

Mandated report: Assessing the impact of recent changes to Medicare's clinical laboratory fee schedule payment rates

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Further Consolidated Appropriations Act, 2020, mandated MedPAC to investigate PAMA changes

Congressional mandate requires the Commission to:

Review the methodology
CMS has implemented for
the private payer-based
CLFS rates

Report on the least
burdensome data
collection process that
results in a
representative sample
of all laboratory market
segments

Report due in June 2021

Roadmap for today's presentation

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**CLFS
historical
background
and changes
made under
PAMA**

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Results from
the first round
of data
reporting

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Analyzing
survey
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Summary,
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Medicare's clinical laboratory fee schedule

- Medicare covers separately payable clinical laboratory tests under the CLFS
- In 2019, Medicare spent over \$7.5 billion on 428 million CLFS tests
- Almost entirely furnished by three types of laboratories:
 - Independent (e.g., Quest, LabCorp, regional laboratories, etc.)
 - Hospital outpatient
 - Physician office

Source: Acumen LLC analysis of Medicare CLFS claims for MedPAC.

Historical background on the CLFS

Prior to 2018

CLFS payment rates were set based on local laboratory charges, updated for inflation, and capped at certain amounts

Payment rates were not adjusted for efficiency, technology, or market conditions

In 2013, OIG found that Medicare paid between 18% and 30% more than other insurers for 20 high-volume or high-expenditure laboratory tests

Changes made to the CLFS under PAMA

Beginning in 2018

Private payer rates became the basis of CLFS rates as required under PAMA

PAMA established a long phase-in of payment rate reductions

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Change in CLFS payment rates differed by type of laboratory test

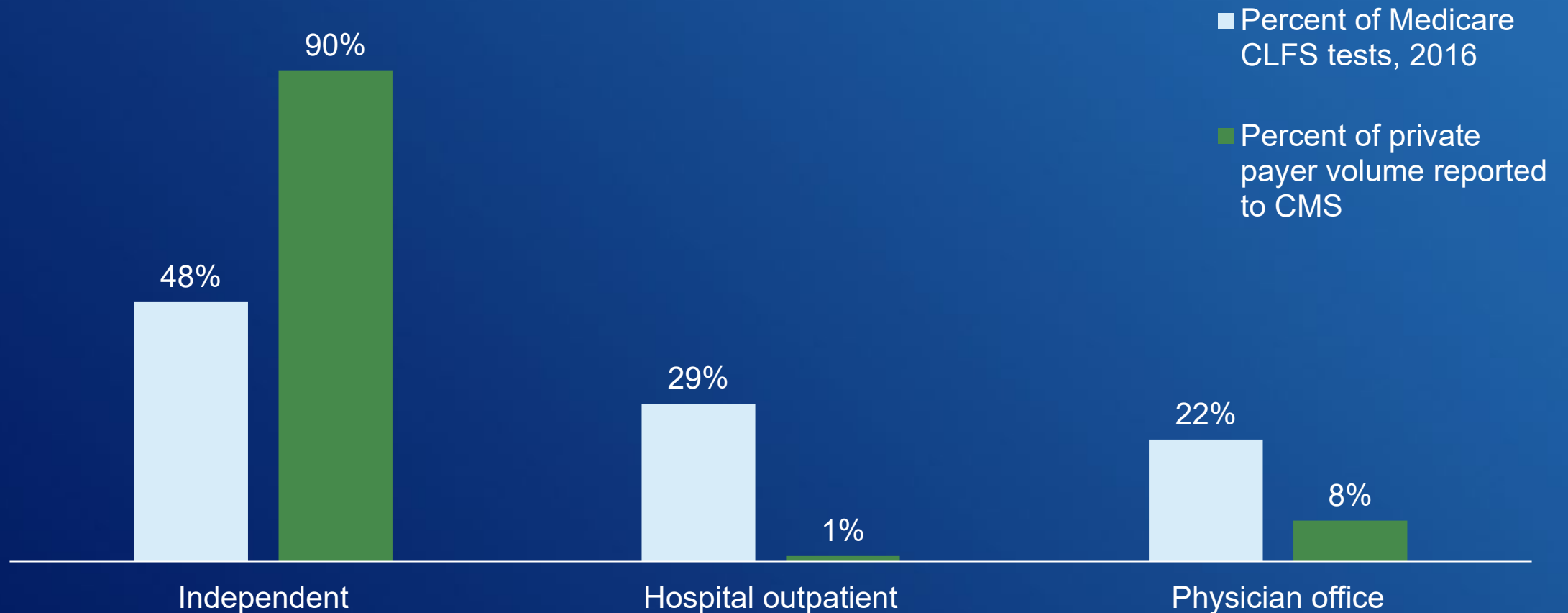
Medicare CLFS payment rates will decrease by an average of 24 percent once private payer rates are fully phased-in

However, payment rate changes are not uniform across types of laboratory tests, increasing for about 23 percent of tests

- Routine, low-cost tests: Declines between 20 percent and 30 percent
- Newer, more expensive tests: Smaller payment rate declines or payment rate increases

Source: MedPAC analysis of CLFS claims and private payer rate data.

Independent laboratories were overrepresented in the first round of data reporting



Note: Numbers do not sum to 100 percent because tests furnished by other types of laboratories, such as those located in urgent care centers, are excluded from this figure. Such laboratories accounted for about 1 percent of tests in both the Medicare CLFS and private payer data.

Source: MedPAC analysis of CLFS claims and private payer rate data.

Hospital outpatient and physician office laboratories reported higher private payer rates, on average

- Relative to independent laboratories, private payer rates were, on average:

45%

higher for

hospital outpatient laboratories

53%

higher for

physician office laboratories

- Since independent laboratories were overrepresented, private payer-based rates calculated by CMS were closer to median of independent laboratories

Note: Analysis of the differences in payment rates between types of laboratories was limited to the 100 CLFS tests with the highest Medicare spending in 2016.

Averages are weighted by 2016 Medicare CLFS spending.

Source: MedPAC analysis of CLFS claims and private payer rate data.

Utilization of CLFS tests was stable after implementation of private payer-based rates

Average tests
per beneficiary:

2017: 12.8

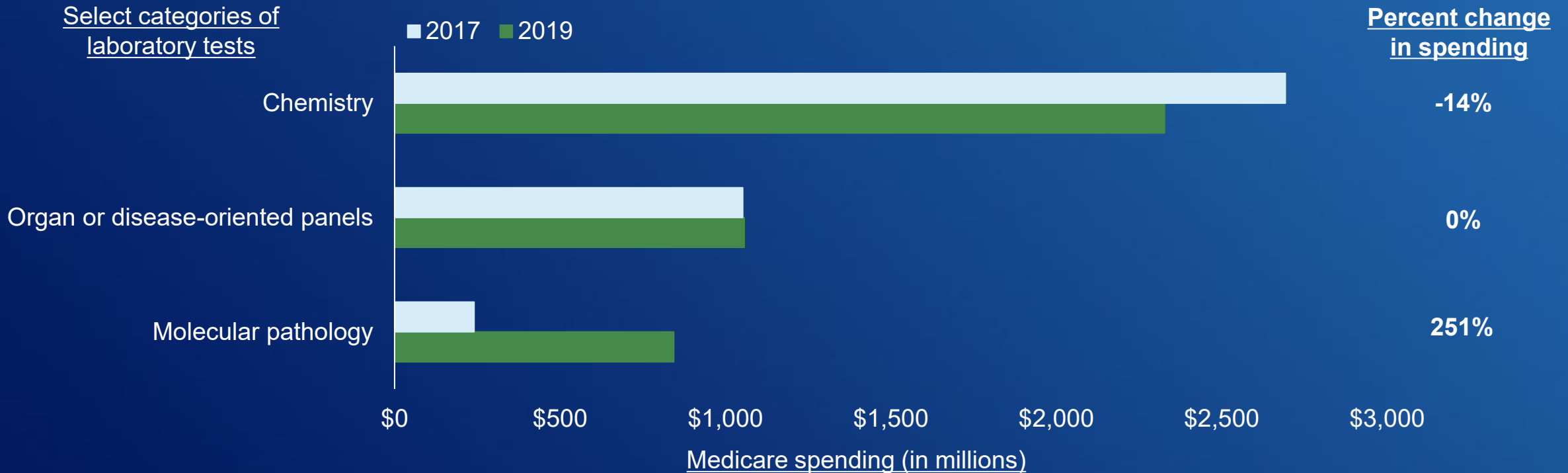
2019: 12.9

- In aggregate, suggests stable access to care immediately after the implementation of private payer-based rates
- Stable for routine laboratory tests, with rapid increase in high-cost tests

Source: Acumen LLC analysis of Medicare CLFS claims for MedPAC.

Medicare CLFS spending increased from 2017 to 2019

- Spending increased from \$7.1 billion to over \$7.5 billion, driven by technical changes under PAMA and new, high-cost tests (e.g., molecular pathology tests)



Source: Acumen LLC analysis of Medicare CLFS claims for MedPAC.

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Examined survey methodologies to collect a representative and valid sample

RTI International examined survey methodologies that could be used to collect a representative and statistically valid sample of independent, hospital outpatient, and physician office laboratories

- Evaluated multiple sampling methodologies based on two criteria:
 - Generating accurate estimates of prices
 - How many laboratories would be required to report data

Setting payment rates using a survey is feasible and could substantially reduce reporting burden

1

Survey could produce accurate estimates of private payer rates for independent, hospital outpatient, and physician office laboratories

2

Survey could reduce the number of laboratories that would be required to report private payer data by up to 70 percent

➤ Analysis is a proof of concept and further testing is warranted

Basing Medicare payment rates on a representative sample of laboratories would increase spending

- To estimate the effects, we ran simulations on the 100 CLFS tests with the highest spending in 2016
- Each simulation incorporated more data from hospital outpatient and physician office laboratories but used varying assumptions
- We estimate that Medicare spending would increase by 10% to 15%

Source: MedPAC analysis of CLFS claims and private payer rate data.

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Summary

- As of 2018, Medicare relies on private payer data to set CLFS rates
 - Payment rates for many (but not all) tests declined substantially
 - Independent laboratories were overrepresented in private payer data and received substantially lower private payer rates
- From 2017 to 2019, no evidence of substantial utilization changes, but spending increased largely due to new, high-cost tests
- Conducting a survey to collect a representative sample is feasible and would reduce burden, but would increase spending

Issue 1: For routine tests, high private payer rates may reflect provider negotiating leverage

- For routine tests, policymakers should consider excluding high private payer rates that are likely related to provider negotiating leverage, not the costs of furnishing tests
- Medicare should set payment rates to ensure beneficiary access, while maintaining incentives for laboratories to be efficient
- Medicare could set payment rates based on private payer rates of relatively efficient laboratories

Issue 2: Setting payment rates for new, high-cost laboratory tests

- Private payers may have a limited ability to negotiate rates for new, high-cost tests
- In the future, the Commission will consider alternative ways to set payment rates for new, high-cost technologies

Next steps and feedback

- Staff seeks feedback from the Commission
- Final report due in June 2021