procedures. Growth for E&Ms, which PCPs rely on, but also major procedures where about half the volume and intensity growth.

So I would say there probably is less ability for PCPs to grow their volume and intensity, but I do think other types of clinicians probably fall into that bucket as well, and we can look at that.

MS. KELLEY: Okay. That's the end of Round 1, Mike.

DR. CHERNEW: Okay. And I think Round 2 is going to get kicked off with Jonathan.

MS. KELLEY: Right.

DR. JAFFERY: Great. Thanks.

And like others have said, this is a great chapter. I mean, so much educational material in the background and the history of it was really, really

helpful.

I'm going to start with -- since I think a lot of this is really ultimately about access for beneficiaries to high-quality, affordable care, I'm going to talk about a couple of things, make some comments about some things in the chapter that I think speak to that as a sort of foundation. And then I'm going to try and really couch my comments to address your four questions that you have on the slide up there.

But I was struck by some of the data you presented about how we anticipate that over the next X number of years, we'll see that practice costs for patients that continue accept Medicare, patients will increase by 35 percent, while payments will increase from 2 to 5 percent under the current methodology of the differential updates.

And it strikes me, like many things we've talked about in this Commission over the past several years, that I worry a little bit about something that could be a lagging indicator versus a leading indicator.

I mean, I think as we sit here, it's still pretty anathema to most physicians to think about not taking Medicare patients, but there could come a point where the

issue gets forced. And once practices stop taking them, I think it's going to be too late to fix it. It's going to be really hard to reverse, especially if we continue with along the lines of what we see projections around physician shortages. And there will be too many other patients, and so I worry about that.

We talked a lot about this and will, I'm sure, again in December and in January when we talk about the updates. We talk about some of these things every year. One of the things on page 25 that stuck out to me that I've seen in previous years in the December chapters around this notion that relatively smaller -- a small share of beneficiaries reported experiencing trouble getting health care last year, and it's 8 percent. And that's the quote.

And I think, yeah, 8 percent is, I guess, small compared to 92 percent, but it's still 1 in 12 beneficiaries and more than 5 million people. So I just think we should be careful with that language because it's a big deal to a lot of beneficiaries and their families.

Page 27, you outline reasons that providers may choose to accept Medicare, and I think the one thing that I want to mention that I don't think I saw there was prompt

payments are another thing that is really helpful for providers. So whether Medicare is considered a good payer or not in terms of absolute dollars, CMS does tend to pay promptly. And this is, I think, notably a problem as more and more beneficiaries shift into MA plans, because that's not consistently the case with those plans.

In fact, I know of health systems that are really struggling with their contracts with MA plans because of that. It's often less about the payments that they're negotiating as it is about -- or how much they're going to get as it is about just getting them to pay them promptly. And that's not just a slow payment. It's denials that then get reversed and things like that.

So kind of with that as a context to go to the four questions, number one, should we think about incorporating some portion of inflation? I think we have to. When I look at SGR, the history that we have and the history that we saw in the last -- you know, four of the last five years when there have been zero percent updates, we've seen Congress go back and change that.

And, yes, predictability is important for anybody when they run a business. That's one of the things that we

hear over and over again from people in all kinds of sectors and industries. But if we're really stuck at 0.25 or 0.75, which is -- you know, 0.25 is very close to nothing. Going back to that huge differential between practice expense and cost of living, inflation, all that, I think it's just going to continue to be a problem. And we'll continue to see -- whether we think it's right or not, we're going to continue to see it mitigated on an ad hoc basis annually or perhaps more than annually.

In terms of some limit on spending growth, I'm not sure what we mean there. I think those are some of the policy goals. If we're talking about putting absolute limits on, I worry in the way that -- you presented decades of experience leading up to SGR and stuff, that I think we really want to avoid getting into that cycle again because that was quite problematic. So I think it's actually the policy goals are there. I'm not sure what we mean by actually limiting it, and so I worry about that.

The site-neutral payments, this is complicated, as we've talked about already, the way that this ties into concerns about consolidation. There's obviously a lot of discussion about site-neutral right now, both within the

Commission and on the Hill and in other places all across the country. So I worry a little bit about conflating all those conversations with the physician payment updates.

Again, there is, I think, a considerable concern or opportunity to discuss how this impacts consolidation and things like that, but I worry a little bit about how that -- if we're trying to make the updates to the physician fee schedule, address that issue at the same time as it's being looked at in other places that's going to be a confusing issue.

That said, I think I really some of the exploration around linking some of those payments, and maybe it's the practice payment-- practice expense payment to some of the hospital outpatient department updates, to at least mitigate some of those discrepancies and differentials.

And then, finally, on the advanced APM bonus, I always really like this idea of differential updates as a method for trying to encourage people to go into advanced APMs. I think what we are seeing in practice here is something that is probably not workable and partly because the differentials may not be big enough and because the

absolute numbers of the updates, as we've said, 0.25 or 0.75, just don't work in a time of inflation as high as we've seen it or even normal times of cost-of-living increases.

I was not on the Commission in 2016. I was on the Commission for the recommendation about an advanced APM bonuses being something that should go to the organizations that only achieve shared savings. I've said this before. I don't agree with that, and I think that these bonuses are used in a couple different ways.

First of all, you mentioned that they're only $1,500 per provider, but as we're just talking about with the MIPS payments, these are generally going to -- or often at least going not to individual providers but to systems or organizations that are investing in the capabilities to succeed in value-based care. And so what those organizations are often doing are using, they are using that to have some certainty that they're getting some money up front. They're going to get those dollars to pay back for those investments into those capabilities, and there's a bit of risk mitigation.

We can have discussions. I think it's a

reasonable discussion about how long we support that. I don't think we're in a place where people are engaging consistently on advanced alternative payment models, to say that we did it and this infrastructure is there. I think people are still very worried about the increased infrastructure costs and the risk mitigation issue, particularly as the models keep changing. You can be doing very -- I mean, I saw this experience when I knew that next gen was something we could perform in and then had to go into two different models in two subsequent years, and that uncertainty came right back.

So I think that's something worth discussing, and in my mind, if the goal is to reward people for good performance in achieving shared savings, there's more efficient ways to increase those rewards to people than a separate bonus payment.

So those are some of my thoughts, and again, thank you. This is a great chapter and obviously a very important discussion.

MS. KELLEY: Stacie.

DR. DUSETZINA: All right. Great. I'll just be brief here. Thanks, Rachel, Brian, and Geoff. I agree

with what others have said about this being an exceptional chapter, and especially the historic overview of the payment system and how it has evolved was very helpful for thinking about ways to think about it moving forward.

Just really briefly in response to the questions, I do think it's important to consider adding an inflation factor here. It feels a little bit -- like, you know, we've seen how much inflation has changed over the last couple of years. Looking at some of those graphs with the updates relative to inflation, it just feels like an obvious thing to do.

But then in the chapter, you do a really nice job -- and in the slides -- of kind of showing us that that's not the full picture, and that volume and intensity part is really another important part of this.

So there was one thing that it was kind lingering in my mind, and it gets to the last question about the A-APM. And to me, that was, do we have any evidence of differences in volume and intensity by A-APM participating clinicians versus not? Because it felt like that was something that was alluded to, and maybe the goal there is trying to pull back on volume and intensity in those

settings or for participants. But it would really help, I think, to be able to answer that last question about should we incentivize people to go into those arrangements if we knew if they were different, if they were different in volume and intensity or if their trend had looked different over time.

So I guess I felt, in reading this, I'm very much in favor of adding an inflation piece but also trying to rein in some of the volume and intensity issues. I'm very pro site neutral. I'm also very pro thinking about the overvaluation of codes and how to try to rein that in.

So I'd say incredibly supportive of doing something, because I think, as Jonathan mentioned, we want to be really careful about not getting behind here. Like if access is good now, we don't want access to change before we start to do something or to respond to try to make sure that we're adequately supporting payments in this space.

DR. CHERNEW: Brian, let me just answer Stacie very quickly. The staff may disagree. The evidence on whether alternative payment models influence volume and intensity, I think it's pretty clear that they do. It's

also pretty clear that the effects are relatively modest. There is evidence that, for example, they reduce low-value care. So there is a change in utilization associated with these alternative payment models. Certainly, they use less care in terms of post-acute.

How much of that is like coding issues versus real care pattern issues is a different issue. So there's a lot of nuance there, but I think, broadly speaking, in what I consider to be models that could really have some design improvements that would help, but even in the models we have, I think there's clearly been an impact.

But given time, I will say more, and let me emphasize that. Given time.

So, Dana, who's next?

MS. KELLEY: Lynn.

MS. BARR: Great chapter, one of the best. I agree with the Commissioners.

So I am definitely opposed to increasing the gap in pay between specialist and primary care, and I think we've got to pay a lot of attention to that because we don't have anybody wanting to be in primary care anymore. And if it was up to me, I'd just pay them twice what we pay

them because we desperately need them.

I'm definitely in support of adding MEI, but again, I would look at it differentially to the classes of providers. And I don't totally agree with Michael's opinion about making sure we're looking at behavioral mental health providers as well, not just PCPs.

There's some limit on spending growth. I think that's what we do. So I'm not going to even address that.

Considering updates that promote site-neutral payments, this has been, I think, an issue that has divided the Commission historically, and we've talked a lot about the fairness of whether we pay the same in one location versus another, and we should incentivize people to choose the most efficient location. I'm not convinced that we've really done enough, and maybe I've just missed this. And I would appreciate if the staff could point me to this, of the value of the services at different locations. If I have cancer and I have a severe cancer, do I go to a freestanding oncology group? Do I go to a cancer center? Do I go to an academic medical center? I'm going to have very different outcomes and very different options based on those choices. I want to understand too as we talk about

site neutrality -- I mean, we have a responsibility for value, right? And I'm not sure -- well, I actually am quite sure. I don't get the same value of even a PCP visit in a freestanding clinic as one that's attached to a hospital that has put in quality reporting and processes and oversight. So I don't think site neutral is neutral.

As far as the A-APM bonus goes, it has been a tremendous driver of joining the risk-based models, and without the A-APM bonus, I don't know if we would have been able to move. And we were in my last year of Caravan before I left. We were able to move 90 percent of our providers into a risk-based model, right? And I'm talking about 750,000 providers, and the APM bonus was one of the number one drivers.

So I think that, A, we need to protect that A-APM bonus, and we also have to protect providers that enter into these models, take this risk, and that if they don't receive the bonus and they don't make -- if being in MIPS is more attractive than getting an A-APM bonus, we need to address that. There has to be a floor where they don't get less, right, because it's hard, and it's super expensive.

So support as MEIs again for PCPs, and, oh, the

other question about globals, go to global zero. That seems like an absolute no-brainer. We're just wasting money there, and it's not on your list. But that was in the chapter, and I totally agree with that.

Thank you.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks, Dana. So, Geoff, Brian, and Rachel, I first just wanted to commend you on really an amazing writeup. I agree with everybody who said that the historical piece of this ended up actually being really fundamental, I think, educational, but also covered a lot of really relevant ground as we're thinking about inflation updates and other factors. So thank you for taking what is a very multifactorial and complicated topic and distilling it to something that was really, really a wonderful read, and I learned a lot. So thank you for that.

I want to try to organize my comments and try to be as efficient as possible. The first thing is I'm very struck by the fact that when we talk about reforming the fee schedule or trying to work in this space that there could be very different policy goals, you know, intentions and motivations. And even in the context of thinking about

how inflation might interact with it, we still might have multiple different goals. And it strikes me that many of the Commissioner comments are probably coming potentially at different directions, and that's good, but motivated kind of by what underlying policy goals they might have. So we might worry about access. We might worry about consolidation and think about site neutrality from that perspective. We might worry about inflation in the context of lack of wage growth for physicians. We might worry about symmetry across the different payments rates and schedules that exist in the Medicare program. We might worry about PCP versus specialist differentials.

And I think, you know, obviously it would be very complicated to try to take each of these in turn, but to some extent I think that -- to me that becomes a kind of governing point, is it's going to be very hard to accomplish everything at once, and so to some extent the question is, you know, where should we focus? Where do we have the empirical justification, since that's how MedPAC as a Commission had traditionally done thing, looking at the data and trying to drive toward things there.

From that perspective, I guess I would say the

empirical basis to me seems most likely strongest, particularly with respect to the inflation side, on the site neutrality part of it, given that that's consistent with, you know, Commission principles and other work that we've done as well. So I support the idea that we want to think about an inflation adjustment, kind of addressing the first bullet point here or question here, very much in the context of a governing philosophy of how do we continue to promote site neutrality. So I wanted to just sort of articulate at least the vantage point that I'm coming at this with.

The second point is I think, you know, I'm very generally supportive of the idea that we need ways and policy levers to try to address volume and intensity growth overall. I'm very struck, especially given the wonderful writeup on the historical pieces, that getting the incentives right is really fundamentally important. So having some kind of ad hoc, ex post type of volume and intensity adjustment as we saw previously was essentially disastrous. I think it doesn't make sense for us to do that because that's got either some national -- has been historically at the national level, maybe it could be done

as a regional level. Regardless, it's not going to filter down to the individual clinician incentive.

So I think that seems fraught to me in that kind of a such based on the sort of history that we have there, what we understand of the economics and psychology of clinicians.

Interestingly, just parenthetically, you know, MIPS was sort of -- while I'm generally supportive of the idea that MIPS does not really work, quote-unquote, "to get its goals done," the interesting feature about MIPS is that it drives some of those cost incentives in the future, episode-based cost measure and other things to the clinician level.

That leads me to the next question around, you know, how would we potentially try to address this volume and intensity growth, and I think I agree with Lynn and perhaps others around this notion that, you know, A-APMs are probably the most effective way we have to actually drive those incentives down to the individual clinician, or at least for the organization that's managing individual clinicians that can influence their behavior. And so I think it makes sense that we would want to restructure or

reform the APM or A-APM bonus structure, but I think we do want to keep the incentives generally aligned around trying to incentivize more movement into A-APMs, since -- first, I think tell us the best example of a way to drive those kinds of volume and intensity incentives down to the clinician level.

The fourth point I wanted to make is around overvalued codes. We covered this. It's not on this slide, but I think, you know, there's the broad question around the relative value of different codes, primary care, specialty. I think that it would be great to take up that work. I think that would be hard to kind of jam in with the rest of the stuff that we have here. Other than these overvalued codes, as Lynn said, it seems like, you know, potentially a no-brainer there, that we're not getting any value from what the MedPAC analysis shows.

So the last thing, I just wanted to kind of reflect upon all this because there's so many different dimensions here. I think my general feeling here is that there's a lot -- I feel most compelled in the short run to think about the site neutrality philosophy in the context of the inflation adjustments, because that seems like it's

just empirically the most justified, to a certain extent. I think that should be paired in the context of work that is trying to address efficiency in the fee schedule from a volume and intensity perspective. The global codes piece of it might be easy low-hanging fruit to start with, but I think that's probably not the full extent of what we want to do there. And I think we could certainly dial into or continue to develop complementary work around things like the primary care-specialty elements as well, although as I said I see that more as a complement than something that has to be integral as part of this.

Thank you so much.

MS. KELLEY: Scott.

DR. SARRAN: Yes, I'll be brief as what I'm going to say I think largely is consistent with other comments.

First, in terms of should we reform or be in favor of reforming the current law, I think absolutely. I think one of the very nice outcomes of the staff having done such an excellent job of recapping the history of policy in this space is it gives us perspective -- or it should give us perspective that we've got to do something different and better and more consistent with where we want

to be in several years. So a strong yes on that.

In terms of Question 1, absolutely, I think for all sorts of basic fairness and other reasons, we have to slice off the practice expense piece from the rest of the payment and appropriately incorporate MEI into that. You know, we do it everywhere else in all the other provider sectors. That is just real basic, and lots of reasons that others have alluded to today on that.

Question 2, Amol, I think you said it really well. There's just -- just trying to put a cap at a huge macro level doesn't work. It's the wrong tool.

Question 3, yes, I think as a Commission we've had pretty strong consensus that moving down the site neutrality road, albeit with a lot of thought to the nuances that are important to incorporate in that, that's absolutely the right thing to do, so I think we keep our foot on the path there.

Question 4, yes, I think MIPS -- I think we're in agreement. It's just the wrong -- you know, it's the right public policy goal or it embodies the right public policy goal, but it's the wrong tool for a variety of reasons. And I strongly believe that we've got to keep -- same

analogy, keep our foot on the gas on the A-APM because, directionally and messaging-wise, it's so darn important. Even if we believe that we don't have a perfect way of operationalizing that direction, we've still got to go in that direction. And so anything we do that takes our foot off that gas pedal, you know, that sends a conflicting message about the directionality I think would be a real mistake.

Thanks.

MS. KELLEY: Robert.

[Pause.]

MS. KELLEY: Robert, I'm sorry. We can't hear you.

[Pause.]

MS. KELLEY: I'm going to go to the next person while we try to figure out Robert's audio issue here. Let's go to Betty.

DR. RAMBUR: Thank you so much for this fascinating discussion and fascinating chapter. I'm looking forward to see it as a blockbuster on Netflix.

A couple of comments, and then I'll go over the four points briefly. I was not on MedPAC when the

recommendation to eliminate MIPS was made, and I just have to say that I would have found that difficult to support because I think it's absolutely essential that taking on responsibility for the cost and outcomes of care is essential, that it's not voluntary, it's essential. And, you know, there can be off ramps for small groups or whatever, but without really thinking about all-inclusive models, we're still supporting cure-based, care-centric care in a time and an age group that needs care-centric teams. Teams were mentioned by Gina, et cetera. Also, the essential nature of eliminating waste, and Larry and others have rightfully mentioned access, and I do think that's really important. But there are so many sacred cows, and if I just may illustrate one, the United States has just lowered the age of mammogram routine screening, even though we know other wealthy nations do not do routine screening and have relatively the same death rate from breast cancer. So that's a heretical thing to say, and as a woman and a nurse, I feel like I can say it. I'm not picking on that in particular, but I'm saying we really have to get to what really matters in terms of outcomes. And I don't know how you can do that without new payment models.

Respectfully, Lynn, I'm going to add just a caveat to your point. We don't see physicians wanting to be in primary care. We see nurses flocking to primary care, as well as physician assistants. And I do think we have to think about incomes for primary care physicians, primary care providers. I'm not convinced that more money will make the difference. I'm just not convinced, because as you've heard me say, primary care is very, very difficult. And if you're a physician, being a specialist is easier. If you're a nurse, it's still difficult but it's not as difficult as being a nurse in an understaffed hospital or nursing home, et cetera. So I agree with your point. I just have to, you know, elongate a little bit.

In terms of inflation, I was really pleased on page 37 of the document, 53.5 percent for practice expenses, of which 25.5 percent represents staff of some sort, some practice or clinical staff, others not. If we tie something to inflation and it's supposed to go to people, that should actually go to the people. So I'm concerned that some sort of inflationary factor gets put in place, opportunities shift, whether it was AOI and other things, and then it never goes down, it still is baked in

the cake.

I'm a bit more interested in limits on spending growth, to explore that, than perhaps some of you have been, only because so many states are doing things in that area on the commercial side. So I don't know what it would look like in Medicare. I'm not sure if it would be something we would support, but I am curious about it.

I'm interested in hearing more about site-neutral. If I'm understanding it correctly, it's quite different than our other discussions, but I would want to understand that better, but on the surface it sounds like I'd be very supportive of that.

And finally, like Lynn, I very much support the APM bonus. I think that the money is one thing, and I also think the message is another. The message is you're going to go one way or another, but this is where we're incenting people to go. I think it's really, really important.

So thank you all, and I look forward to seeing what comes next.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. So this is a really complex case, lots of different moving pieces, and, you

know, I think we all need to be a bit circumspect about changes, because the great history that was presented to us in this document shows the challenge this is of getting this right, and things don't always work out as intended. But with that, in terms of the inflation factor, I do think that we need to consider including that to address issues related to the increase in practice expenses, but at the same time, I think we have to be careful and counterbalance that to try to sort of -- continue to use it on some level as a mechanism to control volume intensity. I know it's an imperfect lever, but I still think we have to think about slowing the growth in spending by virtue of these payment updates and how much of an inflation factor we were to add.

In terms of site-neutral, I'm generally supportive of continuing to explore that space, and, you know, where services are equivalent, you know, paying them in an equivalent fashion. So I would support, you know, continued discussion on that topic.

In terms of the issue of re-evaluating services, I'm 100 percent supportive of that work.

And then, lastly, in terms of the A-APM bonus, I think I'm interested in seeing that potentially

restructured. I appreciate the other Commissioners' comments about how the bonus is used to, you know, make changes within organizations to allow them to participate in this space. So I think that that's important. But I think what is challenging my thinking about this case was we're continuing to operate and achieve our objectives on a fee-for-service chassis. And so I think the question for me is: How do we continue to push for population-based payment models to try to incentivize providers to be thinking about the total cost of care and providing services as a lever to try to tamp down on volume and intensity?

MS. KELLEY: Okay. Let's go to Brian.

DR. MILLER: So many things that Cheryl said I agree with, I can't even enumerate them all. I started to write them down and lost track. So let's just say I agreed with just about everything she said.

A few points I wanted to make. I 100 percent agree with everyone on an inflation update is needed. We also shouldn't let it go wild. That is a valid concern. So we definitely should have some portion or completeness of inflation updates. A limit on spending growth would be

hard to do operationally. The other argument could be that Congress could also revisit it if it starts to go too high. Updates that promote site-neutral payments is sort of a must-do, especially since the lack of site-neutral payment drives untold billions of dollars in expense every year, much to the detriment of the fiscal solvency of the Medicare program and also add increased costs to the beneficiaries themselves without a clear metric for improve quality or outcomes. Plus, you know, of course, it drives consolidation.

I'll get to the A-APM bonus in a second. Amol mentioned something about overvalued codes. I think CMS has long known where the overvalued codes are and, frankly, have not addressed it. I'm not sure us collectively and staff enumerating what those overvalued codes are and telling CMS, which already knows that they're overvalued, is necessarily a good use of our time.

I also wanted to echo Betty's comments about MIPS and that MIPS -- putting the physician fee schedule on a risk corridor in principle is good. It was an execution problem, and that also the incentives were frankly not very high.

I'm very concerned about the A-APM bonus actually, especially with the recent CBO report showing that CMMI and alternative payment models net large have increased spending. If our goal is to decrease spending or have alternative payment models as a way to equivalent costs, higher quality, or lower cost, higher quality care, or some combination, we shouldn't be paying people to participate in a model that then drives up cost. So I think that the A-APM bonus is very concerning. If anything, it should be equivalent net, of course, to the MIPS bonus. If not, given the evidence of increased cost, the A-APM bonus should be decreased or go away.

MS. KELLEY: Larry.

DR. CASALINO: Really good discussion. This discussion is reminding me of a saying among medical groups about the way the medical groups pay their own physicians, and the saying is, you know, "We had our payment method last year, which was terrible. We have a new way of paying physicians this year, which is even worse, but next year, we're going to have a paying method that will solve all our problems." And I think we're probably in the same space here.

Two general comments. One is I'm so glad that we're spending time on this. We spend so much time every year on updates and what should be the update this year for physicians, and we have to do that. But it's so important, really, to try to get in the big picture, the payment methods right, rather than physicians get another half a percent or more in their annual update.

And the other thing I would just add to that, as a general comment maybe, just thinking about future Commission work, I do believe that most important to physicians, especially primary care physicians and non-procedural physicians, but all physicians really, is reducing the administrative burden. And I think if you asked a primary care physician certainly, would you rather get 3 percent more pay this year or would you rather get some of these administrative burdens relieved, they wouldn't hesitate to say administrative burdens. So that's something we could talk about another time.

Just quickly, in response to the questions, yeah, I think definitely some proportion of inflation at the outpatient, but the main point, I think, is this is not something that should be fixed years in advance by current

law, as it is now, nor is it something that should be patched every year, as it also is now, really. But there should be some tie-in to MEI and some rational way that people can anticipate. I'd be very supportive of that.

Macro limits on spending growth is pretty obvious that those don't work from past experience, and it's not surprising it didn't work, given the kind of tragedy of the commons problem. So I think we are going to have to rely, as the staff said or suggested, some combination of A-APMs and not probably increasing payment rates very rapidly.

The third point, I've been a strong supporter of site neutral, and I still am, though Lynn's comments on that were very good. Where would you rather get your cancer treatment? And I suspect Robert may have something to say about site neutral as well that would give us all pause.

I was disappointed not to see a question about overvalued codes here and revising the way that the relative values are set. I think you probably did that just for reasons of space, but this is an area that's really important. It cost a lot of money, caused a lot of discontent across specialties. It's so obvious amiss.

There were such obvious solutions. MedPAC has put forth some of those solutions in the past.

I think this is one area where it's not hard to come up with a rational way to approach it. Politically, it's hard to change, but just for that reason, I think MedPAC should be very, very strong about reforming the process, and certainly, evidence on the global codes, global surgical codes is overwhelming.

And then the last point, the A-APM bonus, you know, if the government's feeling and the Commission's feeling is we really want everybody in the A-APMs, it's a rational thing to do, but I don't think it's a rational thing to do forever, right? I mean, at a certain point, the reward for being an A-APM should be delivering better care because you're doing so well in quality and spending, you're getting your investment in better care returned and a bit more. Just giving 5 percent a year more or any percent a year more forever doesn't make sense to me.

When the cutoff would be, I'm not sure. The five years we've had or whatever, this may not be enough. Maybe it does need to go in for a while.

I think that -- and then MIPs, again, I think

MIPs is such a disaster in so many ways, and it does add to administrative burdens, usually, and physician cynicism, and you can't really say enough bad things about it.

Measuring and rewarding performance at the individual physician level is kind of a fool's game, really. It can be done maybe within organizations, to some extent, but it can't be done by payers, I don't believe. So getting rid of MIPs, we had some kind of proposal for alternatives, others could come up with, but I wouldn't make getting rid of MIPs dependent on having a substitute for MIPs.

That's it.

MS. KELLEY: Okay. One more time, we're going to try Robert.

DR. CHERRY: Okay. Hopefully, you can hear me now.

MS. KELLEY: Yes. Thank you.

DR. CHERRY: All right. Technology is great when it's working, so thanks for your patience.

I just want to echo the other Commissioners' sentiments in terms of how the staff did and really teed this up. I think whenever we're talking about payment

updates, it's very challenging. It's nuanced and sometimes less than satisfy, and I think that the report actually threaded the needle quite well in teeing up this discussion in a really productive way.

I would say the questions posed; I think what's most appealing to me is the indexing of the payment rates to some sort of inflationary factor. It does make a lot of sense, particularly this inflationary cycle that we currently are. There's numerous examples of how this is already done in areas like Social Security, where there's cost-of-living adjustments, local communities that apply rent stabilization measures that's based on local inflation, and then it's capped accordingly. Even mortgage rates are informally but reliably linked to the 10-year treasury, so why not have similar models in health care. So I definitely favor studying this and coming back up with options.

I think what's also interesting and perhaps somewhat provocative as well is the zero day codes that would eliminate payment when there's no postoperative visits.

I would also include in that if there's no

postoperative notes inpatient stay as well. It would be interesting to bundle those two together. I would strongly support studying this as well, and I believe that equally important, though, is feedback from various constituency groups and individuals that are impacted by something like the zero day codes, I think, would be helpful and actually necessary to make an informed decision about perhaps unfavorable downstream impacts associated with that type of proposal.

I think what's least appealing to me is alternatives that restrict volume and tangentially related intensity without actually impacting access to care. So it seems a bit counterintuitive in how you would reduce the volumes, yet still have -- favor access for patients that need it in a moment. In terms of the energy and resources of the staff, I probably would favor putting them more on the shelf. I'm not sure the squeeze is actually worth the juice on that.

And then the concept of modulating incentives that drive payment to one setting that's lower in care, we've already had a robust discussion on site neutrality, and we've adopted some language that we've approved and

recommended to Congress that really speaks to aligning payments across the ambulatory setting. My personal feeling is to kind of take a wait-and-see and see how Congress adopts this recommendation.

And I would also like to see how CMS actually implements it, particularly and hopefully with an eye on appropriateness criteria that would allow certain patients to be cared for in a higher-cost setting because it's simply safer.

As you know, we went through a lot of back-and-forth about making sure in that language around site neutrality that we included language that was both safe and appropriate, and appropriate is really a nod to CMS to consider appropriateness criteria to make sure that an individual patient is able to get safe and effective care.

The last recommendation, which has to do with differential payments to clinicians that are already participating in APMs is a little bit tricky, but I think ultimately, it has to follow a principle that payments should be linked to clinical performance. I think many might agree that we do need a better model.

But for now, if MIPs is actually retained, then I

would favor keeping the APM participation bonus pending an improved model, and of course, if it's not retained, then some sort of alternative incentive program that drives clinical outcomes should be considered.

Once again, I want to thank the staff for really a well-done report.

MS. KELLEY: Jaewon.

[No response.]

MS. KELLEY: Jaewon, I'm sorry. Now we're having trouble with your audio. Hang on. Can you try again?

[No response.]

MS. KELLEY: Okay. Let's go to Kenny, and we'll work out Jaewon.

MR. KAN: Can everyone year me?

MS. KELLEY: Yes, we can.

MR. KAN: So, Geoff, Brian, and Rachel, outstanding and educational chapter on the historical evolution of the physician fee schedule program. This is a very, very complicated topic, as Amol also articulated.

Looking at the questions on page 28 here, I favor incorporating some inflation factor, some limit on spending growth perhaps by addressing the value and intensity

growth, but obviously, the tricky part is how to ensure that you don't compromise access.

I do favor site-neutral payments, and I do favor restructuring the A-APM payments, as I don't believe they're working well, but yet at the same time, you know, I actually am a plus-one on what Cheryl echoed still occurring in a fee-for-service environment. So maybe we can try to be a little bit more innovative and think out of the box. It's a very complex issue.

So thanks again. Outstanding effort. I look forward to the next analysis.

MS. KELLEY: All right. I'm going to try Jaewon again.

DR. RYU: Can you hear me?

MS. KELLEY: Yes. Thank you. Go ahead.

DR. RYU: All right. I was just going to echo many of the comments already made. So I'll be fairly brief, I hope.

I really enjoyed the history part of the reading materials. I think that was exactly right. In particular, the RVU process and the role of the RUC, I think that was really good reminders for all of us on exactly how that

works, because I think it plays heavily into the material and the topic.

Getting to some of the questions, I do think there needs to be some inflationary aspect factored in. In particular, I think Figure 1 from the readings was pretty compelling, and yes, there have been some compensatory dynamics, whether it's volume, intensity, or both.

I think Tamara's points on that, I really appreciated because I think those compensatory dynamics don't play out equally, and I do think that those are levers that are probably more available to procedural areas. And so, given that those dynamics are not occurring evenly, I also don't think that the inflationary factor should be necessarily applied evenly, and I think they can be used, whether it's to promote site neutrality along the lines of what others have already mentioned, or I probably fit in the camp where I think we should still have some sort of an incentive around APMs.

Now, I don't know -- and I agree that that shouldn't be super long term, but I think that would be another area where you wouldn't necessarily need to spread it evenly. And maybe that's something to incent more

heavily. I think primary care, as others have mentioned.

The other that I didn't hear mentioned, I think safety net is another area that we could maybe have more prominent factoring in of inflation, if we wanted to use it as a tool to continue to bolster certain areas that I know the Commission has been focused on before.

Otherwise, I think just Question 2 on the spending growth, I think in concept, you know, it's intriguing, but I'm not sure how that would work. I think some others have raised that question, and I think if there is some sort of limitation, I don't think it should be solely on the provider fee schedule, that it should apply to other sectors as well or not be there as all.

And then the last point, just on APMs, I think, obviously, I would continue to push for mandatory participation in which case you wouldn't need to have the discussion around incentives and so forth, but otherwise, great chapter. Thank you all.

MS. KELLEY: That is the end of my queue, unless I've missed someone.

Mike?

DR. CHERNEW: It is a miracle that we are exactly

at one o'clock. This has been a remarkably, remarkably rich discussion. I will not attempt to summarize it all. I will summarize a few parts of it.

There seems to be widespread support for the idea of, in some way, changing the current default mechanism for updating physician fees. There seems widespread support for worrying about volume and intensity and much less consensus around how that might be done beyond a general disdain for collective models like, for example, the SGR.

There seems to be an acknowledgement that the issues around symmetry and updating between independent and facility-based settings is a reasonable thing to do, but the structure around that is important.

I think there is a lot of concern about how this plays out differently across different specialty types, primary care, behavioral health specialists and there's a bunch of thinking to do around that point.

And I think the discussion of the A-APM bonus, at least what I largely heard, was consistent with how this was actually presented in the presentation, which is your feeling may depend a lot on MIPs, but if MIPs remains where it is, some sort of level playing field seems like a

reasonable thing and some restructuring seems like a reasonable thing. If there's other changes, then one might want to sort of revisit that, and I think that all sounds reasonable.

So that's where I am on where we've been. This was the first in an incredibly rich discussion, and there will be many discussions on this point. To those of you at home, I'm sure there's a lot of thoughts on this. So please don't hesitate to reach out to us. You can do that at MeetingComments@MedPAC.gov. Otherwise, send messages. We really do look forward to hearing from you.

Paul, do you have anything you want to add before we sign off for lunch and come back?

MR. MASI: No. Just thank you for the great discussion, and we'll look forward to continuing this work in the spring.

DR. CHERNEW: Great. So, everybody, please come back and join us. We're going to be coming back at two o'clock. We're going to start by talking about staffing ratios and turnover in nursing facilities. We're going to move on to a discussion of inpatient rehab facilities, and then finally a lot of what our work plan is related to

generic drugs under Part D will close out the day.

So, again, I'm really looking forward to this afternoon. I really enjoyed the morning.

To the staff, unbelievably good job, and to the Commissioners, thanks for your engagements. And we'll see you all in about an hour.

[Whereupon, at 1:04 p.m., the meeting was recessed, to reconvene at 2:00 p.m. this same day.]

AFTERNOON SESSION

[2:02 p.m.]

DR. CHERNEW: Welcome back, everyone. This is the afternoon of our October MedPAC meeting. We're thrilled to be here. We're going to be discussing nursing

homes, rehab facilities, and generic drugs in Part D. I think I'm going to start with nursing homes, and I think we're going to Kathryn first. Is that right?

MS. LINEHAN: That's right.

DR. CHERNEW: There. Now I see it on my screen, if it wasn't blocked by my chat. Perfect. Kathryn, take it away.

MS. LINEHAN: Good afternoon. If the audience would like to download the slides, you can find them in the handout section of the Webinar control panel.

I'm here to discuss staffing in nursing facilities. The adequacy of staffing in nursing facilities has been a longstanding concern that intensified during the coronavirus pandemic. Last year, the Commission expressed interest in using nursing facility staffing data to better understand the care the program is buying under the skilled nursing facility benefit.

This presentation has five parts that distill the information presented in the paper.

First, in the background I will discuss federal and state staffing requirements.

Next, I will present data on nursing facilities'

staff-to-patient ratios and staff turnover rates.

Then I will compare LIS shares and margins among SNFs with relatively lower and higher staffing ratios.

Next, I will summarize CMS' proposed minimum staffing rule.

And last, next steps, where we would like to get your input on the information presented and understand the Commission's interest in pursuing policies to support staffing in skilled nursing facilities.

So first, some background. Direct care staff in nursing facilities are essential health care workers who care for some of the most vulnerable and frail individuals in our society. Three types of nursing staff provide most direct care to nursing facility residents: registered nurses (or RNs), licensed practical nurses (or LPNs), and nursing assistants.

While we focus our discussion here on nursing staff, I just want to note there are many other types of staff who work in nursing facilities, including therapists, activities directors, and environmental and dietary staff.

The relationship between staffing and the quality of nursing home care has been studied extensively, using

staffing metrics such as hours per resident day for total nursing staff as well as RNs, LPNs, and nursing assistants independently; and ratios of licensed or RN time to total nursing time (referred to as "skill mix").

Studies have used a variety of quality and patient safety measures, including pressure ulcers, infections, emergency department use, hospitalizations, and facility deficiencies.

The evidence of the relationship between quality and total staffing is mixed. But the evidence for RN staffing is more clear.

Recent systematic reviews of findings from a few dozen studies (published between 2000 and 2021) concluded that RN staffing was associated with fewer pressure ulcers, fewer infections, and lower rates of pain.

Researchers have also found large daily variations in nursing facility staffing, with RN staffing in particular dropping on the weekends. Higher within-facility daily variation in staffing has been associated with lower rankings in Medicare Compare's 5-star survey and quality measures.

Nursing facilities that are certified to provide

services covered by Medicare and Medicaid are required to have: a director of nursing who is an RN; an RN on duty eight consecutive hours per day for seven days a week; and a licensed nurse -- either an RN or an LPN -- on duty for 24 hours per day for seven days a week.

Nursing facilities must also have "sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."

Sufficient is not quantified. In September 2023, CMS issued a proposed rule with minimum staffing requirements that I will summarize briefly at the end of the presentation.

Nursing facilities are also subject to their state's minimum staffing requirements. Thirty-eight states and the District of Columbia have more prescriptive minimum staffing requirements than the federal requirements. But states' requirements vary.

For example, eight states and the District of Columbia -- can we go back a slide? Thank you.

Eight states and the District of Columbia have requirements of 3.3 hours per resident day or higher.

The type of staff with required minimums also varies by state. For example, the District of Columbia requires a registered nurse on site for a minimum daily average of four hours per resident day, 24 hours a day, seven days a week.

Ten states have minimum hours per resident day standards for nursing assistants, ranging from 1.04 to 2.44. In addition to minimum staffing requirements, states have payment policies to direct spending on staffing.

Specifically, 11 states use wage passthrough policies, which require nursing facilities to spend a specified portion of their Medicaid rate on staff wages or benefits.

Thirty-two states plus D.C. have cost-based payment policies that tie a portion of Medicaid rates to the allowable costs of direct care.

Three states have direct-care spending requirements that specify how much revenue must be spent on

direct patient care. Direct-care spending requirements are similar in concept to medical loss ratio requirements that seek to establish how much premium revenue that health insurers must spend on providing health care services.

More detail about all of these policies is included in your mailing materials.

Next, I am going to show the facility-level variation in nurse staffing ratios for approximately 14,600 SNFs in 2022. Our analysis excludes Medicaid-only nursing homes and uses acuity-adjusted hours per resident day as described in the paper.

This figure displays the median and interquartile range of all SNFs total nursing hours per resident day in 2022. The median SNF had 3.6 hours per resident day of total nursing. Fifty percent of SNFs had total nurse staffing hours per resident day between 3.2 and 4.2.

Staffing ratios vary by facility type and ownership.

Freestanding SNFs -- which were 97 percent of facilities -- had median nurse staffing of 3.6 hours per resident day, and hospital-based SNFs -- which make up just 3 percent of facilities -- had median nurse staffing of 4.9

hours per resident day. This amounts to a difference of an hour and 20 minutes per resident day, a median.

When we look by ownership type, for-profit SNFs (which are about 72 percent of all facilities) had lower median staffing than nonprofit and government SNFs.

It's not here but it is in your paper: SNFs in urban and rural areas had similar medians and distributions of total nurse staffing hours per resident day.

The figure on this slide is like the previous figure but it shows the distribution of RN hours per resident day by the same facility categories. As discussed in your paper, RN staffing has a demonstrable association with better patient outcomes.

Like we saw on the previous slide, freestanding SNFs had lower RN staffing than hospital-based SNFs.

For-profit SNFs had lower RN staffing than nonprofit SNFs and government SNFs. The higher median ratio for RNs among rural nonadjacent SNFs, which tend to have fewer beds, likely reflects the current federal requirement that facilities have an RN on duty eight consecutive hours a day, seven days a week, regardless of the size of the facility.

Now turning to turnover. As I mentioned previously, recent research has found an association between nursing facility staff turnover and outcomes.

This chart shows the percent of SNF staff that have turned over in a 12-month period by type of SNF.

As of the fourth quarter of 2022, the 12-month turnover rate was 53 percent for the median SNF. One-quarter of facilities had turnover rates greater than 64 percent, meaning nearly two-thirds of their nursing staff left the facility in a 12-month period.

Hospital-based SNFs had lower median turnover than freestanding, and nonprofit and government SNFs had lower median turnover than for profit SNFs. We saw similar medians and distributions across geographic categories.

Freestanding SNFs have had double-digit Medicare margins for over 20 years, but we have also consistently found wide variation in these Medicare margins. SNFs with higher margins have lower standardized costs per day and tend to be larger, so some of the difference in margins may reflect economies of scale. We have hypothesized that variation in staffing could be a factor in some of the variation in Medicare margins.

Last spring we also presented data on the relationship between Medicare margins and low-income patient volume, and found that facilities with higher shares of LIS beneficiary stays had higher Medicare margins. We speculated that this too could be related in part to these facilities' staffing.

Next, we will look at the relationship between staffing and low-income share and staffing and financial performance.

We determined quartiles on total nurse staffing hours per resident day in 2021 among all SNFs, and grouped freestanding SNFs into these groups, displayed on the X-axis. For those groups, we then examined the share of Medicare stays for beneficiaries receiving the Part D low-income subsidy. The median and interquartile range of LIS shares are displayed for each group.

We found that freestanding SNFs in the lower staffing quartiles had higher median shares of LIS beneficiary stays -- shown in the dark blue box. For the median SNF in the top staffing quartile, 32 percent of Medicare fee-for-service stays were for LIS beneficiaries, compared to between 47 and 59 percent for the lower

staffing quartiles. Freestanding nursing facilities in the highest staffing quartile also had lower shares of Medicaid days, on average.

These results may help to explain our earlier findings of higher Medicare margins among SNFs with higher shares of LIS beneficiaries. Facilities with a greater share of LIS Medicare stays and Medicaid days may keep their costs lower, in part through lower staffing, contributing to their higher Medicare margins.

Next, we examined freestanding SNFs' Medicare margins and total margins for those same staffing quartile groups.

In the figure on the left, we see that freestanding SNFs in the highest staffing quartile have lower Medicare margins (the median of 3 percent), and SNFs in the lowest staffing quartile have the highest Medicare margins (the median of 26 percent).

When we compare the figure on the left to the figure on the right, which shows total margins by staffing quartile, we see that these differences across the quartile groups are smaller, likely due to differences in payer mix and cost control strategies. Providers may adjust their

costs depending on the revenue they receive from other payers. Facilities with a greater share of relatively lower-revenue Medicaid days may keep their costs lower, in part through lower staffing, than facilities with a greater share Medicare or private-pay patients.

Next, I am going to summarize CMS' proposed minimum staffing requirements for Medicare- and Medicaid-certified long-term care facilities which CMS issued in September 2023.

Recall that the current federal requirement is to have an RN on duty eight consecutive hours a day, seven days a week, and a licensed nurse -- either an RN or an LPN -- on duty 24 hours a day, seven days a week.

In the current proposed rule, CMS nursing facilities would be required to have: an RN on site 24 hours per day, seven days a week (effective two years after publication of the final rule and three years for rural providers).

Facilities must also have minimum reported staffing ratios of: 0.55 hours per resident day for RNs and 2.45 hours per resident day for nursing assistants? Those requirements would be effective three years after

publication and five years for rural providers.

Using data for the second quarter of 2021 -- click that again, Angie. There you go. And again.

Using data for the second quarter of 2021, CMS estimated that about 41 percent of nursing facilities had reported RN staffing below the proposed minimum and about 68 percent of nursing facilities had reported nurse aide staffing below the proposed minimum.

I also just want to outline a few more details from the rule.

First, it includes criteria for exemptions to the 0.55 RN hours per resident day and 2.45 nursing assistant hours per resident day requirements.

It does not propose minimums for LPNs or total nurse staff.

It does not include provisions for payers to increase payment rates.

And in addition to the proposed staffing minimums, the rule would require states to report the share of Medicaid payments for Medicaid-covered services in nursing facilities that are spent on compensation for direct care workers and other staff.

The Commission does not plan to comment on the proposed rule because we do not have any policy footprint or recommendations on the subject of minimum staffing requirements.

In the March 2024 report to the Congress, our assessment of Medicare payment adequacy for SNF services will incorporate staffing data in several ways. Total adjusted staffing and turnover rates presented in this paper will be discussed in the quality section of the SNF payment adequacy chapter. We plan to use facility-level data on staffing to contextualize provider cost and margin differences we observe among freestanding SNFs.

For an informational chapter in our June 2024 report, we will update the analyses in this paper with staffing data through the third quarter of 2023, as well as 2022 cost report, claims, and beneficiary data. Today we seek your feedback on additional analyses of interest.

And we are also interested in whether the Commission would like to consider future policy options to improve staffing, including minimum staffing requirements, wage pass-through policies, and direct-care spending requirements for skilled nursing facilities.

This concludes my presentation and I look forward to your discussion. Thank you.

DR. CHERNEW: Okay. Kathryn, thank you very much. So many Medicare beneficiaries are affected by what goes on in nursing homes. I think it's really important that we think through that and see the quality of it, and this was really a very informative chapter. So thank you very much.

I think we're going to jump to the Round 1 questions, and I think Tamara is first, and then Dana will manage the queue. Is that right, Dana?

MS. KELLEY: Yes, that's correct.

DR. CHERNEW: Okay. Tamara.

DR. KONETZKA: Kathryn, thank you very much for the excellent work. I'm really thrilled that you dug into the PBJ data. I think that will be really useful moving forward for all our SNF analyses. And I just really appreciated the work that went into this chapter.

I'm going to have a lot to say in Round 2, but my Round 1 question is just about the hospital-based facilities. I don't think that's actually the most interesting comparison here, but most of us who do research

on SNFs often just sort of discount the hospital-based facilities since they're such a small percentage now, but also because of problems in the data sources in that, you know, if you look at the cost reports, my understanding was always that it's really hard to derive good data out of the cost reports for hospital-based facilities because their sort of cost allocation or accounting practices are so strongly tied to the hospital and that their accounting practices might just be different. I haven't really thought about that issue with the PBJ data and whether we might see similar challenges in sort of allocations of staff for hospital-based facilities.

So I guess my question is: What's your sense of whether the data were really good enough for you to come up with, you know, sort of valid hospital-based staffing ratios as well as margins?

MS. LINEHAN: So the Commission shares your concern about the margins for hospital-based SNFs. We typically make our update recommendation based on the freestanding SNFs' margins, and that's what I showed here. That excluded hospital-based SNFs.

With respect to whether there's a difference in

the hospital-based SNFs' reporting of staffing, I don't -- I haven't seen any -- and you might know just as well as I. I haven't seen any discussions of the limitations of those specifically, but it's a good question, and I could look into it.

Does that answer your question?

DR. KONETZKA: Yes, thank you. I haven't seen anything looking at that specifically, but, yeah, I think it's --

MS. LINEHAN: It's a plausible concern, and there could be differences there, but I don't know.

DR. KONETZKA: Okay. Thanks.

MS. KELLEY: Cheryl?

DR. DAMBERG: Thank you. Kathryn, great chapter. It was really -- I have two quick questions. One, do you know how Medicaid payment rates vary across the states for SNP and what the relationship is to staffing? That's question one.

And question two is, do you know whether states with higher ratios have lower turnover? Hopefully, I didn't miss that in your chapter.

MS. LINEHAN: On your first question, Medicaid

payment rates, MACPAC did a paper on this that they presented last spring, and they made recommendations about some data transparency problems in coming up with Medicaid payments and whether they cover providers' costs. I can send you a link to the paper where they kind of array what they found with respect to Medicaid payment rates. It's not as easy to get that information as you might think it is, but they made recommendations about needing more transparency for payments, costs, and so on. So I can link to that.

Also, there's a summary of that paper in the safety network we presented last April. So you could also look there.

With respect to whether states -- was your question do states with mandatory ratios have lower turnover?

DR. DAMBERG: Yeah, with higher ratios. Yeah.

MS. LINEHAN: Yeah, with higher ratios. I haven't looked at that specifically. I did look at it at the facility level. I didn't present it in the paper, but that's something we -- an analysis I could do in the future, look at the relationship between the facilities

levels and turnover rates.

DR. DAMBERG: Thanks.

MS. KELLEY: Lynn.

MS. BARR: Kathryn, great, great paper. Wow. It's really interesting data, and I think we learned a lot from this.

I have a couple of questions. One of them is I have an ongoing concern about how these policies are going to affect low-volume facilities, rural facilities, and I think that it would be very helpful if we could look at this data from a rural versus urban perspective, because I think it's going to have some pretty crazy results. And I'm very -- you know, we're already very concerned about quality and rural SNFs.

I was curious about quality in general. You picked several metrics, pressure ulcers, et cetera. But not looking at the overall sort of star ratings of these different hospitals, I guess, we have -- is it because we just don't really think that's a good measurement system or -- I was just curious as to why you just focused on a few measures.

MS. LINEHAN: I think you're referring to my

summary of the literature. So I was summarizing what was in the literature, and they do talk about --- several of the studies that I talked about do include star ratings as one of the measures, so --

MS. BARR: Okay. Would it be -- I know you guys have a tough year. I don't want to ask for anything, but would it be hard to take the PBJ data and correlate it with star ratings to see what -- because what I'm thinking about is value. What are we paying for? And so just knowing more about that and the impact of it would be helpful for me.

And then my last question was you mentioned 53 percent turnover, which as an ex-CEO just makes my stomach turn. Is that a COVID thing, and could you give me some context on that? What's turnover in a hospital or, you know, is there -- I'm just not sure what that number means, but it just really scared me.

MS. LINEHAN: Sure. So we don't have staffing data like we have -- like the PBJ data for any other sector. So we can't calculate an analogous turnover rate. So I don't know what it is for hospitals. I'm sure that's out there in smaller studies or anecdotally, but I don't

have that.

MS. BARR: All right. Don't put extra effort into getting that on my behalf. I was just curious. I was trying to put it in context.

MS. LINEHAN: In terms of whether this is a COVID thing, I looked at data from 2019 to 2022, and the turnover rates are similarly high, even in the pre-COVID periods. They might be up a percentage point or two different, but this isn't like a big spike post-COVID or during COVID.

MS. BARR: Awesome. Thank you very much.

MS. KELLEY: Brian.

DR. MILLER: I want to say I really enjoyed the literature review in this chapter, as this is a space I've long been curious. So I've learned a lot reading this. This is a very tough topic, right? And there's a lot of stuff to parse through, and there's a lot of data, and recognizing that this chapter will be controversial, however it is written, is going to make somebody upset.

With the aims of improving our chapter, could we and should we include, whenever we make comparisons, numerical values, statistical testing, and p-values to note that the things that we are comparing are statistically

different or not? And then that way policymakers can answer the question, looking at these two markets, whatever the comparison is in the chapter.

Yes, they're statistically different and it's -- or statistically significant difference, and I think this is significant from a policy perspective, because if we make those comparisons without doing the statistical testing or if we've done it and we don't show it, it's really hard to interpret any of the data comparisons.

MS. LINEHAN: Is that -- that's a question? Yes, we can do that.

DR. MILLER: Thank you. And we should do that for every comparison in the chapter, precisely because of the nature of how controversial this chapter is going to be.

MS. KELLEY: Amol.

DR. NAVATHE: Kathryn, thank you so much for putting together this chapter on such an important issue. Really great work.

So I have two questions. The first one is a bit of a two-parter, but hopefully, it won't be too hard to follow. So I really appreciated the literature review. I

think it was -- and I like the way that you also kind of broke it out and made it organized and easy to follow.

One of the questions that I had is it looked like in the sections where we went over the literature that looked at the state-based policies and the changes that were kind of pre-post as I understand these state-based policies, it also seemed like there's quite a bit of variation in the state-based policies. And so some of the literature was pointing to weak effects from potentially weak constraints from the policies, and I was curious if there were any kind of subtler insights, if you will, from the policies that are closer to, for example, what Medicare's CMS is proposing right now.

And, in particular, I was curious about how that intersects with the unintended effects. The paper did mention unintended effects, but it looks like that was focused around staffing mix, and I was curious if there were any insights around patient outcomes.

MS. LINEHAN: I just want to make sure I understand the question. Are you asking about the studies that looked at the effects of state policies?

DR. NAVATHE: I am. In particular, the state

policies where the states had more stringent requirements rather than weak requirements.

MS. LINEHAN: I don't think I have a good summary of all the state evaluations at my fingertips, especially because -- there's a lot of nuance to those because some are like looking at a pre-post, some are comparing across states. And so I would be hard-pressed to summarize that right now, but that's something I could do in a future iteration.

Some of the studies evaluating state policies are also quite old. I mean, they're definitely pre-PBJ data. Some of the state policies, like the direct care payment policies, are new. So they haven't been evaluated, but I could give a fuller treatment of the literature on the state policies in a future iteration of the paper.

DR. NAVATHE: Okay. That's helpful. I think, in some sense, calling out the ones that are more relevant, perhaps, where the policy design was a little bit more similar to what we might contemplate or to what CMS has proposed, I think, might be helpful, just because of the variation both now that you're highlighting and also in timing the temporality also.

And then the second part of that first question -- and then I have another question -- is can you give us a little bit more sense of what might be under the sort of unintended effects category? I think the one thing that was mentioned in the paper was staffing mix toward a lower-skill staffing mix, and I was wondering if there are other unintended effects that have been called out later on patient outcomes.

MS. LINEHAN: There's one paper that I think is from 2015 by Chen and Grabowski that I cited in the paper that looked at some unintended consequences, and they -- I think that's the paper -- they found that there were some unintended consequences of just shifts to different types of nursing but shifts away from other types of staff, like dietary staff and sort of non-direct patient care staff. So that's one that comes to mind.

DR. NAVATHE: I see. Okay. So I guess, in some sense, it doesn't sound like there's that much of the literature on the patient outcomes part of it. The kind of processes of care, the staffing is where the majority of the data is. That's my takeaway.

The second question I had, full stops, but

totally different question is around the staffing turnover piece, and I was curious if there's any qualitative work that's been done that has described outside of the broad relationships that we highlight. Is there other qualitative work that's describing factors associated with higher turnover versus lower turnover at facilities?

MS. LINEHAN: I believe that's addressed somewhat in the study that CMS contracted for to do the minimum staffing rule. There are a lot of qualitative components. They did a lot of interviews. They did site visits with nursing facilities and looked at some of these.

This isn't a literature I'm super familiar with either. I can look into that, factors contributing to turnover.

DR. NAVATHE: Great. Thanks, Kathryn.

MS. LINEHAN: MM-hmm.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. While on that point, any sector with a 53 percent turnover rate obviously has some fundamental problems, something wrong.

I have a question for Kathryn. Tamara, I have a question about your Round 1 question. You said you don't

think the most interesting comparison is freestanding versus hospital based. I hope you'll say more about that in Round 2. Kathryn, you mentioned when you showed the first quantitative slide that this was excluding Medicaid-only facilities. Could you tell us a little bit more about what those facilities are? How many of them are there? Would the numbers look very different if we were looking at those?

MS. LINEHAN: I didn't look at whether the numbers were different because I excluded them. There aren't very many of them. We typically don't look at Medicaid-only facilities.

DR. CASALINO: Why would someone be a Medicaid-only facility? Are we talking about 20 in the country or --

MS. LINEHAN: No, it's not 20. But the vast majority are dually certified. Like 96, 94 percent are dually certified, Medicare and Medicaid.

DR. CASALINO: And they're Medicaid-only because they couldn't get Medicare certification, or there's some advantage to being Medicaid-only?

MS. LINEHAN: I don't know why they opted to be

Medicaid-certified only.

DR. CASALINO: But the numbers are small, like less than 100 in the country maybe?

MS. LINEHAN: No, there's more than 100.

DR. CASALINO: Okay. So not tiny.

That's it. I don't have any more questions.

MS. KELLEY: Gina.

MS. UPCHURCH: I hope this will be fast. The new minimum staffing rule, does that apply to residents who are there under the Medicare Part A, or is it for also people that may be on Medicaid or that are there for long-term care services and supports? Are those rules for those groups?

MS. LINEHAN: For the entirety.

MS. UPCHURCH: Okay. Thank you.

Second question is, I mean, we say it like it's just okay, but I have a little problem with the weekends being so poorly staffed. I have known too many people that have to deal with that. They get discharged from a hospital and go into a facility on a Friday night and feel like they're just there for long-term care services, and there's a lot of hope and stuff. Is that just -- is that

sort of the -- is that anything we've ever worked on, or is that just sort of an accepted thing? Weekend requirements being so minimum.

MS. LINEHAN: We haven't made any kind of statement about whether the weekend staffing is acceptable or variation in staffing is acceptable or not acceptable. That's not something we've opined on.

MS. UPCHURCH: Okay. And then the other comment, when you talk about for-profit versus not-for-profit or government, are the for-profits generally these conglomerates that are like private equity or publicly traded, or are they more like family-owned, private -- would it matter to break that down to look at that a little bit more? Do you have any sense of that?

MS. LINEHAN: They can be all of those things. It's gotten easier to identify who owns the facility. I haven't dug into those data yet. That's another data source that's available for nursing facilities, but it's doable. We haven't gotten it yet.

MS. UPCHURCH: Okay. And it might be important. I don't know. That's why I was just curious.

And my last clarifying question is, you know, we

just mentioned that dual eligibles are more likely to be in long -- you know, there for longer term, and I would just posit or -- and maybe you have data about this -- is they just don't have anywhere else to go. It's not that -- or is it potentially that they're not getting the care that they need for whatever reason, or is it there's literally nowhere else for them to go because they don't have the money to support that when they're discharged? Do we have any sense of that or any data sources for that?

MS. LINEHAN: I'm not sure I understand your question. Can you say it again?

MS. UPCHURCH: Yeah. Sorry. So we said that dual eligibles are more likely to be there longer, like the longer-term stay. So then my question is, is it because they're not getting -- or do we have a sense that they're not getting as good therapy, or is it because literally there's nowhere to discharge them to?

MS. LINEHAN: Well, I don't know that the causal arrow runs that way. Dual eligibles can be nursing home residents, and being a nursing home resident can make you ultimately eligible for Medicaid.

MS. UPCHURCH: Yeah.

MS. LINEHAN: So you've got dual eligible.

MS. UPCHURCH: Right. Okay. All right. Thanks.

MR. MASI: And if I could jump in for a moment, I just wanted to say thank you very much for these clarifying questions, and it's really helpful to get this feedback about additional analyses and questions we could ask.

I did just want to step back for a moment and add the context that this is our -- the first time we're talking about this issue as a Commission, and so questions are really helpful. And I think a lot of the times, it will involve us kind of going back and seeing what else we could be able to do, so happy to stay in touch as we continue working on this.

DR. CHERNEW: A postscript to what Paul said was we are not right now contemplating a recommendation, certainly not this cycle. This is informational work, and there's a lot of challenging issues that we would have to do to get to where we would get to a recommendation when we would get there. So, if any of you want to comment on that basic situation of where we are, please feel free to do that, and I would emphasize in Round 2.

And I think if I'm right, Scott is the next and maybe the last Round 1 question, Dana.

MS. KELLEY: Scott is the last person I have in the queue.

DR. SARRAN: Thanks, Kathryn, again, for your very important and very cogent work.

Just one quick question. Given that most of what we're looking at relies on acuity-adjusted staffing levels, what's our level of confidence that acuity adjustment in fact does represent the relevant metric we're looking at in terms of predicting the staffing needed, the nurse staffing needed to safely maintain a resident in-place and monitor them and prevent the kinds of adverse outcomes we're looking at? How robust is that metric? How well is the reporting of that metric tracked and monitored, et cetera?

MS. LINEHAN: So the acuity adjustment is based on a study that was conducted I believe in 2006 that looked at the amount of time that each type of nurse spent with patients in different RUG categories, which is the former case-mix system for SNFs. And that study I think was conducted in 200 to 300 facilities. So going forward, I think CMS is going to need to come up with a different

case-mix adjuster because the data to calculate RUGs isn't going to be available anymore.

So this might be something that CMS is looking at. I assume it is. So it might -- yeah, so it might be something that is going to be updated given how old and -- given the vintage of the data.

DR. SARRAN: So it may behoove us then just to insert a comment about the importance of that metric and attention to its ongoing maintenance and ensuring accurate reporting on that metric?

MS. LINEHAN: Sure. I will say that, you know, when you look at reported data that aren't acuity-adjusted, you get at least the relatives that are similar across facility types in terms of the levels of staffing.

MS. KELLEY: Okay. That is the end of Round 1. Shall I go to Round 2, Mike, or did you want to hop in here?

DR. CHERNEW: No. You should go to Round 2, and, again, it is Tamara kicking us off.

DR. KONETZKA: Great. I have kind of a lot to say here. I'll try to be efficient.

So, first of all, just a note on the context of

Covid. This is slightly peripheral, but I feel the need to say this, because, you know, every article, every piece on staffing in nursing homes right sort of points to Covid, and I just want to make it clear to everybody that the tragedy that we saw in nursing homes during Covid was not about actually poor quality or low staffing. There's plenty of poor quality to go around, and low staffing. But the research shows pretty clearly that this was not a bad apples problem -- right? -- like with low-staff nursing homes having all the outbreaks and deaths. The two biggest predictors of bad outcomes in nursing homes were the facility size and the prevalence of the virus in the surrounding community. And even sort of prior infection control problems was not at all predictive, so you had very high-quality facilities -- like that first Kirkland home in Washington was a five-star facility and had this first major outbreak of Covid.

And so the evidence on staffing in Covid is that actually facilities -- there was either no effect or facilities that had higher staffing and more bodies moving in and out, just because that provided a vector for transmission, you know, facilities with higher staffing

actually were more likely to have an outbreak in the beginning. By the end, everybody had an outbreak. Like virtually all nursing homes in the country had an outbreak. Where staffing played a role was that once there was an outbreak, higher staffing levels could reduce the number of deaths and help to contain the outbreak. But that effect was really dwarfed by just the prevalence of the virus, like were you in a hot spot or not?

And so I guess the lesson there is that staffing, as important as it is, would not prevent the next pandemic, would not have prevented the last one. This was a big public health failure. So I'll leave that topic then, but I just wanted to say that.

So about staffing, it is sort of the one thing that everybody agrees on, right? It's probably the only thing in terms of nursing home care that everybody agrees on. Advocates, consumers, policymakers, and researchers, you know, providers -- everybody agrees that staffing is fundamental to nursing home quality. In that way, it's almost, you know, the best quality measure we have. Again, I'm just really thrilled that we're using the PBJ data and looking more into that. Obviously, there are some caveats

with it as well, but it's a really important thing to look into.

The analysis was obviously very well done. Most of the comparisons to me were absolutely not surprising -- right? -- that hospital-based facilities have a higher staffing. To me, Larry, you know, I think that was not the most interesting one because, one, they're less than 3 percent of facilities; there used to be a lot more. Those have kind of gone away for a lot of reasons. But I don't think they present sort of a model for other facilities moving forward.

It's not surprising at all that for-profits have lower staffing and a higher proportion of low-income patients. And the stratifications by margins makes a lot of sense as well. To me, the problem is how to interpret these differences, and I think one thing that's important to understand about the SNF sector is that, you know, for-profits and not-for-profits don't behave in the way one usually assumes, right? Nonprofit SNFs are not in the business of providing charity care. They are aimed at -- they're generally smaller facilities aimed at a higher concentration of Medicare patients, and they focus on

complex care. And they will be very transparent about how they can provide the highest-quality complex care, and that is by avoiding Medicaid. They are not in the business of trying to take care of Medicaid patients if they don't have to.

And so, on the other hand, you have for-profit facilities that are much more likely to be large facilities located in low-income neighborhoods and highly dependent on Medicaid, right? And so in some ways, these are just very different facilities, and so when we compare the staffing ratios in for-profits and not-for-profit, it's long been known that for-profits have lower staffing ratios. But the problem is, you know, how do you interpret that and what do you do about it?

And so, yeah, do they keep staffing ratios low to increase their margins? Now, sure, but you could actually rephrase that question in a number of ways.

And so the problem, you know, isn't really a problem here that MedPAC can solve. The underlying problem is that these causal connections among these very different types of facilities and their staffing ratios just remain very murky. So, on the one hand, you have advocates

arguing that there's enough money in the system for these staffing ratios to be increased and quality to improve. Right? And then, on the other hand, providers argue that, you know, this high dependence on Medicaid imposes a ceiling on quality, including on staffing, and that without additional funds, one can't meet, for example, these new higher staffing ratios.

Personally, based on the research, I think both are probably true, but it's absolutely impossible to tease these out because we don't have transparency about the flow of public funds; and then that, combined with a lack of transparency about increasingly complex ownership structures, right? So we have these related-party transactions where even looking at a cost report for a single facility, we can't really tell what's going on because, you know, that facility sold its real estate to a different owner who then charges rent back to that facility, but the owner of the real estate and the owner of the nursing home are actually the same company in some ways, or are related.

And so the data just aren't there to tease out these sort of causal connections, which makes it hard to

know what to do moving forward.

So I think we should continue to do these comparisons. It's good information. It's just hard to interpret them. And so in terms of your questions about, you know, what we might do moving forward, I have a couple of ideas and suggestions, with the caveat that I know that there's going to be limited work time and you probably can't do all of these things.

But I'm trying to focus on like how can we take this huge problem and focus in on analyses that can help us think about how will staffing ratios in nursing homes and potentially new policies affect access to care and quality of care for Medicare beneficiaries?

So one thing I think we can do is perhaps make these comparisons a little bit fairer by perhaps stratifying on payer mix. So, you know, these big comparisons like that are just problematic in some other ways. If we look at facilities that, for example, have a similar percent Medicare, similar specialization in Medicare, and then look at how differences in staffing ratios, you know, relate to their outcomes and to their profitability, I think that would be useful.

I would say specifically look at some of the facilities below the threshold for the new staffing regs, right? Because that's where we're going to see the action. So facilities for whom the new regs will be binding, and see what's going on among those facilities now in terms of their staffing ratios and also moving forward.

I think, you know, the prior research on minimum staffing requirements and wage passthrough policies has been a little bit underwhelming. You know, it has a little bit of an effect, makes some marginal difference. I would love to see more research on those three states that have imposed these direct care spending requirements, right? They're going to raise the Medicaid rate, but they're going to require that money to be spent on staffing and have a certain percentage of their revenues being spent on staffing. So I think that's where a lot of the policy momentum is, so I'd love to see some analyses of what goes on at those three states with respect to staffing.

As you mentioned, Kathryn, the new regulation excludes analysis of LPNs. I think there's a reason for that, and that is the research is always really murky. Really, it's hard to find any good connection between LPNs

and quality, but they're also super-important and do a lot of work in nursing homes. And I think the reason we don't see a connection is because in the absolute sense, LPNs are important, but often they're sort of substituted for RN care, and that could be a decrement to quality, right? And so the research has been unable to tease those out, but I would say moving forward it would be helpful to also include some analyses of LPNs and not just the RNs and CNAs.

And then, finally, perhaps most importantly -- and I'll stop after this -- to me, because of all this murkiness about whether or not there's enough money in the system, I'm guessing that one of the reasons -- so it's clear in the rule there's no additional funds for these new staffing regs, right? And I think part of the motivation here might have been this is the brute force test of whether there is enough money in the system, right? So if there is enough money in the system, providers will find a way to do this. If there's not, we might see a lot of exit, especially given the sort of precarious financial status of a lot of nursing homes after the pandemic.

And so I would love to see an analysis moving

forward that sort of ties some of these staffing analyses and changes in staffing to changes in the market structure of nursing homes, looking at occupancy, exit, and perhaps if you can get the data, some of these changes in ownership structure. You know, my guess is we're going to probably see a lot of action in terms of exit or we're going to see a huge proportion of facilities applying for those extensions, because, you know, at the prevailing wage rates now, I think it might actually be really hard for a nursing home to find enough staff to hire.

I could say a lot more, but I'm going to stop before I run out of the entire time.

MS. KELLEY: Okay. I have Scott next.

DR. SARRAN: Yeah, well, I've got 40 years' worth of thoughts on this, but I'll try to be brief.

First, highlighting some of Tamara's points, including the murkiness of the entire sector due to how the ownership is split typically between the management and the real estate and other ancillary providers in that space and so forth, and I think that has always -- as we do any work in this space, it is always, I think, worth our referencing in any document we put out the need for continued focus on

better and better transparency, because without that we have no real useful data on which to make decisions. So I think that's always worth highlighting.

Tamara's point --

DR. CASALINO: Can I -- sorry.

DR. SARRAN: Sorry?

DR. CASALINO: Do you mean ownership transparency?

DR. SARRAN: Yes. Yes, of the various parts or pieces that add up to a functioning nursing facility, including real estate, the direct employed staff, ancillary services, et cetera.

Tamara's points about we're dealing with at least a couple of high-volume different kinds of businesses in this space, and separating out by or segmenting by payer mix as well as by acuity adjustment may be very useful, because what that will do -- and I think, Tamara, this is where you were pointing us -- is there are the post-acute high-acuity-oriented facilities that get a significant volume of referrals from hospitals. They will have a high Medicare mix. And then there are the -- although they are Medicare-certified, the primarily custodial Medicaid-

oriented facility use whose only Medicare business essentially is in their own long-term care residents who have gotten ill, gone out to a hospital, and are coming back to their place of residence, but now in a skilled bed. And those are two -- yeah, there's blurring of those two, but they're fairly distinct types of businesses with different ownership interests, et cetera. So worth, I think, doing some segmentation by that.

The particular comments I have, I'm very much in favor, for all the reasons that have been discussed, pushing on this lever of nurse staffing. And I don't think we need to belabor why, because I think Kathryn did a nice job of outlining the "why."

That said, the caveats that I think we want to make sure we're all aware of is that, first, it's an imperfect proxy. It's a classic process measure -- right? -- rather than an outcome measure. What we care about, of course, are outcomes. So at best, this is an imperfect crude proxy.

Second -- and this has been discussed -- it is a classic unfunded mandate, and unfunded mandates just, you know, are fraught with all sorts of bad problems.

Third, it's subject to gaming. I mean, this is an industry that, unfortunately, despite the large number of really well-intentioned actors, has a not insignificant number of problematic actors, and every kind of metric like this is subject to gaming.

Fourth, there are a lot of unintended consequences that we -- not a reason not to go down this road, but we need to be aware of, guard against, monitor for, et cetera, and, Tamara, you teed up some of these. But we're likely to have some closures, and that may not be a bad thing in some locations, but -- and I bet Lynn would agree -- in other locations, particularly rural, that can be really problematic in terms of beneficiaries having access to needed services. And there likely will be some. As a consequence in terms of closures, there's likely to be resulting further consolidation and further shift to large for-profits who have the ability to potentially game the system and survive, you know, the challenge.

Also, under the unintended consequences, in order to meet a staffing requirement for one particular type of staff, assuming totally aboveboard good behavior, the money will likely come from somewhere else that may hurt

beneficiaries, such as -- and Tamara mentioned -- may come from other staff, whether it's LPNs, dieticians, et cetera, may come from clinical programs, activities and so forth that are really critical drivers of the outcomes we all care about -- quality of life and avoidance of or mitigation, early detection and management of acute exacerbations of chronic diseases or new acute illnesses.

And lastly, and a most important point, if I can -- in my mind, is that most critically this work -- again, I'm not trying to say we shouldn't go down or support going down this road, but it fails to address the root cause issue, which is that we have an artificial dichotomy between Medicaid-funded housing and Medicare-funded medical care. And frail beneficiaries, frail duals living in long-term care facilities never benefit from the dichotomy and artificial distinctions. They are a mix of people needing safe housing and excellent medical care, and there's a whole series of very great consensus on what excellent medical care looks like. And the solution to that is to change the incentives that currently exist and are perverse between Medicaid and Medicare. Let's just be clear. The incentive issue of running a Medicaid facility from a

business -- if you're running a facility where the residents' room and board is paid by Medicaid, your business incentive is to drive down your cost on a daily basis, which includes staffing and programs, right? It's not about supplies and bricks and mortar because those were already driven down as low as they can go, so it's staffing and programs. Drive that down and let residents get sick, go out to the hospital, and bring them back on a skilled bed. I'm not saying that well-intentioned actors do that deliberately, but that's the business incentive, right? And then Medicare lives downstream from that and picks up a high volume of skilled days that could have been prevented with better outcomes for the resident by appropriate monitoring and management of their condition so they did go out to the hospital.

And so I'd like us in all the work we do please to highlight -- and my recommendation is in all the work we do to highlight the artificial dichotomy and the perverse incentives that currently exist and continue to recommend that we explore through all venues possible ways to disrupt and remediate that artificial dichotomy and perverse incentives.

Thanks.

MS. KELLEY: All right. I have Lynn next.

MS. BARR: Thank you again, Kathryn.

You know, it's funny because prior to this session, I have always believed from what I've heard over the last few years is that we're overpaying SNFs, we're overpaying SNFs, right? And I realize that Medicaid is a big part of this, but, you know, if we don't have adequate nursing and we have 53 percent turnover, I'm not sure that that's an indicator that we're overpaying them. I think that we do have to put some guidelines in, but we may actually have to pay them more to be able to provide kind of quality care they need.

So what I not sure of because of the various analysis in this is there are kind of three concepts that have come up in this paper. One of them is, do we need -- you know, we need 24/7 nursing, right? And that's from CMS, right, saying we need somebody in the building all the time, and I don't think anybody would disagree with this. It's a skilled nursing facility. We need a nurse -- we need a nurse in the building.

But then there's another kind of position that's

just we need more nurses. The more nurses we have, the better the outcomes. But I'm not really sure how those two compare. If I have one nurse 24/7, do I get better outcomes, or is that better associated with higher quality than just having more nurses? I don't know what the relativity of this is.

And the other piece is, you know, that we should be thinking about is this turnover issue, right? And in your paper, you say the higher the turnover, the worse the outcomes. Now that I know that the average is 53 percent, my mind is blown by what you were even talking about. What kind of -- you know, what kind of turnover do you need to show even worse outcomes?

So I don't know where Medicare should be investing their money. Should we be investing in turnover? Should we be investing in more nurses, or should we be investing in making sure there's one 24/7 and the payment policies would be different for each? And I agree with the unfunded mandate. If we need a 24/7 nurse there, maybe that's something we pay for, right, that's excluded from the rest of the payment model, or if we really have to determine, have to fix turnover, maybe that's something we

pay for.

So those are my general comments. I'm not really clear from here where the relative value is of the investments that Medicare would make, and I was hoping, Kathryn, that somehow you could try to associate these things to the PBJ data to some other data that we have in terms of quality or stars or whatever to see if we could get some idea of relative impact -- unless you don't.

MS. LINEHAN: Are you asking whether I can associate staffing data with quality data? I mean, that's --

MS. BARR: Yeah. Those three variables, could you look -- could you tell us which has the greatest impact? Is it one nurse there 24/7, or is it just more nurses? Or is it if you reduce turnover, you get better outcomes? Where should we be focused?

MS. LINEHAN: We can see what we can do.

MS. BARR: Thank you. I know it's a big ask.

MS. KELLEY: Okay. I have Betty next.

DR. RAMBUR: Thank you. And I apologize. My internet is going off and on. So maybe that's a message. I'll be very brief. I hope I don't repeat things others

said when I was offline.

I'm really glad we're looking at this because these are our most vulnerable citizens, people, and we will someday, many of us, be in the position of needing this care. So, as you've heard me say before, to create the system any of us would want to be in or work in.

It may surprise you that I traditionally have not been all in on minimum staffing requirements because I see that a regulatory response to what I perceive as a market failure. Kind of building on what Scott said, in many ways, the nurses are the air traffic controllers in these systems, and yet we're using them or thinking about them as if they are staff, something that should be contained as low as possible.

So if you think about them as really being the vanguards of safety and effectiveness, I think we have to think about staffing requirements.

Skill mix is really important. So it's not just how many RNs, in my view. It's the mix of RNs, LPNs, nursing assistants, what are the other support staff, like dietary.

The issue of the difference on weekends is very

alarming, I think.

And in terms of key indicators, I've always thought that if we can have strong enough key indicators and link payment to that, that that's the way to go, because then the staffing follows, so, you know, falls, pressure sores, family satisfaction, et cetera, et cetera. So, yes, we need to look at minimum staffing requirements in this era.

The wage pass-through policies, Tamara, you mentioned them. Maybe others did when I was offline. My recollection of those is that the effects were modest but there, and maybe the wage passing through wasn't enough, or is it the idea or the execution?

And then, finally, I personally am very interested in direct care spending requirements. If we're going to increase the money to places, the concept being similar to a medical loss ratio actually does make sense to me. But looking at states and places that have done it and the outcomes, I strongly support.

And then, finally, do we have the right outcomes? Do we have nuanced enough outcomes that we're measuring? Do we really know always what is a quality outcome? Some

are obvious, but others, I think, are more subtle and certainly should include some measure of the frailty of the individuals.

So thank you so much for this work so far.

MS. KELLEY: Brian.

DR. MILLER: Thank you. A few thoughts, briefly.

I think Tamara said it best when she said staffing is a quality measure, and then Scott mentioned that it is a process measure. I think a lot of harm has happened in the Medicare program when we use quality measures as direct regulatory requirements, which multiple people have mentioned are unfunded mandates. I view this in sort of the same way. I'm fine paying for a quality metric that's related to staffing. That's okay, but I don't think that it should be a regulatory requirement for conditions of participation as an unfunded mandate when we have a massive nursing shortage.

There was a great letter from the American Hospital Association a couple weeks ago that I think was September 1st penned by Ashley Thompson, which actually enumerated many of my concerns, which is that we're going to be pulling staff, I think, from the hospital industry,

which is already struggling to staff its floors. They're having high costs for travel nurses. They have high nursing turnover. I don't think that we can expect that the post-acute care space is going to be any more successful, and so recommending a staffing requirement that something like 80 percent of facilities cannot comply with is, I think, best described as the definition of policy insanity.

I also think I agree with former Secretary Burwell and former Administrator Don Berwick that we should be paying for value and we should be paying for outcomes. The concern which all of us share is that the quality of care in nursing homes is not adequate, and that we have different populations. You have the Medicare post-acute population. You have the Medicaid long-term care population, multimorbid, frail, needs help with IADLs and ADLs. I think a better thing to do is to say, what are the quality measures and outcomes that we desire for care in this population, create a system to grade and pay for that, not overly burdensome, and do that rather than specifying how they have to run their business.

I think that direct care spending and wage pass-

through policies are going to be massively manipulated by industry. A good example is the medical loss regulation that came out of the ACA. I teach a graduate course on insurance design, and the first of -- in our vertical lecture, the first thing I do show that supply chain, and I say here's how you get around MLR regulation. And all the grad students have already actually suggested that vertical integration as a strategy to do that. There's no reason to think that the market is not going to happen or behave any differently here.

So in addition to looking at paying for value and paying for outcomes as an alternative to crushing hospitals, nursing, staffing, and creating an unfunded mandate for staffing in post-acute care, I think we should be thinking about GME, and then I also think we should be thinking about I-SNPs.

As Scott mentioned, that population, the dual eligibles who are medically frail, we need to think differently.

So I guess I would say I don't think that any of these policies are going to be effective in the long term and will probably cause more problems than they solve.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you.

I think this is really just a highly informative chapter that was that was drafted here, and I think what's resonated with me, as many other people, is just this whole idea of the impacts that staffing has on the overall clinical outcomes of patients, whether in a skilled nursing facility or hospital setting or a physician practice. And the whole idea that there's literature out there that's credible, that speaks to daily variation, poor weekend coverage, and high nursing turnover, that has implications or associations with five-star ratings and infection control citations and increased hospitalizations and ED utilization is rather compelling.

I do realize that the literature is still mixed in this area, and it still needs further study and validation, but I think it's worth actually looking at.

Not every quality measure is a traditional measure, so I do believe that there are some operational measures like turnover that do enable over the short and long term, you know, the clinical outcomes that many of us want to see. So I'm not entirely dismissive of looking at

these metrics but do recognize their shortcomings as well.

I think a couple of points that Commissioners have brought up, which includes this dichotomy and contradiction between Medicare and Medicaid in terms of trying to provide appropriate resources and the fact that in some cases when it concerns nursing, in particular, that different facilities like hospitals and skilled nursing facilities may be cannibalizing each other, trying to look for the same population of providers to provide staffing for their for their institutions are certainly problematic.

At the end of the day, though, we do want some of these skilled nursing facilities to survive over the long term, and we've mentioned that some of the more areas -- some of the more vulnerable areas are in the rural population.

I would go one step further, particularly after our safety net discussion. I realize a lot of us have put sort of a wish list here, but I do wonder if we applied our safety net index to skilled nursing facilities, whether we can find some sort of appropriate balance in terms of trying to make sure that we have the skilled nursing facilities appropriately resourced in the areas that they

need to be, and that they're not at a risk of closing in more vulnerable communities.

So I know you're getting a lot of proposals here, but I want to put one more, one more log onto the fire for consideration as well, particularly given all the good work that we've put into the SNI model. So thank you for a really good report and an engaging discussion.

MS. KELLEY: Kenny

MR. KAN: I'm greatly supportive of the body of work. Thank you.

For future analysis, I'd really like us to explore the clinical and financial ROI of any staffing policy options so that we don't just saddle the nursing home industry with a lot of unnecessary costs.

I mean, we are currently as a nation experiencing the highest interest rates in 20 years. Such policy options, if not being thoughtful, could potentially fan higher inflation and would not be good for the health care sector.

Thank you.

MS. KELLEY: Cheryl, did you want to get in here?

DR. DAMBERG: Oh, thanks. I just was going to

say that at the bottom of the slide that's shown, I think these three different options have challenges that -- and I recognize some of the challenges with the data availability to be able to do empirical analyses, but I wonder -- and obviously, staff resources are constrained -- whether any of this work could benefit from some qualitative interviews with nursing homes. So I just put that out there for consideration.

MS. KELLEY: That is the end of my queue, unless I've missed someone.

Larry, did you want to get in here?

DR. CASALINO: Yeah. Go?

MS. KELLEY: Yes, please.

DR. CASALINO: Yeah, very briefly. First of all, I like Robert's - it's a little bit of a tangent to the focus of this report, but I do Robert's comment about thinking about safety net index in this context, planning the previous work we've done on that in relation to households.

There's two numbers that stick in my mind in the report. One is the 53 percent average turnover rate. The other is the 26 percent average margin for SNFs that have

low staffing ratios. I'd really like to see the correlation between the SNFs that have 26 percent average margins and turnover rates. Something is wrong here, right? I mean, if people are taking home 26 percent profits and they have high rates, maybe higher than 53 percent of staff turnover, they're not paying their staff enough. They're just taking the money for themselves. I think this is -- if I'm understanding this properly, that's pretty outrageous, and it might be something we might want to think about a little bit when we're recommending updates.

MS. KELLEY: Okay, Mike.

DR. CHERNEW: Okay. We have five more minutes. If anyone wants to talk, it's -- I have to say, as an aside, it is always a challenge to figure out how to make sure there's enough room for the people in the queue without cutting off the comments we got. I guess in the end of the day, it worked out.

I will make a few summary comments before we move on to rehab facility. The first one is there's a -- this is now just Michael talking, but I think I'm summarizing sort of what I heard. There's a lot of concerning things

in the data. We can spend a lot of time trying to figure out how many more concerning things there are in the data or nuances of the concerning things there are in the data, but at the end of the day, I'm pretty confident that we'll find there's a lot of concerning things in the data.

The challenge, in my mind, has been a challenge in almost everything we do in this space, which is the somewhat awkward fragmentation between Medicare and Medicaid and other funders in this space. It's particularly interesting because many of the people that are getting Medicaid services, long-term care services, are actually Medicare beneficiaries. So we certainly care about the care they're getting, even the care that we're actually not paying for.

The set of comments really spanned a lot of ideas around the bullets on the on the slide, but there certainly was no shortage of people concerned about the unintended consequences of trying to do these various things and, you know, would the money get where we need, the ability or lack thereof of understanding what's really going on underneath the hood and how do we encourage it.

The staff and I, Amol and Paul, we're going to

talk about this more, but I do want to leave this session with one broad comment. There are a lot of policies that are important that might affect Medicare beneficiaries that does not mean that it's Medicare's role or Medicare is best suited to solve those problems. So this could well be a case where there's really, really good policies that need to be put in place, and those policies are simply not policies that should be put in place through the Medicare set of levers, because we're fundamentally focused on the post-acute portion of this. And while we certainly care about Medicare beneficiaries that are outside of the post-acute setting in the institutional setting -- and certainly, I-SNPs is a way of getting in there, into that kind of population -- it is not necessarily where -- the core problem is not necessarily a post-acute problem with staffing. The core problem is Medicare beneficiaries, perhaps, not getting the care or attention they need in situations that are actually not consuming Medicare-funded services. And that makes the leveraging of what we do a little bit complicated.

So I remain a little uncertain about the way forward, but luckily, the staff is exceptional. And as we

debrief on this, we will see where we play out.

I do hear a lot of interest in this area, a lot of concern about what's going on, and we will ponder how to get into this space, because I do think it is an area that we need to at least be aware of. And we certainly need to be aware of it as we think through our regular order of business like the updates.

Last point -- you gave me an extra minute, so you're going to have to listen to it -- is when we go to the update recommendation, I do believe we will continue the standard MedPAC principle of focusing on things like payment margins for post-acute, and then we will wring our hands, and that really does -- one of the things that does keep me up at night, thinking about how uncomfortable we are with that, given the holistic sense of what's going on. So that's a little preview of sort of my angst.

Paul, do you want to add anything before we take a quick break and then jump in? We're going to do a little switch here, and we're going to move to rehab facilities. But anything you want to add, Paul?

MR. MASI: No. Thank you, everyone. Great job, Kathryn.

DR. CHERNEW: I got to get to that point. Thanks, everyone. Great job. Thanks, everyone. Great job.

Let's take a quick break and come back at the bottom of the hour, 3:30, and we're going to talk about rehab facilities.

[Recess.]

DR. CHERNEW: Okay, everybody. Welcome back. We are now going to move to our session on rehab facilities, and there's a lot of issues there, and I think the analysis, like all situations, is outstanding.

I'm going to turn this over to Carol, so, Carol, take it away.

DR. CARTER: Thanks. Good afternoon, everyone.

Today we will present options for using an alternative method to set payment rates for select conditions treated in inpatient rehabilitation facilities. Before we get started, I want to remind you that a PDF of these slides is available from the webinar's control panel on the right side of your screen.

Here's a roadmap of what we'll cover today.

First, we'll provide some background on IRFs. Then we'll discuss CMS' definition of qualifying and nonqualifying conditions in IRFs.

We'll compare the characteristics of the patients treated in IRFs and similar patients treated in SNFs.

We will also compare Medicare's payments for nonqualifying stays in IRFs with those made to SNFs for similar stays.

We'll outline, at a high level, alternative ways to establish payment rates for IRF nonqualifying stays.

And, finally, we'll outline future analyses and present some discussion topics for your consideration.

MedPAC and others have documented the overlap in certain types of patients treated in IRFs and SNFs.

To evaluate this overlap, and in response to a congressional mandate, in 2023, MedPAC evaluated a unified payment system for post-acute care that would establish site-neutral payments across PAC settings.

We concluded that while a PAC PPS could establish accurate payments, it would be complicated to implement. The Commission stated that it would look for opportunities for smaller-scale site-neutral payments.

Before our work on a unified payment system, MedPAC considered the overlap in patients treated in IRFs and SNFs. In 2015, the Commission recommended site-neutral payments between IRFs and SNFs for select conditions.

The policy problem is thus: The types of patients treated in the two settings continue to overlap, yet the payment rates remain considerably different.

While IRF services are more intensive than those in SNFs, not all patients treated in IRFs require this level of care.

Medicare's payment rates are considerably higher than those in SNFs, even for those patients with conditions that typically do not require the intensity of an IRF. The Commission has posited that Medicare should base its payment rates on the resources needed to treat patients in the lowest-cost setting.

This year, we will explore an alternative way to narrow the difference in payment rates between IRFs and SNFs for patients with select conditions.

Just a little background sketch of the IRF industry. There are about 1,200 IRFs nationwide, but they

are not distributed evenly across the country, and we'll talk about that in a minute.

Medicare spending in 2021 was $8.5 billion. Medicare margins in this sector have been in the double digits for years. In 2021 the Medicare margin was 17 percent.

We appreciate that IRFs and SNFs differ in the services they provide.

IRFs are licensed as hospitals and generally provide intensive services. The care is physician-led and a rehabilitation physician sees patients three times a week. RNs are present 24 hours a day. To be admitted to an IRF, a beneficiary is expected to tolerate and benefit from intensive rehabilitation, which is generally thought of as three hours a day, five days a week. And beneficiaries require at least two therapy modalities. IRFs are paid under the IRF PPS on a per stay basis.

In contrast, SNFs are licensed as nursing homes. There is no requirement for daily therapy, and Kathryn just went over the staffing requirements. LPNs have to be present 24 hours a day, while RNs have to be present eight consecutive hours per day. A physician must supervise care

but the required physician visits are infrequent -- once every 30 days for the first 90 days.

To be admitted to a SNF, a beneficiary must require a skilled nursing or therapy service, and the patient must have had a prior inpatient hospital stay of at least three days. SNFs are paid on a per diem basis.

While the level of care is clearly higher in IRFs, our question is whether Medicare should pay for this level of care for conditions that typically do not need intensive rehabilitation.

CMS has two categories of conditions treated in IRFs. The alternative payment method to pay for stays that do not require intensive rehabilitation would rely on Medicare's definition of qualifying and nonqualifying conditions.

Qualifying conditions are those that CMS has identified as typically requiring intensive therapy. There are 13 of them, and they include things like stroke, spinal cord injuries, and hip fractures. There is a complete list of them in your paper.

To be paid as an IRF, qualifying conditions must make up at least 60 percent of an IRF's admissions. This

criterion is intended to differentiate IRFs from acute-care hospitals.

In contrast, nonqualifying conditions are conditions that CMS determined do not typically require intensive rehabilitation therapy, such as debility and cardiac cases.

CMS has stated that nonqualifying conditions could be treated in a lower-cost setting. Nonqualifying cases can comprise up to 40 percent of IRF volume.

Now Corinna will walk through our comparisons of IRF nonqualifying stays and similar SNF stays.

MS. CLINE: To assess the characteristics of IRF stays that may be subject to an alternative payment, we applied CMS' compliance algorithm to identify IRF nonqualifying stays and comparable SNF stays.

The Medicare Administrative Contractors, or MACs, apply an algorithm developed by CMS to determine IRF's compliance to the 60 percent qualifying stay requirement for the IRF to be paid under the IRF PPS. The algorithm uses assessment data and is based on the presence or lack of certain diagnosis codes and other data elements show on the slide. For IRFs that fail to meet the 60 percent

requirement, MACs conduct additional medical record reviews.

We applied this algorithm to identify nonqualifying IRF stays. We also applied the algorithm to SNF assessment and claims data to identify comparable SNF stays. More details on the methods used to identify our study population are in your mailing materials.

We identified 30 percent of IRF stays as nonqualifying. When applying the same algorithm to SNF data, we found that 60 percent of SNF stays meet the nonqualifying criteria, and compose our population of "comparable SNF stays."

First, we examined the share of nonqualifying conditions treated in SNFs. Carol mentioned before that IRFs are not evenly distributed across the country. In fact, we found that IRFs are only in about one-third of markets, in which 70 percent of beneficiaries live. In contrast, we found that nearly all markets have at least one SNF.

Looking at the graph, you can see that across all markets, most patients with nonqualifying conditions -- or 86 percent -- were treated in SNFs.

Even when we looked at markets with both IRFs and SNFs, the majority still went to SNFs.

While the share of stays going to SNFs was slightly lower in markets with both types of facilities, the share was still high, indicating that these conditions are frequently treated in SNFs, even in markets where an IRF is available as a potential treatment setting.

Next, we compared risk scores and demographic characteristics for beneficiaries with nonqualifying IRF stays and those with comparable SNF stays, as shown in the table.

The median risk scores for IRF and SNF stays were similar, and the distributions largely overlapped.

IRF patients with nonqualifying stays were younger, with a much smaller share of patients 85 years or older, and were about half as likely to have low incomes compared with their SNF counterparts.

End-stage renal disease and disability rates were similar between IRF and SNF beneficiaries. These patterns were generally the same within condition categories.

We also compared rates of select impairments for nonqualifying IRF stays and comparable SNF stays.

As seen in the graph, IRF patients with nonqualifying stays had substantially lower rates of incontinence and swallowing difficulty compared to SNF patients. IRF patients may have lower rates of impairment because, to be admitted, they must be able to tolerate and benefit from intensive therapy.

Additionally, IRF patients with nonqualifying stays generally had lower rates of comorbidities compared to similar SNF patients, such as chronic kidney disease, heart failure, depression, Alzheimer's, and COPD, which is not shown on the slide.

Next, we used clinical items gathered from the IRF PAI and SNF MDS assessments to compare functional status between IRF nonqualifying stays and comparable SNF stays. Details on our methodology for calculating motor and cognitive scores are in your mailing materials.

First, we compared motor score. We found that the median motor scores across IRF and SNF stays were the same, but that SNF stays had slightly wider ranges of scores, which makes sense given the broader range of patients who use SNF care and the IRF admission requirement that patients must be to tolerate and benefit from

intensive therapy.

Next, we compared cognitive scores using the Brief Interview for Mental Status (or BIMS) summary scores for IRF and SNF stays. Higher scores indicate higher cognitive function. The median BIMS score for IRF and SNF stays were similar: the median score was 14 for IRF stays and 13 for SNF stays. But SNF patients had a much wider range of BIMs scores.

Lastly, we compared lengths of stay, minutes of therapy a day, and minutes of therapy per stay for nonqualifying IRF stays and comparable SNF stays.

We found that nonqualifying stays in IRFs are shorter than comparable SNF stays. The median IRF length of stay was 12 days. The median SNF length of stay was more than double, at 25 days.

IRF patients receive substantially more therapy per day: the median value was 125 minutes per day. In contrast, comparable SNF stays received less than half of those minutes, with a median value of 56 minutes per day over the longer stay.

For IRF stays that were 14 days or shorter, the median total number of therapy minutes per IRF stay was

1,355 minutes compared with 1,258 minutes for SNF stays. While SNF patients receive much less therapy per day, over the course of the stay, given the long stays in SNFs, the difference between minutes of therapy delivered for IRF and SNF stays narrows to just 8 percent.

Next, we turn to payments. We compared Medicare payments for nonqualifying IRF and comparable SNF stays, using fiscal year 2021 IRF and SNF fee-for-service claims. We summed the per diem payments for the duration of each SNF stay in order to make them comparable to the stay-based IRF payment.

Across all noncompliant IRF stays, the median Medicare payment for nonqualifying stays was $20,880.

Median payments for comparable SNF stays were about 40 percent lower, at $12,650.

Now, I'll turn it back to Carol.

DR. CARTER: Corinna presented information showing that payments are much higher in IRFs than in SNFs, yet IRF patients are either similar or have fewer impairments. Nonqualifying conditions typically do not require the intensive rehabilitation care that is unique to IRFs.

This raises the question: What is Medicare buying for the higher payment rates?

To get at that, we plan to examine differences in outcomes for nonqualifying stays and comparable SNF stays. We will compare risk-adjusted rates of admissions to acute hospitals and discharges to community and Medicare spending per beneficiary.

We're considering two approaches to narrow the differences in payment rates between IRFs and SNFs for nonqualifying stays. Both have precedent.

In the first option, payment rates for nonqualifying stays would be established using the SNF PPS. The IRF PPS would be used to set rates for qualifying stays.

This approach would be similar to the dual payment rate policy mandated by the Congress for LTCHs.

In the second approach, payment rates under the IRF PPS would be lowered by set percentage based on the difference in payment rates between IRFs and SNFs for the nonqualifying stays. This approach would be similar to the reductions made to payments for select outpatient services to off-campus provider-based departments.

We plan to flesh out these approaches and come back to you with more information at a future meeting.

For future analyses, we plan to present estimates of payments for nonqualifying stays under each of these alternatives.

We will model the impacts on the industry, and we also plan to compare outcomes for nonqualifying stays treated in IRFs with similar SNF stays.

We will also discuss how an alternative method could be implemented. This information may be an informational chapter in the June 2024 report to the Congress.

For discussion today, we will answer questions you have about the work we presented and ask if there are additional analyses you would like us to pursue.

With that, we'll turn things back to Mike.

DR. CHERNEW: Thank you all so much. There's a lot here. I will put an underline on the comment what we're getting for the added payment, but that's just my underline. I think we'll go through the queue, and I think Larry is to start, and then Dana will manage it from there.

DR. CASALINO: Yeah, just a quick question. I

enjoyed reading the parts particularly about the interviews with discharge planners from hospitals about, you know, getting patients into IRFs versus SNFs. I thought those were pretty informative.

I don't think you did as much, it doesn't seem like, interviewing of people -- I assume that IRFs have the option of accepting a patient or not, practically speaking. And I would have liked to have known more about from the IRF point of view whether they think and who do they accept and who do they decline.

Was I missing that in the report or could there be more of that?

DR. CARTER: So we can flesh that out a bit. We did interviews with 12 hospital discharge planners around the country over the summer to get a sense of how they think about placing patients in either IRFs or SNFs, and then their sense of who was invited and who wasn't. So we did do some work on that.

I will say that those interviews showed that fee-for-service benes who have a qualifying condition are pretty easy to place, but not the folks with nonqualifying conditions. And we heard actually pretty different

experiences with that. Some IRFs seemed to be pretty careful about only admitting qualifying -- patients with qualifying conditions; whereas, other IRFs take a wider range of patients.

We also did two site visits to IRFs this summer to understand what do they think about the list of the qualifying conditions, in addition to just learning about, you know, their admissions process. They often have limited openings and only take 30 percent, 50 percent of who they are referred. So, they are selective and because they don't have ERs, they wouldn't be subject to EMTALA. So there is some selection going on by IRFs, and it varies. From the site visit and the interviews, it sounded like there was a lot of variation in that. Does that help?

DR. CASALINO: It does help, and I'm trying to think about -- and you don't have to respond to this now. I'm trying to think about whether from the IRF side, selectivity on who they take, whether any payment alternatives we would recommend have a -- whether that has a bearing on what we might think about for payment alternatives.

DR. CARTER: I guess the other thing I should

have said was one thing we heard -- the other thing we heard, was that on any given day an IRF might or might not take that patient, and some of that has to do with how close they are to meeting the compliance threshold of 60 percent. So even from a place that looks like they've got sort of some ground rules -- some facilities don't worry about the compliance threshold. They're way above it and they never really pay attention to it. But we also have heard that other facilities do pay attention, and it really depended on where they were with that compliance threshold.

DR. CASALINO: Thank you.

MS. KELLEY: Okay. I have Amol next.

DR. NAVATHE: Thank you so much. It's great to see this work continue, especially after we did the work on unified PAC and sort of had a promised follow-up. It's nice to see this follow-up coming to fruition.

So I had hopefully what is a fairly simple, straightforward question. In the reading materials, I think it was highlighted a little bit more that it looks like we used the patient assessment data to identify nonqualifying versus qualifying, and in our previous work, in fact, in our unified PAC PPS work, I think we had done -

- we had made some comments and done some investigation that highlighted that the patient assessment data is not always that reliable.

So I was curious, number one, is it correct that they were using patient assessment data as part of this identification algorithm, if you will? And, secondly, if that is true, then do we have any concerns about the integrity of that data vis-a-vis being able to identify similar nonqualifying stays in the IRF and SNF settings?

DR. CARTER: So I can start, and Corinna can certainly jump in.

So our concern with the patient assessment data has to date focused on the functional status information, and so we've been wary of using that.

What we were doing was using CMS's algorithm for identifying nonqualifying and qualifying conditions and applying that to the SNF patients. So we were using whatever is pulled from the patient assessment data from the IRF pie to generate the case-mix groups and the definitions of qualifying and nonqualifying and then running all the SNF stays and assessments through that same group to identify comparable stays. To the extent that the

patient assessment data are variable in their accuracy, that's kind of embedded in both of these payment systems and in both of the case-mix groupings in the assignments of cases to groups.

DR. NAVATHE: So, in another way, this is a follow-up to that, of just saying that in both settings, there would be sort of, generally speaking, a common incentive to code more severely where you can, where it might be appropriate to do so, and so there's a symmetry in essentially across the two elements -- across the two settings. And so we wouldn't necessarily expect there to be any sort of differential, quote/unquote, "upcoding" or anything like that might be happening across the two settings. Is that fair?

DR. CARTER: You know, you raised a question that I think is a good one, which is the case-mix groups for SNFs include -- consider many other factors about a patient compared with the IRF case-mix classification system. So I would say that function probably plays a larger role in the IRF case-mix groupings and assignments than in the SNF case-mix group assignments.

And we haven't done any like trying to figure

out, oh, what share of a SNF payment is therapy-based -- or function-based, I should say -- function-based compared with the IRF. So I couldn't answer your question more specifically except to give a general sense that many more dimensions of patient condition, things like difficulty swallowing, depression, special treatments, skin condition. These are all considered as factors on the SNF payment system that -- except for the comorbidities for some of those things. We wouldn't play a role in the IRF PPS.

DR. NAVATHE: I see. And, sorry, last follow-up is so when we saw the shift to the new classification system for SNFs -- I can't remember the acronym right now. But did that influence -- so, one, is our data influenced by that, or are we using earlier data? Secondly, would you expect that to influence this qualifying and nonqualifying situation at all?

DR. CARTER: So these data are firmly after the new case-mix groups, and so I think whatever adjustment to the new classification system probably would have happened already.

And what was the other part of your question?

DR. NAVATHE: I was just worried if we had pre-

and post-data out, would the introduction of that have created any --

DR. CARTER: Oh --

DR. NAVATHE: It sounds like we used just post-data.

DR. CARTER: Well, you know, the thing is function is really important in the new and the old SNF case-mix groups. So I don't know. Maybe a little less. It does rely more on comorbidities for the NTA component and swallowing and diet, restrictions for the speech language pathology component, so may be a little less reliant and more assignment of cases to medically complex conditions post, but these data are all post.

DR. NAVATHE: Okay. Thank you for putting up with my line of questions.

MS. KELLEY: All right. Brian is next.

DR. MILLER: Thank you. I'll save my policy questions for Round 2, but for a small technical question, I just want to say I really appreciated the nuance in this chapter about patient mix between IRFs and SNFs and how sometimes that could be gaming and sometimes that can be appropriate, because they have -- those markets have

different functions, and I thought that came out really well in the chapter. And that's not easy to do, especially since many folks are not familiar with the IRF marketplace. So kudos to you all for doing that.

Small technical question. In some of the figures, 2, 3, 4, and then a couple of the tables, there were some comparisons. I would just add some statistical difference testing to them. Just go through the chapter and make sure that that's done, or it's probably already been done. Just insert it, because again, when we discuss site neutral, I expect that there will probably be a lot of pushback. And so that will make our arguments stronger.

Thank you. Great chapter.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks, and thank you to the team for a great chapter.

I had a question in terms of the market structure, and I don't claim to understand this landscape. But are IRFs typically part of health systems? Are they co-located? Because I'm trying to think about health care consolidation and potential for self-referrals, just in terms of how people move from one place to the next. So I

don't know if there's any information that would shed some light on that.

MS. CLINE: That's something we can look into further.

Carol, do you have anything to add to that?

DR. CARTER: Well, I wanted to say so something like 40 percent are hospital-based. So they would be part of that system.

And then there is one large chain in the IRF space. So some consolidation in this has already happened, but they're independently owned and operated. But there is a large chain in the freestanding IRF market.

DR. DAMBERG: Thank you.

And then this is a question/comment. On your slide 15, in terms of looking at differences and outcomes, I think that's critically important, but something I'm struggling with or question is I'm wondering whether these outcomes are going to be sensitive enough to assess whether the greater application of resources is delivering better value. And I suspect you don't have other outcomes you can look at, because obviously, we want to kind of know, you know, with all that additional therapy, are we getting

better clinical benefit in terms of functioning. But I suspect you don't have those types of measures.

DR. CARTER: Well, I'll give you my opinion, which is we could look at change in function, right? We have that in the assessment data. We've been so far kind of wary about using that as an outcome measure, given the incentives to start low and end high, you know, and so we include it in the case-mix groups because it's really important for explaining cost differences between -- across cases. But as an outcome measure, we would be worried about whether we'd be really measuring performance or something else -- or the accuracy.

There are other measures that say something like false, and that measure might be subject to how open, if you are -- if you will, facilities are to reporting that, because I think there is some unevenness in whether facilities are complete in the reporting of falls. So that might be something we could consider, but we'd have to have those caveats.

Were there measures that you were thinking of? And you don't have to answer it now. We have some information. So we might be able to do a little more

there. I'd be very interested in your ideas.

DR. DAMBERG: Yeah. No, I'd have to think about this a little bit more, and my recollection in talking to some clinicians in the past is the literature around the clinical benefit of therapy and how much therapy is fairly weak.

DR. CARTER: Yeah.

DR. DAMBERG: Thank you,

MS. KELLEY: Tamara.

DR. KONETZKA: Okay. Yeah. It occurs to me that when we read through these chapters, there's just an enormous amount of work that goes into deciding on some of these data issues that then becomes a footnote. So I'll just say I appreciate all the rigor and all the time that must go into some of these analyses.

So two quick questions. One, in the chapter, you said that IRF occupancy rates indicate adequate capacity, averaging 68 percent in 2021 and 53 percent in rural IRFs. I know that for SNFs, these occupancy rates would be considered unsustainable or really an urgent problem, and I'm wondering, when I think about these changes in payments and access to care for people with nonqualifying conditions

or even with qualifying conditions, thinking about the business model of IRFs, what do we know about -- are those typical occupancy rates? Are those considered sustainable long-run occupancy rates? Is this the norm, or is this potentially problematic? That's one question.

DR. CARTER: So I haven't looked at occupancy rates over time, but I'm sure Jamila has, so we can get back to you on that.

I don't think that these reflect a blip. I think that these are what they've kind of been over time. So, in that sense, there it looks like to me there is capacity. Given the Medicare margins are really high in this setting, they're somehow making this model work, and Medicare is a much larger share in this setting than, say, in the nursing home space. This sector is probably 50 or 60 percent Medicare. I'm not sure. So one thing is you've got super high margins on the Medicare side that gives you quite a bit of wiggle room on not being full.

DR. KONETZKA: Okay. Yeah. So I guess then the question is, if those margins decrease substantially for the nonqualifying, is that still a sustainable occupancy rate? That's more of a round 2 question.

The other round 1 question I have is about this value, the value of what IRFs do over SNFs do, and I'm wondering, first of all, we know that managed care is playing -- Medicare Advantage is playing a big role in SNFs, right? There's really downward pressure on length the stay. It's changing the landscape in a lot of ways, and then we also have alternative payment models, things like bundled payments that have reduced SNF use. Do we have anything? Do we have any evidence? I don't really know. I've never -- I don't remember coming across evidence about what these bundled payment models and what Medicare Advantage does with IRFs. Is there any evidence that sort of shows us that those -- under those kinds of incentives that IRFs are still valuable or that they're still used, or is that also decreased a lot just like SNFs?

DR. CARTER: My sense is that MA plans were never big users of IRF. Everyone we interviewed complained about placing MA enrollees in IRFs, even for patients who clearly qualified. We heard quite an earful about that. And I think other analysts, the MA team, I think, plans on looking at, say, prior auth.

I mean, the other thing was, can you get in the

door, and the other is, how long can you stay? And we heard about issues around both of those and the delays in care and the backup in hospitals while they're waiting for approvals. And I think the MA team is going to be looking at that, and maybe, Jamila, I think for her, at least after this year, is going to be looking more at the MA use, but we haven't done that for this work.

DR. KONETZKA: Okay. But it seems like managed care companies do want to use IRF sometimes, but they have a hard time getting a placement. Is that -- did I just misunderstand what you said?

DR. CARTER: I think the takeaway is they hardly pursue it and are even more restrictive about who they refer on to IRFs. I think it's pretty tough.

DR. KONETZKA: All right. Thanks.

MS. KELLEY: Amol, did you want to get in here?

DR. NAVATHE: Yeah. I can just comment on the bundled payment side, because Tamara had asked that question. So a little bit of it depends on whether these are surgical -- bundles for surgical conditions versus medical conditions, but if I were to abstract or try to synthesize, generally speaking, there have been effects

that showed decreases in IRF, just like SNF, but the effects are much, much more pronounced for SNF, and there's also evidence that there is essentially sort of like a substitution. So you see IRF patients going to SNF and then SNF patients going to home, and so there's this kind of cascade of just shifting people to lower acuity settings.

MS. KELLEY: Stacie.

DR. DUSETZINA: Great. Thanks. This is such an interesting chapter. I had a question about the penalty. If you have more than 40 percent of nonqualifying, I felt like it was very clear from the interview data that people were monitoring that, trying to be really careful not to go over 40 percent. But I didn't find -- and maybe I just missed it. What's the penalty when that happens?

DR. CARTER: So you would be paid as an acute care hospital. That's the penalty. I think it's happened -- Corinna, how many times?

MS. CLINE: I believe four times since 2006 has an IRF failed to meet the compliance rule.

DR. DUSETZINA: Thank you.

DR. NAVATHE: Just to get a ballpark, what is the

percent magnitude of that difference?

DR. CARTER: What difference?

DR. DUSETZINA: The acute care payment relative to what you would have gotten if you hadn't gone over.

DR. CARTER: I think it's about half, but I could get back to you on that.

DR. DUSETZINA: But is it half only for the ones that you go over on or like everybody? Do you just get all your rates kind of --

DR. CARTER: No, it applies to your book of business.

DR. DUSETZINA: Oh. Yeah, okay. That's a big penalty. It might be nice to just like finish that piece on exactly what the penalty is, and that it's rare, but it's really severe.

DR. CARTER: Yeah, that's a good point.

MS. KELLEY: Lynn.

MS. BARR: I join everyone in really enjoying this chapter. I have some questions, though. When I looked at the required services of the IRF versus the SNF, there's very patient-specific intensity. So are we talking -- you know, so I want to know what that cost is, right,

you know, because you've got a physician, a rehab physician, three times a week, right? What does that cost? And so, you know, as we look at these, are we talking about saying, oh, if you're not a qualifying stay, you don't -- you know, we're waiving all those requirements, or we're going to say you still have to have all the costs, but we're also going to lower your payment? I'm just not clear on what we're saying here, but I think it would be helpful to understand what those extra costs are over a SNF and make sure that if we're requiring they do this work, that we make sure that we pay for the work that they're doing.

DR. CARTER: I'll just respond to part of that. In a future conversation, we do plan to come back to you all about, okay, so what are the requirements that would make sense to revisit, and it's exactly those patient-specific requirements like how much therapy, how many physician visits, two modes of therapy. Those are things that are case-specific, and because we are sensitive to what we're going to now pay them SNF rates but still hold them to the IRF regulatory requirements, you know, the Commission has said we don't think that's a great idea. And so we won't -- we want to come back to you with a

fuller discussion. Those are the easy ones.

There's some tricky ones that I'll just put out there, and I'm not sure how we'll noodle our way through this, but like the cost sharing requirements are different. And so what do you do with those and the prior three-day hospital stay requirement, and, you know, do you align qualifying and nonqualifying within the IRF, or do you align them across settings? So that's complicated, and so we will hope you all noodle your way through that because I -- those are the sticky ones.

I think the other ones are a little more straightforward to at least think about, but this other one, I think reasonable people might disagree about which alignment are we talking about and then how would you do it.

MS. BARR: Excellent. Thank you so much.

Yeah. So I think I'll leave it there. Thank you.

MS. KELLEY: Okay. There has been some movement in and out of the Round 1 queue, but I think we've come to the end.

DR. CHERNEW: I had Gina.

MS. KELLEY: Gina has removed herself from the queue.

DR. CHERNEW: Oh. Way to go, Gina.

MS. UPCHURCH: My questions got answered. Thanks.

DR. CHERNEW: Perfect. So, first, kudos, Lynn. Your comment was both a question, so that's Kudo No. 1, and brief, that's Kudo No. 2. So that's a double win.

We're going to go on to Round 2, and we're going to start, I think, with Stacie.

DR. NAVATHE: I think Kenny has a Round 1.

MS. KELLEY: Yes, he does. I'm sorry. Go ahead, Kenny.

MR. KAN: Sorry.

DR. CHERNEW: A last-minute entry.

MR. KAN: For some of the pages, could we get a comparison of fee-for-service versus MA and D-SNP? I'm just curious how those metrics compare, if we have that data? So, specifically, I think pages 10, 11, and 13 and 14 in the slide deck.

DR. CARTER: I want you to restate what you want to see, and then I'll give you my best shot as to whether

we can answer it.

MR. KAN: Would it be possible -- because one of the things that we've been debating in the Commission is sort of a comparison of cost and quality of MA versus fee-for-service. Would it be possible to get a comparison between MA, fee-for-service, and SNP plans for the following pages in page in the deck: basically 10, 11, 13, and 14?

DR. CARTER: We can look into that. I'm not sure if that's possible.

MR. KAN: Thank you.

MS. KELLEY: Okay. So now for Round 2, we have Stacie starting.

DR. DUSETZINA: Okay, I have -- I'll call this a Round 1-B. What happens in the areas where you don't have an IRF or you have a qualifying condition, like do all those individuals just go to SNFs in their areas, or do some of them stay in the hospital for longer because of the intensity of care? What's kind of generally happening in those cases given the distribution of IRFs?

DR. CARTER: We haven't looked at that specifically. My sense is that some of benes will get

admitted to SNFs. Some of the benes differ in how much they value being close to their home, and so let's say you get treated in the hospital, but there's not an IRF nearby. Are you willing or is your family willing to travel to an IRF that's further away or higher travel time? When we talked to urban hospital discharge planners, we heard that these places aren't far but it takes time to get to them, it's not just, you know, rural settings. Some benes will use SNF services because they don't want to travel. Others will travel, and they go to an area where -- we looked at -- the use rates are different, and the question is when the -- we saw -- in the data you see, those patients are using SNF services, and examination on the outcomes side I think will be important.

DR. DUSETZINA: Yeah, and I guess I get to the kind of broader wish list of things to see, would be thinking not just about the nonqualifying conditions, but the qualifying conditions and outcomes for people getting IRF care versus SNF care, and maybe potentially home health, like if they're doing some other substitute. Partly to get at this question about like what happens if, you know, we thought that payment should be lower for the

nonqualifying conditions and then somehow, we managed to make IRF operation less attractive overall, like if they're really providing, you know, a better service for the qualifying conditions, like how much kind of cross-subsidization needs to happen to keep them viable.

So I would say that the main thing would be just maybe considering can we also look at the qualifying conditions and recognizing that's going to be a tremendous amount of selection bias happening there. So with all those caveats, I think that might be worth considering moving forward.

DR. CARTER: Yeah, we thought we would look at outcome measures for the qualifying conditions as well.

DR. DUSETZINA: Thanks.

DR. CARTER: I guess I will say also that we heard in some of our interviews that when benes couldn't get into an IRF for whatever reason -- too far or weren't accepted -- depending on the beneficiary, they would go home, depending on whether they really wanted to avoid the SNF setting, and we did hear that in some instances.

DR. DUSETZINA: And one last thing is this is really exceptional work. I felt like I learned a lot about

this industry reading this report, which is kind of a newer space for my thinking. And I think the qualitative interviews were well worth the time to do. It seemed like you got a lot of rich data from that, so kudos to all of you, and I'm looking forward to seeing this move forward.

MS. KELLEY: Amol, did you want to get in here?

MR. NAVATHE: Yeah, I just had a quick clarification point. I appreciate Stacie's point about looking at patient outcomes for the qualifying conditions as well, but my sense -- and I wanted to just double check this with Carol and Corinna -- is that a lot of these IRFs are kind of collocated with acute-care hospitals oftentimes, so some are independent and some have swing bed-type designations as well. And so if we're thinking about it from the perspective of profitability or attractiveness of keeping the IRF open, I think it's a lot more complicated, I guess is what I would say, I think, given how these organizations can run their accounting. I just wanted to double check that because I think it's relevant to Stacie's point.

DR. CARTER: Yeah, and I can ask the hospital group because I'm remembering that at least on the SNF-

based units, those improved the hospital's bottom line. And I don't know if that's true for IRFs as well, so I can ask the hospital group if that's true, how it affects the hospitals' total margin.

MR. NAVATHE: Thank you.

MS. KELLEY: Lynn.

MS. BARR: Just quickly on that point, I was curious. You mentioned a large aggregate margin. Is there a significant difference in the hospital-based IRF margin and the non-hospital-based IRF margins, Carol?

DR. CARTER: Yes, I assume.

[Laughter.]

DR. CARTER: I can quickly look it up in our bible.

DR. TORAIN: Lynn, this is Jamila. Yes, there's significant difference. Hospital-based IRFs' margins have been around 2 percent, when you compare that to about 25 percent in the freestanding, if that was the comparison you were looking for.

MS. BARR: That's really substantially different, so really that average margin is really all the non-hospital-based -- I mean, if you took hospitals out of it,

then all the margins go everywhere else. But to your point, Amol, there's probably other benefits to the hospital as well. That's crazy. Thank you.

MS. KELLEY: Lynn, I had you next in the Round 2 queue. Did you have a comment you wanted to make, too?

MS. BARR: Very, very briefly in honor of Michael. You know, I'm concerned about MA growth. I've heard anecdotally -- and I know anecdotes mean nothing -- that many of the hospitals I talk to are told they are not allowed to admit patients to IRFs period, you know. And so I don't know where that's going, but I'm hearing big denials on that. And so if we destabilize the system, I'm just curious about the downstream effects, if MA continues to take over the world.

MS. KELLEY: Brian.

DR. MILLER: Thank you. So there was a joke that there was never a site-neutral policy that I met that I didn't like. It's probably somewhat true maybe during a leap year along with a solar eclipse there might be one that I dislike. On policy principles, I think it's a good thing. So I like the idea of us estimating, you know, the fiscal impact of that.

Another thing that we should potentially measure is the fiscal impact of changing that 60 percent threshold and increasing it to that historical 75 percent goal.

And then another thing which I think is important, I really enjoyed the discussion about the additional request that the 13 qualifying conditions might be out of date and not just for superstitious reasons. But I think that we should -- and this is a hard request, so I apologize in advance -- try and have a discussion and maybe do some qualitative interviews with geriatricians, EM&R docs, hospitalists, long-term care medical directors, and sort of get a sense for which potential diagnoses should be considered to be added. I look at that list, and some of them, I think, oh, that's crazy, and others I'm sort of surprised that they're not a qualifying condition. You know, things that are fiscally appropriate we should do, but things that are also good for beneficiaries that we aren't doing we should do, too.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. Just in response to Stacie's comment about, you know, what if there's a rehab facility not near a patient's location, where do they go?

I think this is a similar response to even rehab facilities that are a nearer location but patients and families choose to go far, and this is because -- I don't think, you know, every rehab center is necessarily the same. Some have developed, you know, highly specialized niche areas, like in spinal cord injury or traumatic brain injury, and so, therefore, families may be willing to go further away for those specialized functions.

And so I think it does complicate the discussion a little bit because we talk about, you know, rehab facilities as if they're all functionally the same, but they're really not.

I could certainly also appreciate Brian's comments because when it concerns site neutrality, it does cause me some pause and as a patient as well.

I do think for this particular chapter, though, you know, the analytical support that develops the argument for site neutrality for nonqualifying conditions between skilled nursing and rehab, you know, is really quite compelling. I do have some concerns, though, if we're still asking, you know, the right questions here, and I know that there's some hesitation about asking about

functional status after discharge. But ultimately, if you look at rehab centers, whether it's a qualifying condition or a nonqualifying condition, they're in the business of returning as much function to the patient as possible over the short and long term.

So I think we do need to figure out a way, you know, let's say 30 days after discharge, if we're looking at these nonqualifying conditions, how are they stacking up in terms of their functional status, or if the data's somewhat limited or there are other alternative markers that we could use such as return to work for those that were previously employed. So I think it's important because, you know, rehab facilities, even if it's for a nonqualifying condition, they're going to have a set of resources that are not available in a skilled nursing facility, which includes physiatrists, certain expertise with therapists, and multidisciplinary meetings that don't exist in a skilled nursing facilities that those nonqualifying condition patients will probably benefit from.

The other comment that I'll make, too, is that -- and I think we're taking kind of a bifurcated view that

there's a set of patients that go to skilled nursing; there's another set of patients that go to rehab. In fact, in certain circumstances, it actually represents a continuum of care. Some of these nonqualifying conditions are actually a bridge. You know, so someone can get admitted to a skilled nursing facility with the intent that they would get admitted to a rehab facility at a later date. An example of that might be someone with bilateral pelvic fractures. So until they're surgically cleared and ready, they may go to a skilled nursing facility temporarily until they're ready, you know, for the intensity of services that are available at rehab. I would call these bridge conditions that allow and enable, you know, an individual patient to be eligible for a rehab facility. I think that could also be, you know, a quality marker if we're able to tease that out a little bit better and get a little more granular in terms of what these nonqualifying conditions are and what the intent of the admission is for those individual patients.

But other than that, I thought it was actually very well done, and I'm looking forward to further discussion on this.

MS. KELLEY: Tamara.

DR. KONETZKA: Yes, so I find this whole subject really fascinating, and I know that most of you have been talking about site-neutral payment long before I was on this Commission, and so, you know, these may be obvious things that people struggle with. But I'm having a really hard time thinking about site-neutral payment across these when the requirements are very different in the two settings. Can it actually be site-neutral if the requirements are different? I don't think so.

And, also, the different sort of episodic versus per diem payment to me seems like a very hard difference to reconcile, right? And so some of the options that came up in the chapters about, you know, just sort of applying the SNF payment to IRFs for nonqualifying cases seems to me really rife with unintended consequences if, you know, that model of sort of extended length of stay and less therapy per day is one that, you know, IRFs would have to then take on, you know, which seems very different from their current model.

So I'm just kind of struggling with all of these, and I don't really have any suggestions as to how to solve

them, but we need to keep in mind the sort of -- to me, the sort of impossibility of site-neutral payment unless we can sort of figure those issues out as well in that I would say, you know, mixing the per diem payment -- I know hospitals do this to some extent with different payers, but sort of mixing the per diem payment with the episodic payment seems like it could be a really bad idea in terms of unintended consequences.

MS. KELLEY: Amol.

MR. NAVATHE: Thanks. So as I mentioned earlier in Round 1, I'm really enthusiastic about this work. I think it's important, I think it's a great opportunity potentially for making the Medicare program more cost efficient in a way that still is protective to patients. And to some extent, I think it reminds me of some of the analogous policy that was changed for long-term acute care, where there was also the sort of criteria threshold and payments, and my understanding of the literature there is that the payment changes have been met with more efficiency without any particular harm to patients. So that has been great.

I think the suggested analyses particularly

looking at outcomes, for example, makes a lot of sense. I think there's some literature out there that has looked at this and found functional status improvements for IRF patients versus SNF patients, but I think that was looking at the general population, not necessarily focusing on the nonqualified. And so I think that there is definitely some additional refinement basically over and above what the literature has stated, that we can have that would be really helpful to the policymaking frontier as opposed to just the general understanding point. And I think some of the other suggestions that Commissioners have made have also been really wonderful.

I think the last point is, of course, you know, we don't want to have unintended effects, and Tamara made a point that I was going to make also, which is that payment mechanisms obviously are different across the settings, so I think that's something that we also should be thoughtful about.

So thank you so much. I'm very enthusiastic about pursuing this work further.

MS. KELLEY: Gina.

MS. UPCHURCH: This will be quick. Building on

Tamara's point about the payment and how payments are made, episodic versus per diem, what about consumers -- and maybe it's too complicated for consumers to even understand this. If I'm in an IRA, you know, I have to pay my deductible. They're both Part A, Medicare Part A, but with the IRF you have the deductible. You may have a supplement to pay for it, or Medicaid or some secondary coverage. But then there's 60 days where you're not worried about having to come up with 200 bucks per day; whereas, if you're in a skilled nursing facility, we know after 20 days there starts this sense that you've got to, you know, hopefully maintaining, improving, or compensating for lost function, but that always gets called into question. Are you going to be able to stay? Are you going to be able to get more therapy? Are you going to have to start paying $200 a day?

Do the consumers have any -- you know, does it seem easier to go to an IRF if you're allowed to and is there consumer perspective on this, or do they really not understand the financing that would be involved? I mean, often they hear about it when they're about ready to be kicked out, so I'm just wondering ahead of time, is a decision that consumers have any say in?

DR. CARTER: I do hear in our interviews that sometimes patients went to IRFs because they didn't have a three-day hospital stay. So I guess I'm just supporting what you said because we heard it from some of the folks we interviewed.

MS. UPCHURCH: Well, it's that, and then that would be full pay. But even beyond that, even if you have had a three-midnight stay in a hospital and not under observation status, and you met all the rules, you still -- you know, after day 20 hits, there's this constant need in the SNF to defend -- and I'm with a SHIP program as part of my work, and we're constantly having to coach people about saying maintain, improve, or compensate for lost function, that should be rehab. But it feels like it's a fight on the consumers to continue to get those services. So I just don't know if that's also true in IRF or not, because I'm less familiar with that.

Thanks.

MS. KELLEY: That's all I have in the Round 2 queue unless I've missed someone.

DR. CHERNEW: So Brian wanted to say something before, and I didn't let him because there was a long --

there have been some drops from the queue. But we have five minutes left, so I think, Brian, you should make your on-point point now, and then we'll wrap.

DR. MILLER: My on-point point was to Rob's point about thinking very carefully about the SNF patients who are on the IRF, and I think that what he was saying, which is valid, is that there's some patients who are listed as a SNF qualifying condition are in an IRF, but actually if we had an expanded list of diagnoses, would benefit from that intensive therapy that an IRF offers. The IRF has a whole range of facilitative services that you cannot get in a SNF, and the challenge with getting patients into the IRF is that clinical judgment, who is actually -- it's not just whether you meet the conditions; it's also whether you will benefit from the intensive services that are offered. And so that is actually the bigger funnel for getting patients into an IRF, and so I think -- and, Rob, you can correct me if I'm wrong, but you're saying that there's a significant potential population of patients who are SNF qualifying diagnoses or who actually would medically benefit from being in an IRF, and that's why we should measure those functional status outcomes, which is a very pragmatic

thought and I agree.

DR. CHERNEW: Okay. So I'm going to loosely wrap up. If someone wants to jump in, I'll be watching the chat probably.

So, again, an outstanding chapter to all involved and a really rich discussion. Here's what I take away from this, and it's a little complicated. Most of the time when we talk about site-neutral, at least where we were before, we were basically talking about lowering the payments in the high-payment setting down to what you would get in a low-payment setting.

Here that's not necessarily true -- it might be -- but it really hinges on the added service you're getting in the IRF and whether it's really worthwhile. And if it is worthwhile and people aren't getting it in the markets with no IRFs, that's a completely different problem than if we think people are being treated in the lower-cost setting and basically getting the same quality care.

The challenge -- and this is now on-point to Brian's on-point -- is we've had a long history of skepticism about our ability to measure functional status, and we're unsure about how well we can measure quality, and

we're uncertain about our ability to observe if you'll benefit from therapy, either ex ante or ex post, for that matter. And this means it's challenging overall. MA plans might do a better job except MA plans have the ability to potentially reduce utilization to the lowest optimal, so I would not want to claim that the MA utilization is the gold standard in any way.

So there's a lot going on here analytically and a lot going on here policy-wise, in part because some of the core conceptual issues, like are you benefitting, who would benefit, are not observable very readily. So I'm not going to belabor that point. The point that I'll belabor is thank you to the staff for putting all of this together. Thank you for all of the questions that were raised. And I see we're already getting a queue formed for the next session.

So what I think we should do is take a pause here. We're going to take another five-minute break, and then we will come back, and we're going to talk about the Part D work.

Paul, anything you want to add?

MR. MASI: No. Great job.

DR. CHERNEW: Okay. Thanks, everybody. See you in five minutes.

[Recess.]

DR. CHERNEW: Hello, everybody. This is our last session for today in what has been a terrific day, and we're going to be talking about the work plan for analysis of generic drug prices in Part D. There's a ton of enthusiasm for this work. I will not belabor the point.

I'm not sure who is starting. Is it Tara and Shinobu?

MS. O'NEILL HAYES: Yes, it is. Tara.

DR. CHERNEW: Okay, great. Tara, go ahead.

MS. O'NEILL HAYES: Great. Thank you, Mike.

Good afternoon, everyone. My name is Tara Hayes, and I'm presenting today with Pamina Mejia and Shinobu Suzuki. As a reminder to the audience, you can download a PDF version of these slides in the handout section of the control panel at the right-hand side of your screen.

Today we will share with the Commission our work plan for a project that centers around generic drug prices in Medicare Part D. Our work consists primarily of two different projects to better understand the generic drug

market, including how such drugs are purchased and moved through the supply chain and, ultimately, how the prices are set, which affect what beneficiaries and/or the Medicare program pay for those drugs.

The first of these projects is an analysis of Part D claims data for select generic drugs.

Second, we are conducting interviews with experts from across the industry and academia to better understand how the various entities within the supply chain interact and affect pricing and costs at various points as a drug moves from the manufacturer to the patient.

We will first provide some background of the Part D program for context, discuss our motivation for this work, and then describe in more detail the two different components of our research.

Medicare Part D is operated by private insurance plans competing for enrollees to deliver pharmacy drug benefits. Plan sponsors, or PBMs on their behalf, negotiate with pharmacies and drug manufacturers over payment rates and rebates. Beneficiaries pay monthly premiums and cost sharing, and the Medicare program subsidizes roughly three-fourths of program costs.

In 2023, over 51 million people, or more than three-fourths of all Medicare beneficiaries, were enrolled in a Part D plan. More than half were enrolled in a plan that also covered medical services through Medicare Advantage. Just over a quarter received the full low-income subsidy, or LIS, which covers most of the premium and out-of-pocket costs for such individuals.

The number of plans continue to increase with more than 800 stand-alone PDPs, 3,500 MAPDs, and 1,200 special needs plans.

Beneficiary premiums remained at roughly $26 per month on average, though there is wide variation around the mean depending, for example, on whether an enrollee is in an MAPD or stand-alone drug plan.

In 2022, net program spending was nearly $102 billion after accounting for rebates and discounts.

These graphics depict the current standard benefit design, showing which stakeholder is responsible for what share of costs in each benefit phase, with some notable differences between the benefit structure for LIS enrollees, shown on the right, versus non-LIS enrollees, shown by the two figures to the left.

We would like to remind the Commission that the Inflation Reduction Act will make changes to the benefit design beginning in 2025, but this reflects the benefit structure in place today.

Relevant to today's conversation is the liability faced by each stakeholder for generic drugs. So we've now dropped the graphic for brand-name drugs. For non-LIS enrollees on the left, beneficiary liability is shown in gray. Under the current standard benefit design, enrollee cost sharing is 25 percent above the deductible until reaching the catastrophic phase. It then drops to 5 percent. Plan liability, shown in navy, is 75 percent initially and then falls to 15 percent in the catastrophic phase.

For LIS beneficiaries, on the right, Medicare covers the majority of costs on behalf of the enrollee, and that liability is shown in purple, or perhaps it looks magenta to you. In the initial coverage phase, Medicare pays 25 percent of the cost minus a nominal copay paid by the beneficiary. Plans cover 75 percent. In the coverage gap, Medicare covers 100 percent of the cost, again, minus a nominal copay, and the plan pays nothing. In the

catastrophic phase, plans pay 15 percent while Medicare covers the rest.

Part D enrollees have embraced the use of generic drugs. These drugs account for most, roughly 90 percent, of the prescription medicines taken in Part D. In fact, for some of the most widely used therapies, antihypertensive agents, antihyperlipidemics, anticonvulsants, and antidepressants, generics accounted for nearly all prescriptions dispensed in their respective classes. However, because generic drugs often cost a fraction of their branded counterparts, they account for less than 20 percent of program spending despite their wide use.

Enrollees' broad acceptance of generics has also helped moderate the overall price growth in Part D, as you can see from the graph on the right. The top line represents the growth in gross prices of brand-name drugs, which have increased nearly 80 percent from 2014 to 2021. Note that these indexes do not account for launch prices when a new drug comes to market but simply the change in prices from one quarter to the next after a drug is on the market.

The bottom line shows the same for generic products, which have seen overall price declines of more than 50 percent during this period. However, this decrease in generic prices, like the generic use rate, has plateaued in recent years.

Much of our past work has focused on brand-name drugs because they tend to be more expensive and account for a much larger share of program spending, but we are now turning our attention to the generic market because some of the trends we are seeing and findings from recent studies raise some concerns.

While generic drug prices are typically relatively low and decline over time, studies have found that prices for generics, as set by a Part D plan, can sometimes be higher than the price an individual would face if paying with cash rather than using their insurance at retailers such as Costco or through the Mark Cuban Cost Plus Drug Program.

For example, one study of the nearly 200 most commonly used generics found that in 2018, Medicare beneficiaries paid more for their generic drugs 43 percent of the time, with an overall overpayment of 20 percent

relative to the price available if paying cash at Costco. These overpayments cost the program $2.6 billion in 2018 alone, although this figure does not account for post-sale pharmacy fees.

Studies have also found that prices for generic drugs vary widely. Studies have found that much of this variation is attributable to where a drug is purchased, whether at a large chain retail pharmacy, a big box store, a grocery store, an independent pharmacy, or through a mail or specialty pharmacy. Prices can also vary significantly depending on the dosage form, strength, and route of administration.

Price variation may have little effect for a beneficiary when the drug is on a tier using a copayment. However, if the beneficiary must pay coinsurance, wide price variation can significantly alter the beneficiary's out-of-pocket cost.

There are several consequences that result from high and varied generic prices. Higher prices, of course, can increase costs for beneficiaries, particularly if they are paying coinsurance and for the Medicare program. Significant price variation can also cause confusion and

frustration when patients go to pick up their medicine and face unexpected costs. It can be difficult for beneficiaries to predict their costs, which may be particularly challenging for seniors on a fixed income.

In fact, according to the 2020 Medicare Current Beneficiary Survey, nearly one-fourth of respondents said the Part D benefit was not easy to understand. Better understanding the scope of this issue and the reasons for it is important for policymakers.

The final piece of background information we want to provide is identifying various stakeholders in the generic supply chain. Here is a simplified illustration of how such participants interact with one another to move generic drugs from the manufacturer to the patient. The dotted lines show financial flows, while the dark blue lines show the flow of generic drug products. We have a pharmacy dispensing a drug to the patient at the center.

There are two main transactions that I want to highlight. On the left is a wholesaler who buys generic drugs from manufacturers. Wholesalers sell the drugs to pharmacies. Most independent pharmacies participate in at least one group purchasing organization, or a GPO. GPOs

negotiate with wholesalers on behalf of member pharmacies, and that negotiation determines the purchase price of generic drugs for the pharmacy.

The payment from the pharmacy to the wholesaler shown in the figure is the pharmacy's acquisition cost. On the right is a PBM negotiating on behalf of a plan sponsor, with whom the pharmacy has agreed to participate as a network pharmacy. Again, independent pharmacies typically join pharmacy services administrative organizations, or PSAOs, who negotiate with PBMs contract terms related to payments for prescriptions dispensed and post-sale fees.

I will now turn it over to Pamina.

MS. MEJIA: Now to our work. To better understand the prices paid for generics and the impact of variation in those prices on the Medicare program and beneficiaries, we are engaging in several research endeavors.

This table provides a summary of projects we are working on. Details will be provided in upcoming slides.

First, we are analyzing Part D prescription drug event data to examine the extent to which prices paid to pharmacies for generic drugs vary. We are also conducting

stakeholder interviews to gain insights into how the various players in the pharmaceutical supply chain affect prices of generic drugs.

The first part of our work is analyzing data from 2021 Part D prescription drug events. We will identify the top 150 generic drugs in Part D based on those most commonly used and those are the highest annual spending. Our analysis seeks to understand the various factors that may influence the variability of the price of these products at the pharmacy, such as the number of manufacturers, the number of unique NDCs, or therapeutic class.

We will analyze prices defined as a gross payment for the ingredient cost at both the product and NDC level. A generic drug product is defined by a unique combination of active ingredient, dosage, and route of administration. The NDC also identifies the manufacturer of a given product for which there may be several. The price, as defined, is what the pharmacy received for the ingredient costs, typically consisting of cost sharing paid by the patient and payments from the PBM.

Next, we are conducting a more detailed analysis

based on a subset of the drugs in the initial analysis that were found to have comparatively high price variation. This subset is intended to represent different characteristics that may affect generic prices. For example, some drugs will be selected for their high cost, while others will be selected to represent low-cost drugs across different therapeutic classes. This analysis is looking for variation within and across geographic areas and Part D plans as well as differences by month and pharmacy type.

Now to discuss our interviews and the information we are seeking to gain from them. Our initial interviews are focused on individuals with broad expertise in the generic drug market and the pharmaceutical supply chain, such as academics and policy researchers, some with experience working within the drug supply chain.

Topics of discussion in these interviews will include sources of wide variation in prices of generic drugs, roles that pharmaceutical supply chain participants may play in affecting generic drug prices, and factors that may lead to overpayment for generic drugs among Part D plans.

Multiple actors are involved in negotiations over prices of generic drugs at different points in the pharmaceutical supply chain. Examples of these actors include pharmacies, PSAOs, and GPOs. As we touched on earlier, pharmacies typically collectively negotiate with wholesalers through GPOs to lower acquisition costs of drugs and negotiate with PBMs through PSAOs over reimbursement and other contract terms. Topics of discussion in these interviews will include factors GPOs consider in making purchasing decisions for a generic product with multiple manufacturers, parameters or contract terms over which PSAOs and PBMs negotiate when discussing pharmacy reimbursement contracts, and types of services PSAOs provide to pharmacies with the fees collected by PBMs, such as direct and indirect remuneration under Part D.

Widespread use of generic drugs among Part D enrollees means a higher generic price could have substantial cost implications for Medicare and Part D enrollees. We plan to speak with Part D plan sponsors or their PBMs to get their perspective on generic prices in Part D. Topics of discussion in these interviews will

include how Part D plans and their PBMs may set pharmacy payment rates for generic drugs and if there are instances in which pharmacies receive different payment amounts for the same generic product. Another theme to be discussed is understanding how certain features of the Part D benefit or program requirements may affect prices paid for generic drugs.

This brings us to our next steps. We plan to report findings from the data analysis and stakeholder interviews at a future meeting. We are happy to take any questions regarding our work plan. We would also be interested in your thoughts about potential other aspects of the generic drug market we should be looking at.

This completes our presentation, and we look forward to your discussion.

DR. CHERNEW: Great. Thank you so much. That was really interesting. We spend a lot of time on brand drugs. We have not spent as much time on generic drugs, and I hear there's a lot of stuff of interest here in the generic drug market. So great work, and with that, I think Gina is the first person in the Round 1 queue.

Is that right, Dana?

MS. KELLEY: Yep.

MS. UPCHURCH: Great. Thank you.

I'll first be on record saying that I am a pharmacist. I don't dispense, thank goodness, for the public health. I don't transpose numbers. So it's good that I do not dispense. I'm not part of a community pharmacy. So I just want to say that. I'll have lots to say in Round 2, but Round 1, you know, obviously so much is changing, thank goodness, with the redesign of the Part D benefit. But I do think this is worthy of discussion, and thank you all for that presentation.

The one thing I just want to make clear on slide 4 -- and I think, you know, just so that everybody appreciate it, until this in 2024, those who are eligible for partial extra help will be getting full extra help, which is fantastic. It's really helpful. People below 135 percent or people up to 150 will get benefits that have been reserved for those people with more limited income. So that will be tremendous.

But they still have cost sharing, and I just want people -- and you mentioned it, but I just want to make sure people understand it. The partials historically have

owed small deductible and 15 percent of the cost or a flat copay, and now depending on whether they're at or below 100 percent of the federal poverty guidelines, $4.15 for generics for a one-month or three-month supply, it's the same, whether you get a one- or three-month supply, and then $10.35 if you're on a brand-name drug. Now, that may not be a lot to you or me, but it can be for people on multiple medications. So I just wanted to say there are people with limited incomes, that when you say that they have very little to pay, they would argue with that, because it does feel like a little bit of a stretch to some people.

The other thing I would just say, on the very third column there where it says LIS, all drugs, I just want to point out all drugs on formulary. So if you're on a plan that doesn't cover your drug, you would pay the full cost. The importance of SHIP programs are to make sure people, even when they have extra help, are in plans that cover their medications. So I just wanted to point that out. So it's all drugs covered by your formulary.

Thanks so much for this, and I'll look forward to more in Round 2, but just to clarify a little bit that

there is cost sharing involved for people with LIS. Thanks.

MS. O'NEILL HAYES: Yes, you're right. Very important points. Thank you so much for that.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you.

I'm trying to wrap my brain around all of this, and it's not a space I usually work in, so this is sort of a pre-1 question.

But I'm recalling, I think correctly, that when states started implementing the substitution prescribing, they kind of had a threshold. On page 6 -- or slide 6, you say that in 2021, generic drugs accounted for 90 percent of all Part D. We wouldn't expect it to be 100 percent, right? I know there's variability in other things, but I'm trying to understand, based on previous work with states, like what's kind of the benchmark that we would hope for? Does that make sense, what my question is?

MS. O'NEILL HAYES: As far as a benchmark, what I'm thinking about is like relative to commercial market perhaps or --

DR. RAMBUR: Well, I just -- Gina was nodding.

So maybe she understands my very inarticulate question.

So 90 percent seems really good, right, in terms of that? But there's other issues that are being raised. So I'm just trying to understand if there's kind of a rate-limiting point at which you wouldn't expect any more generics, because it will never be 100.

MS. O'NEILL HAYES: Yeah. Well, Of course, not all drugs have a generic available yet. So, in those classes or for those products, it's going to be zero because there isn't an option.

But the best I can think right now to give you in terms of something to compare it to, this is pretty on par with what we see in the commercial market and across, I think, also in the Medicaid market, so yeah.

DR. RAMBUR: Thanks. Thanks. It's a small point, but I'm just trying to --

MS. O'NEILL HAYES: Sure.

DR. RAMBUR: Thank you.

MS. KELLEY: Larry.

[Pause.]

MS. KELLEY: Larry?

DR. CASALINO: Sorry.

I may be imagining -- I have two questions. The first one is I may be imagining this. It's quite possible that I am, but I feel like I was at the pharmacy a year or so ago and picking up a generic drug, and the person behind the counter said, "If you buy this through your insurance, it's going to cost you $30. If you just pay cash for it, it's going to cost you $5.97," or something like that. Is that legal, and do you have any sense of how often that goes on?

MS. O'NEILL HAYES: Sorry. I didn't quite catch that. Can you ask that again?

DR. CASALINO: Yeah. In cases where the cash price, if you just paid cash and didn't use your insurance, is lower than what you pay if you use your insurance, can the pharmacy tell you that and charge you the cash price, and if so, how often does that happen? Do you have a sense of that?

MS. O'NEILL HAYES: You're challenging my ability to remember. I know that there have been different rules put in place regarding gag orders and whatnot and whether a pharmacist can tell you.

Perhaps someone can correct me if I'm wrong, but

I believe now the pharmacists are allowed to tell a patient if the cash price is lower.

One of the challenges if you are paying cash is that that cost then does not count towards your deductible and you are, you know, moving in the Part D benefit. It would not count towards your spending that moves you through the benefit phase.

DR. CASALINO: All right, got it.

And the second question, could you show the slide showing who pays who, what, with all the arrows and boxes? I think it's the third or fourth slide. Yeah.

So there's not counting -- it says -- one, two, three, four, five, six -- possibly seven, counting the health plan, entities here, each of which is taking a cut, presumably. It's a wonder that any drug costs less than a fortune if you think that each one of these entities has to make some profit. You talk about the administrative costs of the U.S. health care system. Actually, Commonwealth just came out with a report saying one reason our per capita spending is so much higher than everybody else is -- the big reason is administrative complexity. We're certainly looking at it here.

But is there any way to get a sense in your interviews -- I realize that this is probably a pretty complex question -- of just orders of magnitude? What's the take for the wholesaler versus the GPO versus the PSA versus the PBM?

MS. O'NEILL HAYES: Yeah. Our interviews are certainly not -- it's a handful of interviews, so it's not going to be data that we can really base analysis on, but we are trying to get a sense of this type of question that you're asking in our interviews. Yes.

DR. CASALINO: Thanks.

MS. KELLEY: Lynn.

MS. BARR: Thank you. This is a very important chapter, and I also want to talk about this slide. I was surprised that my colleague didn't bring this up earlier, but how does this apply in a rural community? And as you look at the complexity of this, which we've accepted as being okay, we are also seeing rural pharmacies closing and being unable to manage the complexity of the 340B program, for example. So if they can't do 340B for a lot of money, I can't imagine that they're going through all these hoops and they're just choosing to close down instead. I'd be

interested to hear Gina's take on that and what she might know about that.

But, as we look at this, this is the majority of prescriptions that are filled in these rural communities. Is there a way to simplify this and to also suggest that this doesn't need to be like this? If you just took generics and said no, it just should all be by one place or something? I don't know, but that's -- I'm just -- is there anything you can think about there?

I don't know if that's a really good -- that's a lousy Round 1 question. I apologize.

MS. O'NEILL HAYES: No. Lynn, we appreciate --

DR. CHERNEW: You're using up -- you're using up all your kudos from your last wonderful Round 1 question.

MS. BARR: You're right. It was a --

DR. CHERNEW: That's all right. Okay.

[Laughter.]

MS. O'NEILL HAYES: We want to look at differences between rural and non-rural areas.

MS. BARR: Thank you.

MS. KELLEY: Okay. I have Robert next.

DR. CHERRY: Thank you.

I'll try to land a softball question here that's relatively quick.

You mentioned on a future analysis that you'll compare pharmacy types, including retail versus mail order, but specifically for mail order, are you planning on differentiating mail-order domestic purchases from those that outreach and make international purchases, if there's a way of actually collecting that information?

MS. O'NEILL HAYES: I'm going to see. I don't know if Shinobu knows, but she's having technical issues. I don't know if she has the ability to jump in.

But I don't know, with the data that we have, if we're able to distinguish between domestic and international. We will have to get back to you on that.

DR. CHERRY: Fair enough. Thank you. I'll circle back.

MS. KELLEY: Okay. That's all I have for Round 1. Shall we move on to Round 2?

DR. CHERNEW: Yes. And I think that is Stacie.

MS. KELLEY: Indeed.

DR. DUSETZINA: All right. Well, you all know I'm excited about this one. So thank you for being willing

to take on this important topic.

I think it's important to talk about generics, partly because generics are kind of the promise we have in our current system, that eventually your drugs will be more affordable to you one day, and so making sure that that translates to lower cost for beneficiaries, in particular, I think is super important.

So I just wanted to make a couple of notes about things I think we should be including here specifically, and I think the selection of drugs, as you all described it, will probably get there but to just be extremely explicit.

I think some of the key problems here are related to specialty generic drugs. In particular, they have operated in a different way as far as the affordability for beneficiaries. Some of them still are placed on specialty tiers, even after generic availability, which means people are being exposed to a percentage of the drug's price when they're filling it. And so I think being really cognizant to grab all of those -- you know, we're starting to get more experience with high-price generics. We should explicitly include all of those. I think those are going

to be some of the outliers on the real potential harm for beneficiaries and probably some source of dramatic overpayments based on some preliminary work that I've done and some recent reports that I've seen in this space.

Another thing that I think is really going to be interesting to consider here is the role of vertical integration of pharmacies and PBMs and plans, and if you go back to your graphic, I think it might help people to kind of understand like this is going to get really complicated, because what I think is happening in some cases and some of the preliminary information about it's much cheaper to pay cash or go through a discount pharmacy site than use your benefits, there's some dramatic overpayment that's happening, at least in the specialty generic space, which may be overpayments to pharmacies. It may be overpayments to these different entities, but it's really hard to track down who's getting to benefit from those payments.

But you can see in Medicare Part D, the amount coming through on those initial claims or what's being paid for ingredients, I think it's going to be higher than necessary, and the fact that we anecdotally know people can go outside of their benefits and pay cash and get a better

price suggests that there's some overpayments happening. So I think comparing what's happening to the vertically integrated and not vertically integrated will help us to get some sense of maybe where there are some misaligned incentives.

But this also goes to what I think is a missing or incomplete data issue, and I'll kind of throw this back out to the team -- is my understanding of our ability to actually track the post-sale DIR, those kind of "clawbacks," as pharmacies call them, I think that we don't have as much visibility as we would like. Like that's not usually tied explicitly to the pharmacies, but ideally, what you would be able to tell would be if there are very large overpayments for some of these generic drugs.

When you are overpaying your vertically integrated pharmacies, maybe you don't claw that money back, but maybe you do when you're paying or overpaying pharmacies that aren't yours. And I don't know that we're going to have that level of detail, but that is something that I am suspicious about and also think it would be great if we did have that level of detail.

So I will maybe pause and say like from what you

know, can we or can we not track at the individual pharmacy like that post-sale DIR?

MS. O'NEILL HAYES: This is another question that is best for Shinobu, but my understanding is that we cannot at the individual pharmacy level.

DR. DUSETZINA: Okay. That's my general understanding as well, but maybe that goes on the wish list or in the data we wish we had and really could use for figuring out how big of a problem this is.

And then my last wish-list item here is to really be clear about what this means for consumers. I think there are two kind of core issues. One is the specialty generics where people may be dramatically overpaying their costs, which is a real problem and something we need to fix.

There's also the smaller overpayments. So when you're thinking about a lower-cost generic drug that has a $20 copay or $10 copay, but it only costs a dollar or two for the pharmacy to get it, like so thinking through the dynamics of these kind of higher and lower amounts of overpayment, because I think that they have different implications for beneficiaries, we certainly want a benefit

that doesn't create a system where everybody needs to pay cash -- well, we could do that, but like that's not how we've set up the benefit today, and we should have the benefit really, you know, help to support access to these drugs.

Okay. I'm sure that Amol was timing me or Larry was. So, hopefully, I didn't go too far over. That's it. I'm very excited about this work stream, so thank you.

MS. KELLEY: Okay. I have Gina next.

MS. UPCHURCH: Great. Thank you.

I'm going to talk a little bit about what Stacie and Lynn referred to a little bit earlier. I'm going to be talking about community pharmacists and the value that they bring and how it's related to generic drug pricing.

Well, first of all, if we're trying to help somebody get the lowest cost medication that has Medicare, it pays to compare. So we're going into the open enrollment period.

Just so you know, as an example, in Durham, we went from 24 stand-alone drug plans to 21, but in Medicare Advantage plans, we went from 54 to 79. So we have 100 choices for people. So we've made comparing just insane.

And so we know that consumers can save on generics and brands by comparing, but we're making it challenging. So that's the first thing I would just like to point out.

Second thing is I believe that community pharmacies can bring incredible value. We know with COVID-19, they were saving grace in many ways on the front lines with that, and we know, as Lynn discussed -- we've had pharmacies that have had to close down, because they're not making margins to stay open.

During our break, I called a community pharmacist that I know well and asked him some questions. So I'm just going to share a little bit about that. But they've had to deal with prior authorization, step therapy. Since the beginning of Medicare Part D, they've had a lot of work to do to deal with all these different insurance companies, and every year, somebody's insurance changes, and they have to do the wallet biopsy to see what people have to figure out how they're going to build the prescriptions for them. It's a lot of work, all these different plans.

So I have real concerns about direct and indirect remuneration fees. They call them "pharmacy concessions," as Stacie referred to them as "clawbacks." You don't know

about it until later. This coming year, the consumer will pay, based on after the pharmacy clawback has happened, but that doesn't mean the clawback is not still happening to pharmacies. They're still having to give that money back, and they don't really understand why, because it's not really clear to them why they're having to give it back. It's not -- if it's based on quality, it's not clear how to even meet those quality metrics.

The second one is every year, preferred pharmacies change, and I think the preferred has to do with this vertical integration we keep hearing about. So I'm like Stacie. I really want to see the information about the integration of PBMs with insurance companies, with certain -- you know, especially larger pharmacy chains and what that means in terms of the clawback and how that does or does not happen and the price, how that relates to generic pricing.

And lastly, when I spoke to this community pharmacist -- and I've heard this from lots of people through the years -- they're not making money off brand-name drugs much at all. In fact, this pharmacist I talked to says he can't hold GLP-1s. They're the new -- some of

the medicines for diabetes. He can't afford to have them in his pharmacy anymore, because he has them, he dispenses them, but it takes him a while to get paid back, and he doesn't have that cash flow. So he doesn't even carry them in his pharmacy. Any medicine over $800, he doesn't even carry it anymore because he can't -- and he loses money when he dispenses them, either breaks even or loses. So they make money, not off these specialty generics, but off the run-of-the-mill generic drugs. They make a small margin that keep them -- barely keep them afloat. And I do think Lynn's point of rural versus urban and how much volume you have really matters in generic. They do rely on some profit from generic medications to keep their doors open. It's not only the payment, but it's the lag in payment, the time it takes to get reimbursed. It really hurts some pharmacies, but they do need the generic margin.

My last thing I would just say is I really appreciate this work that's going to be done. I will point out Kevin Schulman's article that was in Health Affairs that many of us have probably read, concern about the generic floor going too low and what that means in terms of the quality of medications, where they're coming from,

where the ingredients are coming from, and it's leading to shortages in our hospitals and such.

So, if I'm looking at generic medications, I'm not only looking at what is the cost, what does that mean to our independent pharmacies that are accessed or just pharmacies in general in terms of access to health care providers that are right around the corner from you, but also, we need to look at the generic industry in terms of what are the quality of the generics we're getting. And who's monitoring that, and is it leading to -- with the FDA shutdowns and other things, is that leading to shortages of generic medications? I think if we could add that to something we can take a peek at, I think that would be really important.

Thank you.

MS. KELLEY: All right. I have Cheryl next.

DR. DAMBERG: Thank you.

This is really interesting work, and I'm pretty excited about the agenda that you've laid out.

I'm going to channel what Stacie raised about vertical integration. I think that one of the parts of the analysis should be looking at the market share of these

health plans, their ability to negotiate as well as the extent to which they're vertically integrated, say, with PBMs. So I'm just going to pile on to that stream of thinking.

MS. KELLEY: Okay. Brian.

DR. MILLER: I have a different perspective on this. These are more global thoughts. One is the IRA just passed and changed the consumer benefit design and also the plan responsibility, which is going to massively change pharmaceutical product markets in the coming years. So it's unclear to me how effective the advice from our work that emerges looking at for that change will be in informing policymakers. So I wonder if this is maybe a stream of work that might be better done later in a different cycle a couple of years from now.

Another thing that I have enjoyed about MedPAC is that the Commissioners come from a variety of backgrounds, hospital executives, trade associations, consumer advocates, health economists, geriatricians. I note that amongst us, there is not someone currently running a pharmaceutical product manufacturer, generic or branded, and the reason I say that is when I look at our PowerPoint

deck, I see that we're using a payment policy lens when there are lots of other factors that affect generic drug prices.

I wrote a couple of them down. FDA product regulation, pharmaceutical manufacturing, right? So there's a lot of shortages and higher prices driven by pharmaceutical manufacturing regulation. I agree that no one wants glass in their drug, but that's something that we also need to consider that addresses costs.

There are tax incentives that have resulted in shift in manufacturing facilities, and then even going a little farther, there was actually a price-fixing case amongst generic pharmaceutical product manufacturers, where seven companies, not to name names, have pled guilty and paid hundreds of millions of dollars in fines.

A long way of saying, given that major legislation just passed affecting this space, this might be something we'll want to do later. We don't have the requisite industry expertise amongst us, and even if we disagree with everything that expert says, we don't have someone who currently is working in that space.

And then on top of it, there are a litany of

nonpayment policy factors that are very important in this space, and I don't see them being considered amongst our discussion.

So I'm very interested in generic prices. I think it's a very good topic. I think it might be something we want to do later.

MS. KELLEY: Tamara.

DR. KONETZKA: This is half suggestion, half question. When I think about generic pricing, I can't help but think about supply and shortages -- I guess Gina mentioned shortages -- and also competition. So is part of this work plan to also look at the number of producers of these drugs and how that affects the price and the role of competition?

MS. O'NEILL HAYES: Yes. The number of manufacturers is a factor that we will be looking at.

DR. KONETZKA: That's all.

MS. KELLEY: Okay. Betty.

DR. RAMBUR: Thank you so much for this interesting conversation and presentation.

So, as I think about this and read about it and listen to it, I'm actually stunned by the lack of

transparency in the system, and that's really a problem. So, in addition to some of the other things that were raised about VI, on slide 13, you talked about sources of variation in prices. I'd be very, very interested in that. And then why pharmacies receive different payment amounts for the same generic product, very interested in that. So I think having some clarity on some of these things would be really helpful as an antecedent to any kind of recommendation.

So I'm very enthusiastic about going ahead. Thank you.

MS. KELLEY: Kenny.

MR. KAN: Yes. Great, insightful chapter, Tara, Pamina, and Shinobu.

Two observations. Number one, I'm a plus-one with Brian. Given that major legislation has passed and there's a lot of headwinds, we need to be careful of unintended consequences because half the pharmacies in the United States are independent community pharmacies. So, as you heard from Tamara, they actually make money on generic drugs. So to the extent that we sort of like disrupt this income stream, if they go out of business, it will actually

disrupt access and increase consolidation by the chain pharmacies. So those are two observations. Be careful because we have a lot of impact on regulatory and obviously unintended consequences.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you.

Just a brief comment around future analysis. I think one of the things that really piqued my interest was the low prices that are offered by big-box discount retailers, which I don't think we're really surprised about, but it would be great to get a little more information in terms of are they meeting the expectations of our beneficiaries, and by that, it's just it's understanding the availability of the drugs. Is a particular drug on demand when you want it? And what is the strength of their inventory, particularly when there are shortages due to manufacturing issues or other supply chain issues? Do they do a better job of reasonably keeping that in stock relative to more traditional retailers?

And also, what's the degree of penetration? Do people live close enough to big-box retailers?

Intuitively, it seems that many do, but it would be good to understand that whether there are discount retail deserts, if you will, where there isn't that proximity or access.

Just some suggestions for her future analysis.

MS. KELLEY: Mike, that is all I have in the Round 2 queue. I don't know if I've missed anyone. Please wave your hand if I have.

[No response.]

MS. KELLEY: Okay. Mike, back to you.

DR. CHERNEW: Yeah. So thank you. First of all, to the staff, thank you for this. I think there's a lot of information here.

Just for folks to understand where we are, we had a big body of work on Part B last cycle, and so we had a big body of work on Part D, which actually led to a lot of the redesign stuff or at least contributed to a lot of the redesign stuff, actually before my time on the Commission. So kudos to all of you that were there then. I'm not going to name you. You know who you are. So this is -- it's the very, very beginning stages.

There's several things, several types of comments that might lead someone at home to believe that we're

really pondering policies to get at some of these issues in a range of ways, and I won't say that policies are ever that far from our mind, but right now, I interpret this work as really an informational work plan to understand what's going on. And I think there's been a number of issues that have been raised, the vertical integration issue, some of the other things that you might want to look at. All of that's helpful.

One shouldn't, if they're listening at home, think that we're sort of going to come back in a month or two months or maybe even in a year with a set of recommendations. We're really just getting our bearings on understanding how this very complicated market works, what it means for individuals, and we haven't really begun the process of thinking through where we'll go policy-wise.

And I might add, an enormous amount of the value that MedPAC often adds is just providing data on complex areas so people know what's going on, and that's kind of where we are in this space.

So I very much appreciate all the comments and all of the issues that were raised. I think it is certainly true that -- I'll echo Stacie -- generics are

sort of the promise that after we get to the high-price part of innovation, we're now going to get access to all these drugs, and there are a lot of areas that was mentioned by the staff where we really -- at a time we had a lot of really expensive drugs. Now we have some really, really low-cost drugs. They might -- you know, we can debate what people are paying out of pocket, but relatively speaking, really good drugs relative to the prices being paid for them that are available in generic. And I think that's an important thing, but as this presentation showed, the notion that the generic market is working competitively, the way you might think when things became generic, is probably an oversimplification of a dramatically complicated, crazily integrated market that we're going to try and get a handle on.

So that's my summary of where we are on this work.

Paul, do you want to add anything about the agenda, or Tara? I see you now, Pamina. Do you want to add anything about -- I don't know if Shinobu made it on, but do you want to add anything to any of that before I close us out for the day?

MR. MASI: No. I agree, Mike. This is very helpful to hear, the Commissioner conversation, and we're looking forward to building on our work here.

I would agree that at this stage, it's very much informational and trying to wrap our arms around the problem, and we'll be back with more information.

DR. CHERNEW: I'm going to learn from your brevity, Paul.

Anyway, so that brings us to the end of what was, I think, a really productive meeting on some really important topics. And so for those of you at home, please reach out and give us comments, MeetingComments@medpac.gov. We really, really do want to hear about what you're thinking about, all of the things we've said this afternoon, maybe this morning. It is important to us, to the staff for all the presentations, and even for those -- there's often a lot of staff doing some work behind the scenes on some of these topics. And I can tell you there's a ton of staff working super hard on the stuff that we're going to see in November and beyond. I really thank you for all the work that you've done. We really do appreciate it. It was outstanding, as always.

And so that said, thank you to everybody, and we hope to stay in touch on these topics. And we will see you all in November.

[Whereupon, at 5:37 p.m., the meeting was adjourned.]

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