MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

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11:16 a.m.

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P R O C E E D I N G S

[11:16 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to the last MedPAC meeting of this cycle. It's going to be an important meeting.

Before we jump right in, I want to make a few acknowledgments and thanks. First, and I think really importantly, is I want to acknowledge the hardships of the past year. It has obviously been a very, very challenging year for Medicare beneficiaries who have borne a lot of associated hardships, and obviously their families. And you realize Medicare beneficiaries and their families are really most Americans, and so I really think we are going to go on with our work, but we need to take a second to understand what a unique and challenging and difficult year this has been, and I want to emphasize to the public this is not lost on me or any of the MedPAC Commissioners or staff.

In that spirit I want to give a shout-out to the providers. They really have been heroic in the face of a phenomenally difficult situation, and we owe them a lot for helping us as we've moved through the pandemic. I realize

and MedPAC realizes it has been a really particularly challenging year for providers.

I want to give my personal thanks to the staff. They always do outstanding work. This year has been a particularly unique and challenging year for the staff. It might not be transparent to the public, the voluminous amounts of analysis and work that they do that underlies each of these very brief presentations. It is really outstanding, and pulling it together in the virtual setting has really been remarkable, and I very much appreciate it.

I also want to give a shout-out to the staff that has helped us with logistics. I was not around last April, which was our first virtual meeting, but I think it has really been impressive how well the staff has made this process go given the challenges that we have faced, and so I want to thank all the people that have made that possible, Jim, Dana, and the rest. It really has been a unique year.

And, lastly, I want to thank all the members of the public. I look forward to being able to see you in person and hear your comments in person. I want to assure you that we appreciate all the feedback we get. I want to

thank particularly those who have met with us and sent us comments. We do take them quite seriously, and we review the substance of them and discuss them, and I very much appreciate that feedback from the public. And I will be making a comment at the end of each session this month to encourage you to continue to reach out to us through the many means by which you can do that.

Lastly, I will thank all of the Commissioners. I don't think we could have had nearly as productive a year as I believe we have had without the incredible dedication and professionalism of my fellow Commissioners. And, again, it has been a challenging year for all of us professionally, personally, and otherwise, and I really do appreciate the time and effort you have all put in to moving all of these topics forward.

So, with that, I'm going to stop and turn it over, I think to Carol, and we are going to start with our SNF value-based purchasing program analysis.

DR. CARTER: Good morning, everyone. Before I get started, I want to note that the audience can download a PDF version of these slides in the handout section of the control panel, on the right hand of the screen.

Today we'll continue our discussion of MedPAC's mandated report on the SNF value-based purchasing program. The report requirements are listed on the slide. It is due in June, and we will include it as a chapter in the June report to the Congress.

We'll keep the presentation at the summary level. We've talked about this material at four previous meetings, and the current draft reflects Commissioner input throughout the year. Most recently, in March you discussed the chapter and the draft recommendations.

At prior meetings, we reviewed the flaws of the current program and how the proposed value incentive program design corrects them, so I'm going to run through this material quickly.

First, instead of the single measure that's required in statute, the alternative design would score a small set of performance measures focused on outcomes and resource use. The measure set should evolve over time and include, at a future point, measures of patient experience.

A second flaw is that in determining whether to include a provider in the program, it uses a minimum count that is too low to ensure reliable results for low-volume

providers. A revised program would incorporate strategies to ensure reliable measure results.

Third, the scoring in the current program includes cliffs for rewarding performance. As a result, some providers may not have an incentive to improve. The value incentive program establishes a system for distributing rewards with minimal "cliff" effects. All providers are encouraged to improve.

The fourth flaw is that the current program does not account for social risk factors of the beneficiaries a SNF treats, but the new design would. Using peer groups, the value incentive program considers social risk factors when tying performance points to incentive payments. Peer grouping counters the disadvantages that some SNFs face in achieving good performance. With this approach, performance scores remain intact, say, for public reporting, while payments are adjusted based on a provider's performance and the social risk of its patient population.

The fifth shortcoming is that, as required by law, the amounts withheld from payments are not fully paid out as incentive payments. In the proposed program, all

withheld funds would be distributed back to providers based on their performances. It would not be used to achieve program savings.

An improved SNF quality payment program should be combined with other tools to encourage providers to improve their performance. Public reporting of provider performance, including the measures used in the SNF VIP, motivates providers to improve.

CMS should also target technical assistance to low-performing providers so they can develop the skills and infrastructure needed for successful quality improvement.

CMS could also enhance its Requirements of Participation and the Special Focus Facility Program to more aggressively encourage providers to improve the quality of care they furnish.

In summary, the current program is flawed. Recent legislation corrects some of the shortcomings, but others remain.

A replacement value incentive program is a practical approach to improve the current program.

A new program would result in more equitable payments across SNFs with different mixes of patients, most

importantly their shares of patients at high social risk and the medical complexity of their patients.

At the March meeting, you discussed two draft recommendations.

The first recommendation reads: The Congress should eliminate Medicare's current skilled nursing facility value-based purchasing program and establish a new value incentive program that scores a small set of performance measures; incorporates strategies to ensure reliable measure results; establishes a system for distributing rewards that minimizes cliff effects; accounts for differences in patient social risk factors using a peer grouping mechanism; and completely distributes a provider-funded pool of dollars as rewards and penalties.

This recommendation will not affect program spending. It would be budget neutral to current law.

We expect this recommendation to have positive impacts on providers and beneficiaries.

Access may improve for beneficiaries at high social risk or who are medically complex. Beneficiaries may receive higher quality of care because providers would have stronger incentives to improve.

For providers, the SNF VIP will improve equity across SNFs because it will not disadvantage SNFs that treat patients at high social risk or medically complex patients. It will also increase the incentives for SNFs to improve their performance.

The second draft recommendation reads: The Secretary should finalize development of and begin to report patient experience measures for skilled nursing facilities.

This recommendation will not affect Medicare spending, but CMS may incur additional administrative costs.

We do not expect this recommendation to have adverse effects on beneficiaries' access to SNFs or on SNF participation in the program.

Beneficiaries may experience an improvement in the quality of care they receive from providers because SNFs will have an incentive to improve patient experience when these measures are publicly reported and scored in the SNF VIP. Consumers will have more information about providers when making decisions about where to get their care.

SNFs will have higher administrative costs when the Secretary requires providers to collect and report patient experience surveys.

Now I'll turn it back to Mike for your discussion and voting.

DR. CHERNEW: Terrific. Thank you so much.

I think now we will go to comment, and Dana is going to run the queue. I encourage all of you who want to make a comment to get in the queue. We have shorter sessions this month, so keep that in mind. We are not going to be doing a Round 1 and a Round 2. We're just going to be doing a single round. Dana?

MS. KELLEY: Okay. I have Brian first.

DR. DeBUSK: Good morning. First of all, I'd like to say I strongly support the recommendation as it's written, and I'm also a very strong supporter of this framework. I'd like to compliment the staff for its development. I think it's excellent. And I also wanted to comment on pages 43 through 45 of the reading material. I thought that was a very thoughtful discussion around the trade-offs between minimum thresholds and introducing other nonlinearities into the measurement system, thereby

creating cliffs, versus the benefits of having continuous points assignment. And, again, not to get into the details, but I thought it was a very considerate and thoughtful and mindful discussion of those two trade-offs.

The other thing I would like to comment on is just the overall rubric of this particular methodology. Again, I am a very strong supporter. I think it really addresses four key issues that are important to me, one being this whole philosophical issue of incorporating socioeconomic measures into the actual risk adjustment regressions. I think there is a philosophical issue there, and I know there has been a lot of work on it. And I do think keeping the socioeconomic measures out of those regression models is the right thing to do because then it does not create a pass for quality.

The other thing I wanted to comment on is it overcomes the mathematical challenge of dealing with collinear variables. So there's a lot to like about this particular treatment. Whether you want to take a philosophical approach or a mathematical approach, I do think it's the appropriate treatment for this data.

The other two things I'd like to briefly comment

on, I do think this is a very important step towards standardization. This same framework has been used -- or proposed, I should say, in the hospital quality system as well as in the MA quality system, and I think there's really a lot of strength in offering a standardized platform. I think if Medicare could use anything, I think standards would definitely be very high on the list.

And then the final thing is I think this is an excellent way to abstract the measures from the treatment of those measures. I love the fact that we can add or remove metrics to this model at any time, and I also appreciate the fact that over time we'll have better and better measures of socioeconomic status. I think using full dual eligibility is a very good start, but I think as we get better information, I think our ability to differentiate the socioeconomic strata will only get better.

So thank you.

MS. KELLEY: Okay. I have Amol next.

DR. NAVATHE: Thank you. So, first off, I love this work. I think I'm very supportive of the recommendation in general. I agree with much of

everything, if not all of what Brian has just said, so I want to echo much of that.

I wanted to actually kind of pick up on an area that I know that we had a little bit of back and forth on over the cycle in the context of what to do regarding the social risk factors, challenges, the peer grouping, and think about perhaps -- I am fully supportive of the peer grouping mechanism that we're suggesting here, and that translates, of course, into a lot of our other work.

In the spirit of trying to think about continual improvement and this tension that we oftentimes have talked about and also feel regarding not wanting to disadvantage any providers or facilities that take care of patients who have disproportionate challenges in social factors; on the other hand, not wanting to create this issue potentially of multiple thresholds, if you will, for those providers based on where they are located or who they serve. I just wanted to put sort of a plug, if you will, for continuing to reevaluate the best practices in this space as we move this more forward. In particular, because it is not at all limited to SNFs, it touches almost all of our work in terms of how to actually incentivize quality, how to incentivize

value.

One of the thoughts concretely that I want to put out there is there has been a recent surge of interest cross-nationally, so not just in the U.S. but in other places as well, of using geographic indicators like area deprivation or some sort of community-based measure of social challenges or social risk factors as a way to allocate funds towards value type. Most of this has been, candidly, in the public health sector, not yet in the health delivery sector. And so I think we would be a little bit on the cutting edge, if you will, but I think it's worth considering that as a topic in the future for us to reevaluate particularly because of, again, the fact that it touches so much of our work.

So just to recap, I very much support the work here, support the peer grouping mechanism. I think the work here has been very sound, and I think in a lot of ways foundational, as Brian said, but I support sort of taking some of those measures, trying to build upon that as we go forward.

Thanks.

MS. KELLEY: Dana.

DR. SAFRAN: Yes, thank you. Just adding my very strong support for the recommendations here and my deep appreciation to the staff for the terrific work on this chapter. A lot of what has already been said were points on my list, but I'll make a couple additional ones and maybe underscore some of what has been said, really four things.

First is I do very much appreciate the recommendations around new measures and, of course, moving beyond having a single measure related only to readmissions, as the current program does. But I think it -- and the recommendation for really being able to incorporate a patient experience measure into SNF accountability measurement programs I think is critically important.

But we all are mindful of the real challenges here, both in the paucity of measures, especially outcome measures for post-acute care and also the challenges around sample sizes. So I think I feel very good about the specific measure recommendations that you've made, but just want to underscore that we can't rest on those. Those will, even with patient experience included, not give us

the holistic and complete view that we would like to have of the quality of care and outcomes of care being achieved. Probably the next biggest gap will be to have measures of functional outcomes and well-being outcomes, and we've discussed -- and I won't belabor it here -- the challenges of doing that, but we should not give up on that work. It is critically important.

The second point is around just congratulating and appreciating your inclusion of the really well done text that you have around improving the rigor paid to reliability of the measures and the computations of required sample sizes. As you know, that plus the work that you recommended around the way that scoring gets done to avoid cliffs and to reward ongoing improvement, both of those aspects are things that I personally found made a very important difference in my own work designing incentive programs at Blue Cross Blue Shield of Massachusetts. I found that the attention to reliability was a critical factor in gaining the support and trust of providers whose performance was being measured, and that the handling of scoring in a way that avoids cliffs and rewards both performance and improvement with one approach

really was highly, highly motivating. So I just want to underscore and congratulate those.

Finally, on social risk, I think this is a really important step forward. You know, there has been a debate for quite a long time now in the field about these issues around risk adjustment and for dealing with social risk, and what I really appreciate in this work is that we have -- by adjusting payment rather than adjusting performance, we really are able to have our cake and eat it, too, so to speak, in that we create accountability for providers that does not waiver or change our standards based on the population mix. But at the same time, we acknowledge that caring for different populations probably almost certainly does require different resources and, therefore, should be rewarded differently.

So I really commend you for all of that and, finally, for the recommendation around the use of duals' status as a starting point, but let's not oversimplify and know that we do need to improve our measures of social risk, and I really agree with Amol's point about really taking a close look at geographically based measures. I think I've mentioned before that I think measures that use

data as a Census Block Group level are tremendously rich and in my own work have found that those can be very effective for this purpose.

So thank you very much, and, again, my full and strong support for the recommendations.

MS. KELLEY: Okay. I have John Perlin next.

DR. PERLIN: Thank you.

Let me first begin by thanking the staff for a terrific chapter. I'm stating unequivocally that I strongly support these recommendations.

Almost line by line, Dana hit the points that I was going to make, but let me just amplify. There's so much to recommend this transformation that that seems to me self-evident, but by the necessity for extending incorporation of social risk data is essential.

And to Brian's point, that's essential across all of our programs. The degree to which that can be standardized is also essential.

I do want to make one comment on the sort of transformed function that means that we're not rewarding differently based on risk but on stratifying to adjust. I still think it's imperative that we, as was discussed in

previous sessions that we've held, identify not only peer group performance but national standard performance, so we have an understanding of how a facility fits, both in its peers, given the risk, as well as what is at any given time the best performance, because our goal has to really be to inspire best performance.

And that gets to my final point, which is that it's kind of interesting with the transition from the singular measure to the three, plus the recommendation for developing patient experience. We are sort of getting to AAA and a balanced scorecard, and I think that dovetails back to the very first point. We have work to do not only in terms of incorporation of social risk but really a breadth of factors, including, as Dana mentioned, function, which are so critically important to those individuals who would be in the position of being able to choose what their skilled nursing environment will be, so strong support. Thanks.

MS. KELLEY: Okay. I have David next.

DR. GRABOWSKI: Great. Thanks, Dana.

First, to the staff, great work on this chapter, and I'm very supportive of both of these recommendations.

I was planning to be quick, but Dana really already made my point. So I'm going to be even quicker, just to say we really need to continue to work on growing the measures set here. I love that we've expanded it with the VIP from the existing VBP, but there's a ways still to go.

In particular, there was a New York Times article earlier this month being really critical of a lot of the measures that are currently reported on Nursing Home Compare. It would be great to continue to work towards improving these measures from the minimum dataset, from the payroll-based journal dataset, such that we could have a richer set of measure going forward.

So I really hope this is the end of the beginning of our work on this and not the beginning of the end because I really believe there's a lot of good potential measure that are out there, and we should continue to identify and improve those measures. So thank you.

MS. KELLEY: And last, we have Larry.

DR. CASALINO: Yeah, really elegant set of work by the staff, and I agree with the comments, all the comments really, that my fellow Commissioners just made.

I just have one point about the public reporting.

I do think it's essential so that people can see how the nursing homes are thinking about comparison nationally and ideally within a state at least as well. So, as Jonathan said, it's one thing what the payment incentives are, the public reporting is different, and we do want people to just be able to see, not just have the nursing home, the thing about getting relation to their peer group, but on a national and possibly state scale as well.

That is stated here and there in the chapter, but it doesn't really come through clearly in the conclusion and recommendations and discussion of the recommendations at the end. And I think it's a point that I think a lot of people still don't understand, and I would really like to see it very, very explicitly hammered home again and in parts that people will read, so at the end and at the beginning of the report and the executive summary, so that that message is not missed because I do think it's critical. And although it's in there now, you have to kind of search for it.

DR. CHERNEW: Thank you, Larry, and thanks, everyone else.

So those are all very helpful as we ponder our

work moving forward. I think now we're going to have two separate votes. I'm going to have Dana do the roll call. So I think we'll start with the first recommendation. Dana?

MS. KELLEY: Okay. On the first recommendation that Congress should eliminate Medicare's current skilled nursing facility value-based purchasing program and establish a new value incentive program that features the elements you see listed here, voting yes or no.

Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Marjorie?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes. Sorry.

MS. KELLEY: And, Mike?

DR. CHERNEW: Yes. And the muting creates that level of suspense. I'm sure people appreciate it.

Thank you all. I think that we're going to go --

MS. KELLEY: Oh, sorry. Go ahead. Yes. We have one more recommendation. Sorry.

DR. CHERNEW: Yes. So now we're going to go on to the second recommendation. I'm turning it over to you, Dana.

MS. KELLEY: So the second recommendation, that the Secretary should finalize development of and begin to report patient experience measures for skilled nursing facilities.

Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery:

DR. JAFFERY: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

[Dog barks.]

DR. CHERNEW: That's a yes.

DR. SAFRAN: My dog and I say yes.

MS. KELLEY: I got Dana, but I didn't get Jaewon.

DR. RYU: Yes. Sorry.

MS. KELLEY: Thank you.

Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Sorry. Yes.

MS. KELLEY: And, Mike?

DR. CHERNEW: Absolutely yes.

So thank you, everybody. I really appreciate that discussion. This has been an important body of work, and I look forward to moving forward with it, as you all mentioned.

So, without further ado, I think now we'll move on to the alternative payment model chapter, and I think I'm turning it over to Geoff.

MR. GERHARDT: Yep. That's correct.

Good morning, everyone. Today Rachel Burton and I will continue the discussion of CMS's portfolio of alternative payment models, or APMs.

Today's presentation picks up from the March meeting, when Commissioners considered a draft recommendation that CMS pursue a smaller, more coordinated suite of APMs.

The audience can download a PDF of today's slides from the control panel on the right side of their screen under the Handout section.

Today we will start by reviewing legislative changes made over the last 10 years to the way CMS

implements and tests APMs.

We will then touch on some of the reasons why APMs are seen as a better alternative to traditional fee-for-service payment systems.

Next, we will discuss some of the unintended consequences when providers and beneficiaries are in multiple models and why it might be time for CMMI to change the way it manages its portfolio of APMs.

We will then present a slightly revised version of the recommendation you considered in March, which reflects input from the Commissioners at that meeting.

Finally, we will review the implications of the recommendation for Medicare spending, beneficiaries, and providers.

As a quick reminder, in 2010, the Affordable Care Act provided the agency with more flexibility and resources to test APMs than had previously been available.

The statute created the Center for Medicare and Medicaid Innovation and enables models that meet certain criteria on reducing spending and improving quality to be expanded and made permanent without a change in law.

The ACA also created the Medicare Shared Savings

Program, which is by far the largest APM operated by CMS, and in 2015, Congress passed MACRA, which authorized temporary bonus payments and higher fee schedule updates for clinicians in advanced alternative payment models.

During 2021, CMS expects to operate 12 individual APMs, involving 25 tracks for providers to choose from.

CMMI was created under the premise that presenting providers with the right set of alternative financial incentives would motivate them to furnish care to Medicare beneficiaries more efficiently and effectively compared to traditional fee-for-service.

This premise has been borne out by some of the models tested by CMMI to date, and observers have identified other potentially positive effects arising from APMs. For example, providers that change their care pattern in response to participating in a Medicare APM may extend those changes to all their patients, regardless of whether they are attributed to an APM or not.

Another potential benefit is that reductions in gross spending associated with ACOs and other models may result in lower spending on Medicare Advantage, since MA payments are tied to fee-for-service pending.

And Medicare's pursuit of APMs seems to be encouraging other payers to pursue alternative payment arrangements, which in turn may help to slow the growth of national health care spending.

In its first decade, CMMI approached its testing mandate with vigor, building up the evidence base on innovative payment and delivery models.

Over this period, the Innovation Center operated a total of 54 models, some of which were required by provisions in law, but most were developed by CMMI itself.

While not the only measure of success, only four of the models tested by CMMI have been certified by CMS actuaries as having met the criteria to be expanded into permanent nationwide programs.

Over the last 10 years, evaluation reports have found that APMs often succeed in reducing gross Medicare spending, that is, before performance payments are factored in. But once those payments are included, APMs usually have not generated net savings to Medicare, and some models are associated with large increases in spending. In addition, few models have been linked to improvements in quality of care or health outcomes.

In previous meetings, we identified a number of reasons why the APMs tested to date have not been more successful in meeting CMMI's statutory goals. In the next several slides, Rachel will focus on how implementing numerous independent overlapping models may be keeping APMs from reaching their full potential.

MS. BURTON: One reason why APMs have not generated larger savings or quality improvements for Medicare may be related to the fact that many providers concurrently participate in more than one model and/or different tracks of the same model.

Based on data we recently received from CMS, approximately 580,000 clinicians participated in at least one Medicare APM in 2019, including ACOs, episode-based payment models, and primary care transformation models. Twenty percent of these clinicians were participating in multiple Medicare APMs or multiple tracks of a Medicare APM.

When clinicians participate in multiple models at once, they may face differing incentives for each model. For instance, one model may reward a provider for reducing total cost of care, while another model may tie bonuses to

increasing delivery of primary and preventive care. Since each model's incentives likely apply to a subset of a clinician's patient panel, the impact of each model on clinician behavior may end up being less than expected.

The percent of beneficiaries who are attributed to multiple APMs is also likely to be substantial. For example, one analysis found that 27 percent of beneficiaries in the BPCI model were also in MSSP.

To prevent Medicare from double-paying bonuses when a beneficiary is treated by two sets of providers in two different APMs, CMS has developed model overlap policies. These specify which model's providers will receive a bonus and which will not. They can also add model payments paid to providers in one model to the total cost of care that providers in another model are held accountable for.

Since these overlap rules can reduce the size of bonus payments providers might otherwise expect to receive, they can dilute the strength of the financial incentives in a model.

The number of APMs operating right now is an issue, because it may increase how often these model overlap policies are

triggered.

The number of APMs operating right now also may be hindering evaluators' ability to accurately identify models' impacts. Ideally, evaluators like to compare providers in an APM to a comparison group of providers not participating in that APM or any other APM.

But since a variety of payers have pursued APMs in recent years, it is increasingly likely that an evaluator's comparison group will contain providers who are participating in some kind of APM, leading to contaminated comparison groups.

As Amol has noted, if comparison group providers are improving the care they deliver, it will reduce the likelihood of researchers finding that the APM they are evaluating has generated favorable impacts relative to their comparison group.

Reducing the number of models operating may lessen the contamination of comparison groups, especially if it prompts other payers to also streamline their APM offerings.

This brings us to the draft recommendation you'll vote on today. It reads: "The Secretary should implement a

more harmonized portfolio of fewer alternative payment models that are designed to work together to support the strategic objectives of reducing spending and improving quality."

The recommendation language has been revised to reflect the discussion at the March meeting. We now emphasize the idea that models should be "harmonized," meaning they should have more consistent features, and instead of calling for models to be "more coordinated," we now say that they should be "designed to work together."

Your mailing materials describe some ways this recommendation could be implemented.

In terms of the implications of this recommendation, CBO estimates no net change to Medicare spending within the next five.

Over a longer time frame, it is possible that an improved suite of models could increase providers' incentives to deliver care more efficiently and generate net savings for Medicare.

Beneficiaries could benefit from this recommendation, if the improved suite of models we're envisioning gives their providers stronger incentives to

manage care, deliver a more efficient mix of services, and improve performance on quality measures.

Providers could receive more predictable performance bonuses and could see reduced administrative burden if models had more consistent parameters.

To close, I'll bring back up the recommendation language and turn things over to Mike.

DR. CHERNEW: Thank you so much. This is the first foray of MedPAC into this issue. I think next cycle, we are going to build much more, but for now, I think we'll go around with comments. Dana, I'm going to let you run the queue again.

MS. KELLEY: All right. We have Paul first.

DR. PAUL GINSBURG: Oh, thanks, Dana.

I strongly support this recommendation, and in March, I had been concerned about the recommendation not having enough supporting discussion around what it really means. And I'm just very pleased at the way this chapter came out. So they did a really good job on that. So I'm perfectly happy with it.

I have one issue I wanted to bring up. When you're discussing the types of demonstrations that could be

pursued, one that was mentioned was a geographic version that some areas would only get, say, episode-based innovations and not population-based.

It hit a sore spot with me. I started becoming concerned. When I think of our broad strategic desire, it's to, as quicky as possible, get more and more Medicare beneficiaries into alternative payment models that are effective. I started thinking that even though it was a great research strategy, it could be a major detour from actually moving the country in the APM direction to basically have a hiatus of a certain type of model in some areas. So I just wanted to bring the -- and I think we need to reinforce what our strategic goal is and perhaps say that some very attractive research strategies may not really work out because the degree to which they would substantially delay our strategic objective of getting more and more care into APMs.

MS. KELLEY: Okay. I have Brian next.

DR. DeBUSK: Yes. I support the recommendation as written. I think this is an excellent chapter. I want to echo Paul's comments. You know, I was concerned that the chapter looked a little thin, and I think it's really

blossomed. I mean, I think it looks great.

I'm going to make a couple of comments about the tone in the chapter. I really appreciate the emphasis on harmonization and focusing on the models working together. I hope that is an area that we'll continue to pursue. I think that's excellent work.

And this next comment may be more my perception, so I'm going to qualify that. This is a feeling. It did seem like tone toward ACOs shifted from maybe cautiously optimistic to a little bit optimistic, and our tone on bundles seemed a little bit more neutral to me. You know, I still remain hopeful and cautiously optimistic on ACOs, but I'm also very bullish on bundles, and I hope we can explore bundles and ACOs with equal, or at least relatively equal levels of vigilance and enthusiasm, at least over the next few cycles.

I want to focus also on pages 22 through 27, the possible factors preventing success of ACOs. I thought that was extremely well written. Thank you to the staff and for the other Commissioners for incorporating. I really appreciated the discussion about, you know, is fee-for-service one of the underlying challenges. I loved the

fact that that was the number one listed thing.

I just wanted to comment on one thing. I think the section when we talk about people not understanding how ACOs work -- and I think there was a second section about how the money, basically the providers being shielded, perhaps, clinicians being shielded from the incentives -- we might want to take a look at that particular part of the chapter, because I think people understand how ACOs work, and I do think that a lot of time clinicians are shielded from the incentives. But I think the real story there may be the fact that people just don't understand, necessarily, how their specific actions impact an ACO.

I hear a lot of doctors who talk about, "Well, you know, I received an incentive or was told that we received a penalty over something that I didn't really understood that I controlled." You know, an oncologist wouldn't necessarily understand a penalty or a benefit from choices of, say, the orthopedic surgeons have made. So I think the issue is people understand ACOs. I just don't know that they understand the connections with any specific ACO.

And then my final comment here was on the

beneficiary alignment, which I thought was another excellent point in that same pages 27 to 29 discussion. I was just going to add, maybe that's an opportunity to discuss Medigap and some of the challenges created by Medigap, particularly for APMs.

And those are my comments. Thank you.

MS. KELLEY: I have Betty next.

DR. RAMBUR: Thank you very much. I'm very supportive of the recommendations, and I also want to say I echo some of the comments that Paul and Brian made, and I also remain enthusiastic about ACOs and bundles and agree that on the issue of confusion at the working surface, is at least in part how comfortable fee-for-service is.

But what I wanted to say that I think amplifies the comments, I really appreciated the addition of why pursue APMs, that started on page 26, and I just wanted to say that even though I worked in this space a lot, the idea that I think I first heard from Dana Safran here, about gross spending, is actually an important indicator because it indicates a change of practice patterns. That was not something that I really had thought about before. I was always thinking about net savings versus gross savings. So

I thought that that's really an important piece to add, especially for anybody who is a more casual observer of this chapter.

So thank you very much, and again, I appreciate the great work. I'm very supportive and very much appreciate the addition of why pursue APMs. Thank you.

MS. KELLEY: Dana.

DR. SAFRAN: Thank you. Hearty support for the draft recommendation from me, and just a few comments I would make. First is, you know, this really is a terrific chapter, and, you know, the team has really done an outstanding job. There is so much content here, and I think it is quite clear and quite well done.

A few things I would say. First is I particularly appreciate how the chapter has now parsed different types of APMs in order to really make the inferences related to our recommendations for moving toward a more parsimonious set of programs more actionable. We really talk about the evidence around ACOs, the evidence around episodes, the evidence around the prior care models, and I think that is such a strength.

I would say two things about it. One is to take

one final look as you finalize this chapter, the sections where you are summarizing the literature on each of those three, because I think in a couple of cases the chapter would benefit from a kind of crisp, pithy intro that really synthesizes the evidence that will follow, and it seemed to be lacking that in a couple of cases.

In terms of, you know, tone, I actually felt very comfortable with the tone that you set, because I felt like it was consistent with the evidence that you were presenting, that the evidence you were presenting in Table 1, I believe it shows the particular strengths of ACOs to date, some real strengths but still some remaining, you know, reasons for questions on episodes.

The one thing I would ask you to take another look at is the way that talked about the primary care models surprised me a little bit, just because the evidence that you shared in the chapter really suggests that the primary care models are, to date, showing no evidence of savings, neither gross or net savings. And so while we do see some encouraging evidence around reduced emergency room and hospital use and some evidence that quality may be increasing, I think it could be valuable and important to

just call out that those programs may provide those advantages but without being a source of savings for the Medicare program.

And then the final comment I would make actually has to do with the why APMs section that Betty called out. I had a small concern with that section in that the way it starts out almost seems to contradict the enthusiasm that is expressed in the rest of the chapter for what the evidence is telling us about APMs, by using some language around, you know, reasons to pursue APMs other than savings and quality, and if like, you know, after all this time they are not doing that but they might do these other things. And maybe I read that wrong. That's how I interpret it, and that seemed a little damning of the rest of the evidence that you had just shared.

So, yeah, those are my comments. Thanks very much, and very strong support for this recommendation.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you. Like other Commissioners I am an enthusiastic supporter of APMs, and I also support the draft recommendation as written.

I do want to comment that I want to make sure

that our enthusiasm is not generating a lowered expectation for what APMs ought to be achieving, and the kind of modest progress that we have seen over ten years in my mind is disappointing and is largely attributed to the overwhelming force of the status quo in fee-for-service system. And I think it's really important that we don't lose sight of that, and that our enthusiasm for the theoretical advantages of APMs is not leading us to lower our expectations to say, well, when we look at the data we can find some things that seem to be going okay.

That said, I am concerned that the tone of the chapter is not recognizing what expectations are for other kinds of businesses and enterprises in health care, and that we shouldn't forget the kinds of expectations many of us had over the past decade.

A particular question I have is on Slide 6, which I think is perhaps new material that we hadn't discussed before. The issue here is that about 20 percent of clinicians are in multiple APMs, which strikes me as a small number. And I think there is a strained argument here that 20 percent overlap could have a significant effect on the disappointing results we're seeing. So I'm

worried because this seems to be an example of lowered expectations and look for reasons why the APMs aren't achieving what I would hope they would.

So I think a lot of this goes back to the statements in the chapter that clearly identify the competing incentives to increase use and increase spending, which is really the fundamental challenge.

But in summary I do support the recommendation as written.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Thanks, Dana. I want to start off by just saying, like my fellow Commissioners, I am very supportive of the draft recommendations. I think this is a terrific chapter that pulls together a lot of discussions that we have been having now for quite some time.

And I particularly want to applaud you for bringing clarity, at least to me, for some things, not just simply about the information and the recommendations at hand today and in this chapter but really setting the stage for the next, as Michael put it earlier, the next couple of cycles, for what our discussions and recommendations may be going forward. I think this really moves us along that

pathway in a great way, and it helps us focus in, will help us focus in on some more of those key topics.

One thing in particular I want to call out is I think it's early on in the chapter, and it may be repeated a couple of times, and this speaks a little bit to some of the conversations that we'll continue to have around ACOs and bundled payments and things. And one of the key things that I think this really helps us prepare for in our future discussions talks about when the overlap in models exists that models should be designed to have incentives that increase in strength when combined with other models and are dilutive. And I think that is super important as we think about -- and it actually feeds into maybe Bruce's previous comment about some of the overlap -- when people are in ACOs and the rebuttal payments and how we're going to have to grapple with both of those things, coming into harmony together.

So I wanted to call that out, and then just one other maybe minor comment. On Table 1, I know you've added the number of beneficiaries in each program, and that's really helpful. One thing that struck me, and maybe it's in the text or maybe it's somewhere in the table -- I tried

to look again but didn't see this -- is the CMMI models. And so we don't have the comparison of the MSSP activity, recognizing that it is, of course, a statutory program run by CMS and not CMMI. But when I was looking and thinking about all the numbers of beneficiaries in the different programs and what that might mean, it just seemed like a glaring absence, and then I couldn't pull in the MSSP as comparison.

So thank you, and again, terrific chapter.

MS. BURTON: We can definitely add the number of beneficiaries in MSSP. We don't include MSSP in the table, but we give it a page after the table, where we kind of describe what studies have found.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. So definitely very, very, very supportive of this work on an ongoing basis, as well as the way this chapter has evolved, so thank you very much for the work, Rachel and Geoff and team.

A couple of points I just wanted to quickly highlight. So one, I think that there has been, in my view, a great enhancement and improvement in the tone of the chapter. I think we're now capturing a lot more of the

essence of what the evidence is kind of telling us, particularly thinking about this concept around the gross savings/net savings piece. I really appreciated that. Thank you for incorporating those pieces.

I think, to some extent, we could be -- I agree with some of Brian's comments that we could be even more positive about bundled payments or episodes. But nonetheless, I think very much a great improvement.

A couple other points. So I do echo the comments, some other comments that Brian and Betty made. I will just leave it there. I won't go into those.

Paul, I think your point around the geographic piece is interesting. We actually did some thinking about this, and to the extent that Rachel and Geoff need a site, for example, there is a paper that I wrote with Mark Pauly in Health Affairs that explored that issue a little bit, and if it's helpful I'm happy to send that to you after this.

The last point that I wanted to make is I think one thing that's kind of interesting is the notion, you know, we're taking these alternative payment models, alternatives to fee-for-service, and, in essence, value-

based payment models, and what value means to the Medicare program and what value means to the Medicare beneficiary may not be 100 percent aligned.

And to give a quick example, for the Medicare program, shifting a patient who doesn't really need a skilled nursing facility, doesn't necessarily need that level of care, and instead sends them home with home health or home physical therapy is good value for the program, not for a beneficiary. That actually may create a lot of inconvenience, you know, in some way. And so I think it could be important as we pursue this work forward.

I love the chapter as it is, and I don't think we need to change it in that sense. But as we pursue this work forward I think it would be important to bring that view in, under the umbrella of how we want to think about the value-based transformation alternative model for the Medicare program, at large.

So thank you very much. I'm very, very supportive of this.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. I'm also supportive of the recommendation. I think we have landed at a really good

spot. I appreciate the chapter. I think it does a really good job of laying things out.

I think my only comment was going to be around the notion of uptake. When I think about success in these programs, I think it's obviously reducing spending, improving quality, but the other is -- and I think Paul referenced this earlier -- trying to get more of the care or more of the providers into the models that have proven to be successful. And when I think about that, I think there is a potential linkage that we might even be able to call out a little stronger in the chapter between these recommendations and their ability to make things more direct or obvious or simpler to understand for the providers, which then, I think, gives us a better shot that there's going to be greater uptake into the more successful models.

And so I think it's kind of there. You know, we talk about factors that may be preventing APMs from having more success. It's mentioned a little bit there. I just thought that linkage could be a little stronger.

MS. KELLEY: Sue.

MS. THOMPSON: Thank you, Dana, and I will be

quick. I'm cognizant of the time as well. I just want to express my enthusiastic support for this recommendation. Many, many of the points that have already been made by my fellow Commissioners I simply want to emphasize, and I'm not going to be able to emphasize all of them, but everyone who is supportive of these recommendations recognizing the complexity that exists in today's plethora of models and the impact that's having on our ability to encourage, entice, if you will, particularly our independent physician providers to participate I believe needs to be the focus where recommendations go forward.

The attribution models and determining how to measure and reward specialists who do not receive attribution, I would keep that on the horizon of recommendations that come forward.

And last, but not least, the fact that beneficiaries are generally unaware that they are in an ACO, so they therefore have no incentive to, you know, help support either the quality work or the population health work, let alone reducing costs.

So as this is my last meeting and this topic is one of my -- that's most near and dear to my heart, I just

enthusiastically encourage this Commission to keep working. While we say that this set of recommendations will not reduce Medicare spending, certainly the outcome of the work and the processes that are in place around alternative payment models to me is our hope for tomorrow for the Medicare program.

So thank you so much.

DR. CHERNEW: Sue, we're about to go to Larry, I think, but let me just say, like everybody else listening, you will always be welcome to reach out to us and give us your comments. So while I'm sorry that this is your last meeting, it is certainly not your last opportunity to engage with us on this topic.

So, sorry, that was a brief break. I think, Dana, Larry is next.

MS. KELLEY: That's right. He's last in the queue.

DR. CHERNEW: Great.

DR. CASALINO: Yeah, I can echo the comments about how good the work is. I just want to focus on one area that we haven't talked about very much, and it might deserve a paragraph or two if the chapter can be revised to

that extent before it's published. That's the issue of bundled payments versus ACOs. I think that in terms of overlap of programs and the difficulties that causes, this might be the single -- I mean, there are other areas where there are analogous issues, but this might be the single biggest question, I think. If you want population-based care, then that's an ACO if you define the population as a population of Medicare beneficiaries in a particular area. If you have an ACO like that and there's also bundled payments being done in the same area, then automatically there's some conflict, and it's not easy to figure out how to harmonize those.

I think there are people -- I'm not one of them -- who think that you can bundle everything, not just knee replacement but a year's care for diabetes or some other kind of disease. I think that's mistaken. But whether it is or not, I think the point is -- Peter used the phrase "elephant in the room." I think the elephant in the room here is bundled payments, episode-based care versus ACOs, how can those be harmonized in the same geographic area. I don't actually have answers, but if the chapter just kind of called that out as a specific question, that means a lot

more thinking and discussion. I think that would be great, because given the magnitude of the issue, at least to my knowledge, there has been remarkably little discussion, at least in print, of this issue. And I don't see how APMs can be harmonized unless we make some progress with that issue.

DR. CHERNEW: Larry, that was perfect, and so we're about to go to the vote, but I would like to make a few summarizing comments just for folks listening at home.

The first one is this is an area where generalization is very hard, so it's tempting to say things like bundles work or bundles don't work. I think if you look at the evidence, you'll realize -- and, Amol, as someone who has contributed a lot to this, and I can't see you on my screen very well, I think you would admit -- there here is. I think you would admit that some work quite well and others not so much. So we have to be very wary of generalization. I think that is true broadly across the board, and I hope that comes out of the tone of the chapter. We'll look at it.

I will say in response to some of the early comments -- actually, I want to speak for me. I have no

preconceived notion about which approach is better or not, ACOs, bundles, what have you. The key point is really maybe the most important thing I can say is many of these issues are so challenging, particularly the one you ended on, Larry, which is how we integrate them together in a sort of way that works together; this is why we didn't tackle that this cycle. We need at least a cycle to do the work, to provide analytic recommendations around that type of harmonization and around the issues that you're raising. And we hope to begin that work next cycle, and for those listening, we actually already have begun thinking about how we are going to do that type of harmonization and how we're going to work through the details that several of you have mentioned around attribution and things like that.

The last point I'll make, which is really just egocentric because it's important to me, is because these models inherently span providers and time, many providers that are not actually participating -- in other words, are not literally on a list of a participating provider -- are actually providing care to people that are attributed to these models. So there's a participation in some sense whether you're literally on the list of participating

providers or not. What you do in terms of clinical practice matters for these models, and you can be affected by the multiple ones. That point, by the way, does come up in the chapter at a few points, but in any case, what this whole conversation really highlights to me is how intellectually rich and important next year will be.

So I'm going to leave it at that, and I think for this year the goal was just to begin to change its orientation to some sort of harmonization and recognition of the interactions, and now next cycle we will do some of the hard work about what that really means.

All of that said, we're now reaching time for the vote, so let me say -- I'm going to pause for a second before I turn to Dana to see if anyone wants to say anything else; otherwise, we're going to go to the vote.

[No response.]

DR. CHERNEW: Okay. Dana?

MS. KELLEY: Okay. On the APM recommendation, voting yes or no, Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Karen? Karen is giving us a thumbs up, so we'll take that as a yes. Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: An enthusiastic yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes, and it's a great chapter.

MS. KELLEY: And, Mike?

DR. CHERNEW: Yes. And so thank you all --

DR. DeSALVO: And, Mike, just officially -- this is Karen -- yes. I could not find the right screen.

DR. CHERNEW: Thank you for the official yes, Karen.

So before we go to lunch, I want to say to the public as always, please reach out to us with your comments. Normally, we would be able to see you in person, and you could make your comments. I realize this is the last meeting of the year, but one thing that I have grown to increasingly appreciate is that comments made early, particularly in an area like this where we have a lot to do next cycle, are very much appreciated. So while you might not feel that there's time to change exactly how this particular chapter is -- while we are on a tight time frame for this chapter, there is a lot of work to be done. So if

you have comments on this, the same is true for the SNF VIP model. It was clear from the comments in that session that we will be doing continued work on this area. We often build on our work. So I again encourage the community broadly to reach out to us and give feedback and understand sometimes the earliest feedback is the most impactful feedback. And we are already well on the way to moving forward and anticipating where we are going to be next cycle.

So, again, thanks to all the Commissioners for your comments and the staff for all of their work, and we will be coming back again -- I think we are now at lunch, and we will reconvene again at 2:00 p.m.

Jim, is there anything you'd like to add, or Dana?

DR. MATHEWS: No; I'm good.

DR. CHERNEW: All right. Thanks, everybody. We will see you at 2:00 Eastern.

[Whereupon, at 12:28 p.m., the Commission was recessed, to reconvene at 2:00 p.m. this same day.]

AFTERNOON SESSION

[2:01 p.m.]

DR. CHERNEW: Hello, everybody, and welcome to our afternoon session. We have several sessions now and time is short, so without further ado I think I'm turning it over to Andy and Luis.

DR. JOHNSON: Good afternoon. This presentation addresses the system for setting benchmarks, used in calculating payment rates for Medicare Advantage plans. The audience can download a PDF version of these slides in the handout section of the control panel on the right side of the screen.

The Commission has discussed this topic over four meetings since November 2019. Today, the Commission will vote on a recommendation for a new approach to establishing MA benchmarks that reflects the Commission's discussion.

In today's presentation, I will briefly describe the MA program's recent growth. Then I will discuss issues with the current system of setting MA benchmarks and rebates. Luis will discuss an alternative approach to setting benchmarks and will present the draft recommendation replacing the current benchmark system with

the alternative approach.

After years of rapidly rising payments for MA plans, the Affordable Care Act revised plan benchmarks, causing a decline in payments to plans. Some predicted that MA plan offerings and enrollment would decline. Instead MA plans were able to reduce costs and increase benefits.

Between 2016 and 2021, the share of Medicare beneficiaries enrolled in MA rose from 33 to 46 percent, the average number of plan choices increased from 18 to 32 plans, and the availability of a zero-dollar premium plan rose from 81 to 96 percent of Medicare beneficiaries.

The annual value of extra benefits, which include reduced cost-sharing, reduced Part B and Part D premiums, and a wide range of health-related benefits, increased by more than 70 percent over the past five years, reaching nearly $1,700 for 2021, and accounting for 14 percent of Medicare payments to MA plans.

All of these metrics are near or at record levels in the MA program.

Based on the Commission's discussion of supplemental benefits last month, we summarized the

availability of certain benefits for MA enrollees. The first set of bars shows the 10 most common supplemental benefits available to all enrollees of general enrollment plans, and includes benefits for travel, vision, fitness, hearing, and dental.

The other three sets of bars show the top 5 benefits that are available through three newly created supplemental benefit categories. The first of these categories show plan-wide benefits for enrollees with high needs, where limited meal benefits, transportation for medical needs, and smoking or tobacco cessation are the three most commonly offered services. The last two categories are for benefits that can be targeted to a subset of plan enrollees based on a specific disease, socioeconomic status, or chronic illness criteria. These benefits were introduced two or three years ago, and none of these benefits are available to more than 10 percent of MA enrollees.

Next we consider issues with the current benchmark policy and the ways it could better balance policy goals. Current policy supports a wide availability of plans, but could improve on other goals, such as

establishing predictable and stable payment rates, supporting access to essential extra benefits across geographic areas, and appropriately allocating savings from MA plan efficiency to beneficiaries and to the Medicare program.

The following issues are described more thoroughly in your paper. First, in areas with benchmarks set 15 percent above fee-for-service spending, Medicare currently pays plans 9 percent more than fee-for-service, which has attracted a disproportionate share of MA enrollment.

Second, the quartile system creates benchmark "cliffs" where small differences in county fee-for-service spending result in large differences in benchmarks.

Third, despite plans' demonstrated efficiency relative to fee-for-service, with bids averaging 87 percent of fee-for-service spending, the current system of benchmarks does not leverage any MA plan efficiency, and instead contributes to higher payments to MA plans, which are currently 4 percent higher than fee-for-service spending would be for similar beneficiaries.

Finally, Medicare subsidizes extra benefits for

MA enrollees. Extra benefits represent a growing share of Medicare payments to MA plans, but utilization data for supplemental benefits is not available and therefore, we cannot assess the value of these benefits for beneficiaries.

Without reforms to the benchmark system, these issues will persist or continue to grow in magnitude.

Now, I will turn it over to Luis to discuss a new approach for establishing benchmarks.

MR. SERNA: A revised benchmark system should be rebalanced to both leverage the efficiency of MA plans and support their wide availability. Over the course of multiple public meeting discussions, attributes of a benchmark alternative that Commissioners have highlighted are: (1) eliminating benchmark cliffs, (2) bringing benchmarks closer to fee-for-service spending in the 115 percent and 107.5 percent quartiles, (3) putting at least some additional pressure on some benchmarks in the 95 percent quartile, and (4) an immediate change in benchmarks that is not overly disruptive to basic supplemental coverage.

In October, December, and March, we presented an

alternative system for establishing benchmarks that makes these improvements and replaces the current quartile structure. This system removes the quartile-based payments by blending local area and national spending. It achieves savings by applying a discount factor to benchmarks. We simulated benchmarks and payments for this alternative relative to current policy.

Building on Scott Harrison's work last cycle, we compare our simulations with 2020 base benchmarks, which do not include quality bonus and are an estimated 103 percent of fee-for-service. Including quality bonus would have increased benchmarks by 4 to 5 percentage points.

A blended benchmark alternative would also include prior MedPAC recommendations, which we have incorporated into our simulations where applicable.

We simulate a blended benchmark with a 75 percent rebate.

First, we turn to the weighting of local and national fee-for-service spending. We rank ordered counties by local fee-for-service spending as seen by the light blue line. When we plot current base benchmarks, we see several discontinuities relative to local fee-for-

service spending, as seen by the grey line with pervasive peaks and valleys.

After modeling various local and national weights, we found that blended benchmarks under a 50/50 weighting followed the Commission's guidance of better leveraging plan efficiency without constraining beneficiary access to plans. Overall, a relatively equal blend of local and national spending was the only option that moved benchmarks in the lowest spending areas much closer to fee-for-service, while also applying modest additional pressure on the highest spending areas.

We simulated blended benchmarks using MedPAC areas and found that nearly all MA markets had an average bid below the blended benchmark -- 90 percent of market areas had an average bid more than 5 percent below the blended benchmark. Thus, plan efficiencies could be further leveraged through a discount rate.

Without applying a discount rate, the program is unlikely to share in plan efficiencies and achieve savings. In other words, overall payments would be similar to current policy after changes to benchmarks that blended local and national spending, used only the A&B population,

removed the pre-ACA cap, and integrated a 75 percent rebate. We simulated our alternative benchmark approach by including a discount rate of 2 percent. Lowering all blended benchmarks by 2 percent yields savings of 2 percent.

While a blended benchmark structure would remove the payment quartiles, we examined payments by quartile of fee-for-service spending to compare with current policy. As seen in the cells on the righthand side, circled in yellow, a 2 percent discount rate helps ensure modest savings of 1 percent in the two highest quartile areas.

We also simulated plan availability under a 2 percent discount rate. Assuming no change in 2020 bids, which is likely conservative given that bid levels decreased in 2021, nearly all beneficiaries would continue to have an MA plan available with enough rebate dollars to cover 2020 levels of cost-sharing. On average, even beneficiaries in the lowest-spending quartile areas, indicated in yellow text, would have access to six different plan sponsors offering 15 plans that could provide 2020 levels of cost-sharing.

Results were similar when we examined the ability

of plans to provide 2020 levels of both cost-sharing and premium reductions. We chose cost-sharing reductions because they are most analogous to Medigap supplemental coverage, and we chose premium reductions because they have been most clearly associated with beneficiary plan selection. However, this does not diminish the potential value of some other extra benefits. Taking the availability of cost-sharing and premium reductions together with plans' propensity to lower bid levels after decreases to benchmarks, a 2 percent discount rate would likely have a relatively modest effect on beneficiary access to MA supplemental coverage.

In summary, the MA sector is extremely robust, but the MA benchmark system is flawed, and plan savings are not sufficiently shared with the Medicare program. An alternative approach be would rebalance benchmarks to both leverage the efficiency of MA plans and support their wide availability. Payment would be set on a continuous scale of local fee-for-service spending. Benchmarks currently above local fee-for-service would be brought closer to local spending levels. Additional modest efficiencies would be leveraged in areas where plans bid far below local

fee-for-service spending. And, there would be minimal effect to supplemental coverage.

That brings us to the draft recommendation, which reads:

The Congress should replace the current Medicare Advantage benchmark policy with a new MA benchmark policy that applies a relatively equal blend of per capita local area fee-for-service spending with price-standardized per capita national FFS spending; a rebate of at least 75 percent; a discount rate of at least 2 percent; and prior MedPAC MA benchmark recommendations, using geographic markets as payment areas, using the fee-for-service population with both Parts A and B in benchmarks, and eliminating the current pre-ACA cap on benchmarks.

Relative to current law, this recommendation would reduce program spending by more than $2 billion over one year and by more than $10 billion over five years. Based on our simulations, we do not expect this recommendation to have adverse effects on beneficiaries' access to plans. MA would continue to be a viable alternative for beneficiaries seeking supplemental coverage.

Beneficiaries would likely see modest reductions in coverage of extra benefits. Plans will have lower payments, but the magnitude of change in extra benefits depends on plan response. Plans may choose to reduce profits or otherwise lower their cost of providing the Medicare benefit, that is, they would become more efficient through lower bids, as we have observed in overall plan behavior when benchmarks are lowered.

Our simulations indicate a small effect on plan participation in MA, with little impact on the plan options currently available. Without any change in bidding behavior, nearly all plan sponsors would be able to offer plans with enough rebate revenue to maintain the same level of cost-sharing and premium reductions as currently exists and could choose to continue to offer other supplemental benefits.

Now, I turn it back to Mike.

DR. CHERNEW: Great. Thanks so much. I am not going to take more time, and maybe I'll summarize at the end. But Dana, can we start going through the queue?

MS. KELLEY: Yes. I have Pat first.

MS. WANG: Thank you, and, thank you guys for

adding the additional information on supplemental benefits. I thought it was really helpful, and, you know, will be helpful, I think, for future discussions.

I just want to say a couple of things. The new framework for benchmarks, it is really good in eliminating the cliffs, you know, creating a more continuous slope, and, you know, you've pointed out that the sort of appearance of higher than fee-for-service MA payments is driven by the half of the counties that are in the lower fee-for-service spending areas. The benchmark proposal sort of spreads the pain, I think, by, you know, lowering those counties closer to fee-for-service but also taking some out of the high fee-for-service areas so that it continuous to be continuous, and I actually think that that is appropriate.

You know that I've been concerned about having more explicit language than we normally would put into a chapter about the way that our recommendations on MA interact with each other. I'm sensitive about quality, in particular, because of all of the aspects of the benchmarks that affect benchmarks and get built into benchmarks, you have explicitly sort of called out the quality is also very

much built into the current benchmark structure but it's not really a benchmark recommendation, but it interacts.

So, for example, today, as you know, if a plan is in quality bonus status their benchmark gets elevated as does the percentage rebate that they are entitled to keep. So the benchmark goes up, CMS takes a bigger cut of whatever the rebate amount is, the plan gets to keep a bigger amount, and it flows through the benchmarks. And I just want to be really careful, hopefully in the executive summary right up front, that we say something appropriate that calls out that prior recommendations and this recommendation are independent of each other, they interact with each other. If people wanted to adopt this, because they think it looks great, then we just need to be mindful that it's not meant to be stacked on top of the others, particularly quality. That's the one that I think it's very tangled but it's not explicitly a benchmark feature, quality.

And an example of that is, I understand why that's a totally freestanding matter. We're saying a rebate of at least 75 percent. In the paper, you know, this was described as for modeling purposes, we're using 75

percent, because rebates today range from 50 percent to 75 percent, based on the quality status of a plan. So moving everything to 75 percent for purposes of modeling, but now it's like it put a rebate of at least 75 percent, it seems very rigid.

I just want to make sure that readers understand that this is -- they need to understand there's some flexibility in there, if somebody decided that they wanted within this benchmark structure to continue to incentivize higher quality plans by giving them a higher share of the rebate. Maybe it's something like an average of 75 percent. I don't know. But that's an example of how I feel like this -- it is very related to the quality proposal without explicitly talking about the quality proposal.

I would like to spend, in the future work, a little bit more time, perhaps in the next context chapter, on the Medicare Advantage value proposition. You know, I mentioned this at the last public meeting. It's not just the cost comparison, fee-for-service to MA. It's what is the value proposition? What's the comparison of quality? What's the comparison of member satisfaction? And I love

what you did in the ACO chapter, to kind of actually call out some of the research on that, because there's a body of research that compares MA to fee-for-service, and at least the research I'm aware of, it's very favorable to MA, both in terms of beating fee-for-service in quality and having a positive, a beneficial spillover effect to lower fee-for-service spending in areas where MA enrollment grows. So I would just recommend that to sort of round out our discussion of MA, and not just make it about, you know, like which is more expensive.

The other thing about the cost comparison -- and you guys, I think you've stated this -- I think that the dilemma for us here is apples to apples, apples to oranges. Apples to apples, the cost of providing the AB benefit, MA is absolutely cheaper, as Luis and Andy have pointed out. They provide it for 87 percent of fee-for-service, on average. It is when you add the supplemental benefits the cost equation becomes different, and that, to me, is an apples to oranges thing.

So as we think about supplemental benefits going forward, I think we need to kind of separate that out a little bit. What's an apple, what's an orange, if you want

to put it that way. And also be mindful that the existence of supplemental benefits drives the efficiencies that we are all admiring in the MA program. MA plans, it's a market product, and in order to do well they have to offer the right level of supplemental benefits. That's what's created the efficiency for 87 percent.

So, you know, I would just be careful about sort of making external judgment calls about what's the right level of supplemental benefits, let's homogenize the supplemental benefits. I think each market is a little bit different, and I just want to make the point that they interact.

The final thing about supplemental benefits, I still found -- I found the previous discussion, but even in the new discussion, supplemental -- supplemented by the additional information, the table, a little judgmental about the nature of supplemental benefits. And I hope that we don't do that. I mean, in arraying the most common supplemental benefits, many of these look like Med Sup programs, right? They're attracted to beneficiaries. People vote with their feet when they join a plan. I'm not sure that -- I just found it just a tiny bit judgmental.

We don't see a lot of supplemental benefits around high-needs populations. The table didn't include SNFs, so that might be part of the reason, but even within the normal MA, the average plan that's available for a person, I'm not sure that we should be judging -- I mean, CMS approves every single one of these supplemental benefits. They're actuarially justified. They have to be reconciled. It's a tone thing more than anything. I think the information is useful.

And the final thing on supplemental benefits, I want to urge some patience on evaluating the success or failure of the new program on special supplemental benefits for chronically ill patients that was at the bottom of your table, and it seemed really small. That first became available in the program in 2020, and I can tell you a lot of plans are very excited about that. But there's a lot to try to figure out about identifying members who are eligible, how to make, you know, a food benefit work at a farmer's market in a low-income community that has never done anything like that before. It takes a little time, so I would just urge us to be patient and not judge that people are not doing things in that area just because we

don't see more on the table.

Thanks.

MS. KELLEY: I have Dana next.

DR. SAFRAN: Thank you. So I'll voice my strong support for the draft recommendation as written, and I really want to add compliments to the team. This chapter's really well done, so clear and so informative.

I have just a couple of comments and actually a couple of questions. The first question I have picks up a little bit on some of what I think Pat was going at with respect to the quality program impact and the impact of the recommendations here as opposed to the recommended change to the Stars program or to the quality program made previously.

Specifically as to these recommendations, have you done any thinking or modeling about what you expect the impact to be from decoupling the rebate percent from Stars? Because, you know, what I see in the market is plans absolutely working feverishly to achieve Stars scores of 4 or 5, and so that is the Stars reward. But some of it is certainly the extra rebate percentage that they get. And so I'm curious how you thought about that?

DR. JOHNSON: Just to clarify, is that if the rebate policy was changed from the current policy, from 50 to 70 percent based on Star rating, to a new policy that is 75 percent across the board, what would be the effect of just that change with no --

DR. SAFRAN: Yeah.

DR. JOHNSON: -- change to the 5 percent or 10 percent increase to the benchmark?

DR. SAFRAN: That's right, Andy. That was my question. How do you expect that to change motivation on working on Stars?

DR. JOHNSON: Luis, do you want to start?

MR. SERNA: Yes, I'll start with the financial portions. In terms of the average rebate right now, it's 65 or 66 percent, depending on the year. So this would increase it to 75 percent, and it's close to a 2 percent boost to overall payment.

As far as motivation, we haven't modeled specifically anything that would change regarding quality, bonus, or the desire to improve clinically on certain clinical measures. I don't think we would expect that to change, especially with quality bonuses being so high.

DR. SAFRAN: Okay. So I don't have data to confirm or dispute that. I would just suggest it's probably worth a mention in the chapter about the impact that we would or wouldn't expect this decoupling to have on plans' motivations around quality and specifically around Stars performance.

I did really like very much you're calling out on page 29 that the 75 percent rebate is equated to the highest shared savings possible in the Medicare Shared Savings Program. You know, I think we've talked quite a bit in the last several meetings about the value of trying to get more alignment across the APM program and then the MA program. So I just really liked that you made note of that.

And then the final thing that I had was understanding that with the 2 percent discount across the board that, you know, the way the math will work is that that means a higher percentage decrease for lower-spending quartiles. It did leave me wondering about those lowest-spending quartiles versus the highest-spending quartiles where the decrease in spending would be 1 percent. And, you know, they said I understand if we're doing a flat

discount and then that's just how the math works out. But I wondered if you considered at all the possibility of trying to equate using the current quartiles the percent decrease in spending and then setting the discount accordingly; that is, those who are currently in the first -- in a high-spending quartile would see a discount of, you know, X percent and on down the lines to, you know, Z percent for those in the lowest-spending quartile. I'm just curious whether you considered that, and if so, you know, what the thinking was around allowing kind of a different pain point for highest and lowest with that flat 2 percent.

MR. SERNA: Yeah, that's something we thought about. I think in the end we were trying to focus on the four main things that the Commission discussed, which was moving the lowest quartile still closer to fee-for-service spending. We thought it would just be more straightforward and it would align with that if we actually did 2 percent across the board after the local and national spending blend was in place. So that would also allow there to continue to be continuous scale of local fee-for-service spending; otherwise, you start to have the potential for

cliffs by market area.

DR. SAFRAN: I see that. Okay, yeah. Thank you. That's all I have.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks. So, Andy and Luis, great work. I'm very supportive of the work that you guys have done here. I also echo Pat's comment that the new information that you guys provide on supplemental benefits was really very, very helpful. And we'll probably have some overlap, although I'll try to differentiate a little bit in comments from the prior Commissioners.

So I think in some sense, you know, I most certainly appreciate and recognize the value of the supplemental benefits. They're clearly a critical part of the MA program, and as Pat highlighted, a critical part of perhaps even how the MA plan is generating its efficiencies on the Part A/Part B spend piece of it.

At the same time, I have to say as an economist I struggle with the idea that the way that we actually finance supplemental benefits, you know, whether it's economically efficient or not, I think an economist would say it's probably economically inefficient to do it this

way.

So recognizing also that we can't create big disruptions here, and you guys have put this already in the chapter and the slides and that's really important, I guess what I would say is I support the recommendations here for sure. I would also support the idea of pursuing work further as we kind of go into future cycles, future years of MedPAC work, and think a little bit more about how these supplemental benefits can best be not disrupted. We, you know, preserve the provision of these supplemental benefits, preserve beneficiary choice among them, but do it in an economically efficient way, if you will, you know, particularly given the evidence that you guys have cited around the premium piece, the cost piece, if you will, as being the chief decisionmaking factor for beneficiaries when they're selecting an MA plan.

So I think there's a lot of interesting work to be done here, but that being said, I definitely wanted to register my support for the work here and thank you guys for all the efforts.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Oh, thanks, Dana. Yeah, I

want to express my enthusiastic support for the recommendations and to praise the staff for this terrific chapter. It was really clear and thorough and really, really a great job.

This has been a great decade for MA as far as the increased efficiency and the subsequent large increases in enrollment. And I think some of the increased efficiency, at least with discussions I've had with people in the industry, may very well have been prodded by the ACA cuts in benchmarks as kind of getting the plans' attention about the need to improve their efficiency. And I think we're at the time when some of these enormous gains in efficiency should be directed -- some of them should be directed to taxpayers as well as to beneficiaries and plans.

So I just want to mention that I would be comfortable with discounts greater than the 2 percent. I know our recommendation says at least 2 percent, but I just wanted to mention I think a little higher, and I've learned over the years of being on MedPAC with Bruce, some of the dangerous inadvertent effects of overly large and generous transitions. So, frankly, I was a little surprised at the transition language in the chapter and just also mention

that I'd be comfortable with less in the way of transition.

Thanks.

MS. KELLEY: Bruce.

MR. PYENSON: Thank you, Dana. I wanted to add my compliments to Luis and Andy for the work on this in the chapter and amplify a couple of the statements that others have made looking forward to future work of the Commission.

Dana had mentioned the connection between this work and the ACO work or the APM work, and I think in the interest of harmonization, what we have here is a solid platform for future thinking and future work on how ACOs and other advanced payment methods, alternative payment methods, could be designed.

Paul had mentioned the issue of transitions and, of course, I agree with him and also agree with his comment that I'd be comfortable with a discount rate of more than 2 percent. Amol had mentioned -- sorry, I lost my train of thought. Amol, one of the points you had made I wanted to amplify, but I didn't take good enough notes. If you could reiterate your point?

DR. NAVATHE: My point was that the economic efficiency of the way we finance --

MR. PYENSON: Yeah, thank you. In my view, the supplemental benefits are connected with the impact of Medigap insurance on inflating the benchmark, the fee-for-service spending. So we have an odd system where beneficiaries are paying to buy Medigap and probably inducing costs through the lack of the -- taking away the cost sharing and the elasticity effects, that elevates the benchmarks, which then funds supplemental benefits. So I think for future work of the Commission to really look at the Medigap issue is part of, I think, thinking about how supplemental benefits are funded, and whether that's from an actuarial perspective or an economist perspective, I think we probably get to the same answer.

Thank you.

MS. KELLEY: Marge is our last commenter.

MS. MARJORIE GINSBURG: Yes, I just wanted to, first of all, like the rest of you, compliment the staff for a fabulous chapter and ability to pull all this complicated information together so clearly.

I mainly wanted to acknowledge Amol's comment about the benefits of supplemental benefits, which tied in also to Bruce's comment as well. And I think I may have

indicated this in the past that it worries me, it concerns me that the explosion, if you will, of new ways of using Medicare dollars to bring people into MA plans really I think requires us to sit back and study this in much greater depth than we have the opportunity to do now. And, Bruce, you comment reflecting on what's happening with Medigap plans and how all this I perceive as starting to be a little bit of a vicious cycle, which I'm not sure in the long run is really beneficial for the program altogether.

So my main comment is, yes, I am concerned about the growth of supplemental benefits, and I am concerned about the impact that Medigap plans are having on the growth of supplemental benefits.

So, anyway, I realize that's not tied completely to this chapter and this doesn't reflect the integrity of this chapter as it is, which I fully support, but rather a little bit looking towards the future of where we may be directing some of our interest.

Thank you.

DR. CHERNEW: Great. Dana, I think Marge was the last one in the queue, which is just perfect timing. The Commissioners are so well seasoned.

So first let me make a general statement for folks listening. I've gotten some messages occasionally from folks who think that MedPAC generally doesn't acknowledge the value of MA, and that nothing could be further from the truth. I think it's very clear that we're quite supportive of broadly the MA program and recognize the value in it. We're aware of the value of a range of these supplemental benefits, and many of the comments pointed out the core issue is how we finance it and how we use the Medicare Advantage program to finance those benefits.

So this is a step, I think, as many said, a first step, to begin to move us in that direction. And as others pointed out, there are many other topics, including the role of Medigap, that certainly will be thought of as we consider topics to move forward with. But for now I think it's time we moved to the vote, so, Dana -- is there any other -- let me pause for a second before we move to the vote.

[Pause.]

DR. CHERNEW: Okay. Dana.

MS. KELLEY: Okay. For the draft recommendation

that the Congress replace the current MA benchmark policy with a new policy, voting yes or no, Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Is Karen still here? I think we'll have Karen as not present. Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes, and I look forward to seeing additional language in the chapter. I know it's being worked on.

MS. KELLEY: And, Mike?

DR. CHERNEW: Yes. And, yes, it is, Pat.

So that concludes our Medicare Advantage discussion for this cycle, and as pointed out, it will not be our last Medicare Advantage cycle. So we're going to turn over to Alison and Jeff to discuss IME.

So, Alison, are you starting off?

MS. BINKOWSKI: Yes. Thanks, Mike.

I am excited to continue discussion the Commission's discussion of revising Medicare's indirect

medical education payments to better reflect teaching hospitals' costs. As a reminder, the audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

Today's presentation builds off work presented in September 2019, October 2020, and March 2021, with additional information and minor modifications in response to Commissioner comments, as summarized on page 1 of your mailing materials.

At the end of this presentation, we will present the draft recommendation for the Commissions' vote. This recommendation is one step towards improving Medicare's financing of graduate medical education and does not impede the development of broader reforms moving forward.

As a reminder, Medicare makes two types of additional payments to the roughly 1,100 IPPS teaching hospitals for the provision of graduate medical education. The first type is direct graduate medical education payments, which totaled nearly $4 billion in fiscal year 2019. These payments support teaching hospitals' direct costs of sponsoring residency programs, such as resident stipends and physician salaries, and are made outside of

Medicare's prospective payment systems.

The larger type is indirect medical education payments, which totaled over $10 billion. These IME payments support teaching hospitals' higher costs of inpatient care that are not otherwise accounted for in Medicare's inpatient prospective payment systems, such as additional patient care costs associated with teaching, and are implemented as a percentage adjustment to IPPS payments.

Together these medical education payments supported the training of about 90,000 residents, equivalent to about $150,000 per resident.

The Commission has raised concerns with Medicare's current inpatient-centric IME policy, including that Medicare currently overpays teaching hospitals for their indirect costs of medical education in inpatient settings and underpays for those costs in outpatient settings.

Based on these concerns, we identified principles for IME payment reform. First, IME policy should reflect the range of settings in which residents train. To do so, Medicare should make IME payments for both inpatient and

outpatient services, and base IME payment adjustments on hospitals' ratio of residents to patients across inpatient and outpatient settings.

Second, IME payments should better reflect teaching hospitals' additional costs in each setting, by transitioning to empirically justified payments. The transition should be constructed to minimize adverse effects on teaching hospitals, such as by maintaining aggregate IME payments budget neutral to current policy until such time that they match empirically justified levels.

Lastly, IME policy should support the care of both fee-for-service and MA beneficiaries and carve IME payments out of MA benchmarks.

Revising IME policy to address these concerns would change hospitals' incentives. Under current policy, which only provides IME payments for inpatient services and sets IME payments higher than teaching hospitals' additional costs, hospitals have a financial incentive to provide care in inpatient settings, even when those services could be safely provided in outpatient settings. In contrast, under a revised inpatient and outpatient IME

policy, teaching hospitals' added costs would be included in Medicare's payment regardless of setting.

The revised IME policy would therefore reduce teaching hospitals' financial incentives to maintain services, such as knee replacements, in inpatient settings, and make payments more equitable for hospitals that have shifted, or will shift, to providing more outpatient care.

For the purposes of illustration, we modeled a budget-neutral inpatient and outpatient IME policy consistent with the principles outlined in the prior slides.

As shown in the leftmost bar, under current policy, IME payments totaled $10.1 billion in fiscal year 2019, all of which were for inpatient care. As shown in the middle bar, under the illustrative empirically justified IME policy, aggregate IME payments would have decreased and shifted towards outpatient settings, with the share of IME payments for outpatient services increasing from 0 to nearly 50 percent, and inpatient capital IME payments being eliminated.

Finally, as shown in the rightmost bar, under the budget-neutral policy, these empirical payments were

proportionally scaled such that aggregate IME payments equaled those under current law but better reflected teaching hospitals' additional inpatient and outpatient costs.

As discussed in March, the budget-neutral inpatient and outpatient IME policy would result in a less than 1 percent change in most for most groups of teaching hospitals, in their total fee-for-service payments.

You asked for some more detail on how total fee-for-service payments would change for small hospitals and those with a high resident-to-bed ratio. In aggregate, these two groups would see an approximately 0.6 percent increase and a 0.5 percent decrease in their total fee-for-service payments, respectively. However, as shown in the last two columns of the table, there was significant variation within each group of hospitals, including more than one-quarter that would see a decrease and more than one quarter that would see an increase in their total fee-for-service payments.

While a budget-neutral inpatient and outpatient IME policy would result in a small change in total fee-for-service payments for most teaching hospitals and groups of

hospitals, it would shift IME payments towards hospitals with additional costs that are not accounted for under the current inpatient-centric policy. This includes teaching hospitals that provide a relatively high share of their care to Medicare beneficiaries in outpatient settings, as these hospitals would see relatively large gains in the set of IME-eligible services that IME adjustments would be applied to, and those that have an inpatient-and-outpatient measure of teaching intensity, i.e., resident-to-patient ratio, that is relatively high compared to the primary inpatient-capacity measure used in current policy, the resident-to-bed ratio, as these hospitals would see a smaller decrease in their inpatient IME adjustment percentage and have a larger outpatient IME adjustment.

Among the subset of hospitals for which IME fee-for-service payments constitute a large share of their total fee-for-service payments, these increases would result in substantive increases in their total fee-for-service payments.

In summary, current IME policy is outdated and does not reflect the contemporary range of settings in which hospitals train residents and treat patients, nor

teaching hospitals' additional costs in each setting. Transitioning to an empirically justified inpatient and outpatient IME policy would better reflect teaching hospitals' additional costs and could be done by maintaining aggregate IME payments initially equal to current policy.

Within the broad principles outlined in this presentation, having the Congress grant CMS flexibility on implementation through rulemaking would allow stakeholders to provide input, such as whether to waive beneficiary cost-sharing on outpatient IME payments, and would also allow CMS to update the policy over time, as warranted.

The revised IME policy discussed in this presentation is one step towards improving the financing of graduate medical education and does not impede the development of broader reforms moving forward. Consistent with MedPAC's 2010 recommendations, policymakers should continue to explore opportunities to address broader concerns with graduate medical education, including using Medicare's funding to support future workforce needs.

The draft recommendation reads:

The Congress should require CMS to transition to

empirically justified indirect medical education adjustments to both inpatient and outpatient Medicare payments.

As aggregate IME payments would initially be budget neutral, the revised IME policy would initially not affect Medicare spending. However, over time we anticipate the revised policy would facilitate the continued shift to outpatient care, which would eventually increase Medicare spending on IME relative to current law but decrease Medicare spending on inpatient services.

We do not anticipate the revised IME policy to affect Medicare beneficiaries' access to care or hospitals' willingness to treat Medicare beneficiaries. Depending on implementation, the addition of outpatient IME payments could cause slight increases in Medicare beneficiaries' Part B cost-sharing and premiums.

Lastly, the revised IME payments would be more equitable to teaching hospitals that have shifted, or will shift, to providing more resident training and care of Medicare beneficiaries in outpatient settings.

And with that, I turn it back to Mike.

DR. CHERNEW: Great, Alison. Thanks so much. We

are about to go through the queue, but I will say that the core of this recommendation is actually quite simple, about getting to empirically justified rates in a way that, we are hoping, that we have modeled, does not take money out of the system to start with. And so the core question here is, right now I think we believe that the inpatient rates are above what is empirically justified, and, of course, we don't get credit for outpatient, and then we could have outpatient rates that are therefore, in some sense, underpaid, and this in some ways balances that.

So there is a lot of flexibility, as Alison just discussed, but for now I think we should go through the queue and get folks' questions. So, Dana, I'm leaving it to you to run through the queue.

MS. KELLEY: Okay. Jon Perlin, did you say you had a clarifying question?

DR. PERLIN: I'm happy to go in the queue, either way.

MS. KELLEY: Okay. Then we'll start with Brian.

DR. DeBUSK: Thank you. First of all, I'd like to compliment the staff and my fellow Commissioners for raising this issue. As far as the draft recommendation, I

do completely support it as written. I think it is an excellent technical proposal. You know, as Michael just mentioned, I think, over time, even though the current system has an overpayment over the empirical levels, over time the outpatient procedures are simply chipping away at that. So I think there is a burning platform here for the technical fix in that I think it has to be rebalanced sooner rather than later. So I do like the elegance and the simplicity of the draft recommendation, and again, support it as written.

But this is also just a first step, from my perspective, and I want to first of all compliment the staff on including, in the chapter, the pages on the previous Commission recommendations, on pages 33 and 34. I am very grateful for that. I want to focus on that last bullet point, that talks about increasing shares from underrepresented rural, lower-income, and minority communities.

I'd like to point something out, and it varies based on how you measure it. But about 23 percent of Americans live in rural areas, and 4.3 percent of medical school students have rural backgrounds. And to make

matters worse, as many as half of those students that have rural backgrounds move to metropolitan areas while doing their residency or after completing the residency.

So just using those numbers, that suggests that we are undertraining rural physicians by a factor of 10 to 1. If you're losing half of 4.3 percent in a country that's 23 percent rural, that means we are not even coming close, proportionally, to replacing our rural physicians. This is a huge miss.

And when you consider us as a Commission and you think about, you know, what efforts really have an impact on beneficiaries, I mean, the supply of physicians, the physician pipeline itself, is arguably in our top three issues. Because when you imagine all these other things that we do and all of our other efforts, particularly our rural initiatives, if we don't have the physicians to realize these initiatives, I don't know that any of them have a hope for success.

So again, I want to compliment the staff and my Commissioners for taking on this issue. Excellent technical chapter. But to me this is really just a starting point to a much more substantial work around

making sure Medicare produces the correct geographic mix of physicians. Thank you.

MS. KELLEY: Okay. I have Larry next.

DR. CASALINO: Thanks, Dana. Alison, nice work, as always. Reading this chapter really carefully I realized I have a few questions that I want to pose.

The first point is I'm very concerned about unintended consequences of any policy recommendation we make, especially hospital acquisition of physician practices. Whether it's a good thing or a bad thing, who knows. But it's clear that Medicare, in the last decade, has made policy change after policy change that have had the unintended consequence of purchasing hospital acquisition of physician practices.

Now we discussed this a little bit at the last meeting, and I know you guys tried to, by saying that it would be the physician-to-patient ratio rather than the physician-to-inpatient bed ratio that would determine the payment, but how sure are we that that, in fact, would work, and can't be gained in such a way that would make it advantageous for hospitals to acquire physician practices in order to get higher IME payments? You guys seem pretty

sure about that, but I'm not sure all the Commissioners were last time, and I'm just asking for some reassurance again.

DR. STENSLAND: Yeah, this is Jeff. I think it's pretty clear that the resident-to-patient ratio would go down any time your outpatient revenue goes up. So I think that there isn't much of a question about that.

Now in terms of the other side of the equation that is going to be somewhat off-balancing, is going to be that the amount of money to which your IME adjustment is going to apply to would increase, say, if you purchased a practice, but I think those two are going to be largely offsetting effects. I don't think there is any question that the resident-to-patient ratio will go down when outpatient volume goes up due to acquisitions.

DR. CASALINO: Yeah, Jeff, I agree that there's no question about that. But there's also no question that the volume of services subject to having increased payments would go up as the number of outpatient services provided becomes counted. So what you just said, and I think the way we've all been thinking about it, is very qualitative. But it would be great to have some kind of modeling to

think about -- you know, it's like a see-saw, which side is going to run out. Because it's not necessarily clear to me that if the ratio changes, by using resident-to-patient, rather resident-to-inpatient beds, that will change, but so will the volume of outpatient services. And it is not obvious to me that one would necessarily be greater than the other.

So in any case, I am concerned about that. I have a few more questions, and I don't want to spend inordinate amounts of time on this, but I think it would be a shame, in my mind, if we had yet another unintended consequence that provides financial incentives to acquire physician practices that otherwise, you know, might not -- hospitals might not be interested in acquiring.

You know, the second question is, on Slide 6, if you could show it --

MS. KELLEY: We'll get there, Larry. It takes a minute. There it is.

DR. CASALINO: That's okay. Thank you. So the Commissioners had asked last time for more information about, you know, which hospitals might be most affected, especially adversely affected, and this is helpful. Thank

you. My question is, if we look at any one of these rows -- so, for example, you can see that hospitals with a high resident-to-bed ratio might lose in the 25th percentile, you know, might have a 1.6 percent change in the total fee-for-service payments. Those same hospitals that have a high resident-to-bed ratio might also be the ones with the highest share of low-income patients, so that is -0.4; urban, -0.3; and nonprofit, -0.3.

Now, if I understand the way this modeling is done, it would be incorrect to add 0.3 to 0.3, you know, 0.4, and 1.6, because there's probably overlap among those categories. But still, for any one of these percentages it would probably be higher. You know, there would be some additive effects, potentially, across the different categories. So the effect on certain hospitals could be greater than the effect on any individual row here.

DR. STENSLAND: This isn't the marginal effect. This is the aggregate effect on those hospitals. It's not saying that you get a little bit of an effect because you have a high resident-to-bed ratio and you get a little bit of an effect because you have low-income patients. You're saying what's the total effect of all the characteristics

of these high resident-to-bed ratio hospitals. We're just counting up hospitals and looking at the effects.

Alison might have some internet issues, but she would probably have a better answer.

MS. BINKOWSKI: Yeah, I have been having some internet issues, but thanks, Jeff, for jumping in.

So you are correct that there are hospitals in each of these rows below the 25th percentile and above the 75th, so to that extent, yes, there will be those that experience more and less, but they are not additive. These are the aggregate effects within each row. And maybe to go on what you're saying, it really depends on how inpatient-versus outpatient-centric these individual hospitals are.

So I think the takeaway from this slide is that none of the classic groups of teaching hospitals would consistently see decreases or increases from the revised policy.

DR. CASALINO: Thanks, Alison. Just in the interest of time I'll just go. On page 37 of the draft chapter, again you try to work on distributional effects, which I appreciate, and you compare hospitals A, B, and C to each other, that are different in various ways. But the

concluding part of that section says that Hospital C, you construct it to be exactly the same as Hospital A, except that it treats more patients, and the treating more patients would receive, the chapter says, a 7 percent drop in their IME patients.

So, first of all, is that correct, and secondly, why would we want a hospital that's identical to another hospital in all ways that you modeled to have a 7 percent drop in their IME payments because it treats more patients?

MS. BINKOWSKI: I'll try and be really quick, but basically it has lower teaching intensity, if you think that, you know, residents interacting with patients is one of the drivers of teaching hospitals' higher costs when they're treating more patients, they contracting with a smaller proportion of those patients.

DR. CASALINO: Yeah, so I understand how the math works, but just in principle, it seems strange that you'd be as centers and other hospitals, and because you treat more patients you have a big drop in your payments. I realize that that's a result of the formula of residents to patients, but it seems to me like an unintended, untoward consequence.

Again, Alison or Jeff, if you want to respond, go ahead; otherwise, I won't -- I'll go on to the next point just in the interest of time.

[No response.]

DR. CASALINO: Okay. Just an editorial comment for the chapter. Maybe just to emphasize that the overall recommendation, there has to be -- outpatient care needs to be included in the IME payments. That's number one. And, number two, we want to give CMS -- we want Congress to give CMS flexibility in how it does this.

And then just in the chapter, we provide some suggestions for how this might be done, because, you know, kind of understandably, I think, as the chapter -- if you just kind of read it now, you wouldn't necessarily notice the distinction between we really want to make the point -- two points, outpatient should be accounted for and Congress should give CMS flexibility. And then we have a bunch of suggestions, and my leaning based on those suggestions for how it might be done, but those suggestions are not recommendations necessarily. I think there may be some misunderstanding of that, so just an editorial comment.

Last, my last comment is -- and this is for other

Commissioners as well as staff. We do mention in the chapter that the modeling is done on the assumption that there will be no behavioral consequences in terms of the way hospitals act, and I'm just curious to know if there are behaviors that Commissioners or staff can think of that might generate unintended consequences, because, you know, there's a real danger of that within any policy, and I think that it's late in the game to bring this up, I realize, but it could deserve a little more thought.

DR. CHERNEW: Larry?

DR. CASALINO: Yeah, and I'm done, Michael, so go ahead.

DR. CHERNEW: Well, I understand. I was going to just respond to your main things briefly. The first point is I very much appreciate you pointing out that some of the details that we've been talking about aren't actually in the rec, and there's a lot of flexibility in the recommendation.

Secondly, I appreciate as always to be on the lookout for unintended consequences, and certainly that's broadly important, and it's clearly important here. I have no dispute about that.

The third thing I'll say relative to what you said is there's some language about only getting payments in sites where residents are seeing patients. So certain types of acquisitions you might be worried about wouldn't really affect it in the way that it's playing out. You couldn't just go buy a practice and not doing any training and then change the way in which the payments would work. That doesn't necessarily fix everything completely, and I think your point is true. I think as someone who's worried a lot about and does the work on consolidation, I think there's many, many, many, many reasons why there's consolidation in the health care space. And so I don't take that concern lightly. But I think there's some aspects of this in terms of the flexibility, in terms of some of the limits on it. I am hopeful to mute some of that concern.

That was a quick debate, and we have a quick point and a long queue. So I hope that gives you some comfort. I see a small Larry smile, but --

DR. CASALINO: It was a big smile.

DR. CHERNEW: A big Larry smile. But maybe --

DR. CASALINO: I don't have that much comfort.

DR. CHERNEW: We'll go on to the next comments.

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

DR. PAUL GINSBURG: Sure. You know, this is very excellent work. It was very responsive to our March discussion. My question is more of a clarifying question, and, you know, focusing on the situation where, you know, say in family practice or in dermatology, there's training going on now in an outpatient setting, and some of it probably going on outside of the hospital, you know, at FQHCs, at independent physician practices. And the question is: Could hospitals under our proposal, A, you know, use the money that they're coming through to support outpatient training in these non-hospital sites? That would kind of get into the issue that Larry brought up about incentives to acquire practices. And, also -- and I'm thinking that for this to really work, you would have to somehow count the number of patients that the residents are seeing in these non-hospital settings in order to make it work. So since the real question is, you know, could -- within the flexibility provided under this recommendation, could CMS in their wisdom get it to come out this way so that there was not, you know, really a favoring of

hospital-owned outpatient facilities over other outpatient facilities that the residency program may have chosen to participate?

DR. STENSLAND: That sounds pretty administratively complex to me. You would basically be -- you know, the hospital is going to be getting some amount of money for the outpatient services that are provided in all its outpatient facilities, and then you would basically be saying we would -- where the residents go, CMS would also consider that in essence under their teaching umbrella, and those slots would also get some extra payment, though it would be sent directly to those groups or funneled through the hospital and not land with the hospital.

It would be a little administratively tricky, and it would also create some problems with the whole methodology where we try to make it empirically justified, because we're trying to run those regressions to try to see how much extra cost do they have on an outpatient basis for the different services. And then if we were shifting it to somewhere else, especially if we don't really have costs on those entities, it would be difficult.

I think this is all easier on the direct graduate medical education payments, if you say, you know, the person is spending a certain amount of their time there and the hospital has them on their books and they'll cover their salary when they're at somewhere else and they're getting part of that money from Medicare.

On the indirect side, I think it just gets much more complex.

DR. PAUL GINSBURG: Yeah, thanks, Jeff. You know, I think it's something that would be -- you know, I think a goal that I would have would be to find some way that, you know, there could be support for the pieces, parts of the residency program that uses non-hospital outpatient facilities because really, you know, we don't want -- you know, the broad goal was to have the money be more reflective of where the care is, where the training is going on or should go on. But then, you know, this other wrinkle that Larry brought up about, you know, we don't inadvertently put an incentive for the hospitals to acquire even more physician practices, and I've actually been under the impression that, you know, some of these non-hospital practices are already used today just under the inpatient

indirect adjustment of, you know, that's the places they can get, fine, to actually train the residents in these outpatient services if they don't have suitable hospital outpatient services to do that. You know, they can use their money to do that if they want to.

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

MS. WANG: Yeah, just real quickly, I think it's a really important question that Paul and Larry have put on the table. I just want to -- I guess that I'm -- so today training occurs in non-hospital settings when, you know, certain requirements are met. You know, the hospital incurs certain costs or they have a written agreement with the FQHC, and how that gets counted towards the IME payment is that they get to count the resident time. So right today, Jeff, it's interns and residents to bed, so your numerator, if you will, is very important. You want a whole person there.

Today people are spending time off campus, and it's driven more by, you know, residency review committee requirements, I think, than payment. I don't see why it would be different under this, or would it be different?

Because if the resident time is still being counted off-site, they would still count towards the OPPS services that are paid. Am I thinking about that right?

MS. BINKOWSKI: Yes, that is correct, Pat. The numerator counts residents in any part of the hospital setting, including these off-sites as well as certain non-patient care activities, and the way residents are counted would not change under this policy.

MS. WANG: Right. So I think Paul did -- if it doesn't change, I think that might address the question that you're -- the important question that you're raising. But maybe I'm wrong. I don't know. I'm looking at Alison and Jeff, just trying to think it through.

MS. BINKOWSKI: Yeah, in interest of time, I want to make sure we move forward, but I think hospitals will continue to maintain flexibility in how they want to use their IME dollars and GME dollars to fund various aspects of their program. I thought maybe what you were talking about was adding different adjustments to other FQHC or other payment systems, and I think that is what would be future areas that we could consider.

DR. CHERNEW: We are going to need to move on.

Are you set, Pat?

MS. KELLEY: Okay. Then I have Betty next.

DR. RAMBUR: Thank you very much. Thank you for your hard work on this chapter, and I appreciate the comments from the Commissioners. I just have two main points that I want to make.

One is that I'm still a bit snagged on the issue of cost and the return -- or the revenue that residents generate as well as reduction of labor costs. And I'm not sure that's -- that doesn't impede this right now, but I'm still not fully clear on that. Maybe that's something that could be looked at more clearly in the future.

On the broader point, I just wanted to mention my perspective on this that I think I shared with some of you that this is actually an enormous subsidy to educate a particular type of provider in a particular type of setting and, as Brian has pointed out, particularly urban. So I see this recommendation going forward from the Commission as a really important first step towards better aligning societal need with education of residents.

But the policies were developed initially in a physician-centered, hospital-centered world that no longer

exists, and, in fact, some of the providers that are delivering increasingly more primary care did not even exist at some of these times that policies were initiated.

So I know that that's obviously worked out beyond this cycle, but I think the recommendation on page 34 that the analysis that the Secretary look at based on workforce requirements, health care delivery systems that provide high-quality, high-value and affordable care, I think that that's very important. But it also seems to me that there are important pieces of that that would be under the auspices of recommendations this committee could make in the future.

So good first steps, but a lot of work to do to better align these monies with societal need and the evolution of health care. Thank you.

MS. KELLEY: Bruce.

MR. PYENSON: I agree very much with Betty's comment on future work. I have a question and then a comment.

My question for Alison and Jeff relates to the bar chart that shows the current payments and empirically justified, and I understand that the goal is to maintain

the current payments until the empirically justified exceeds the current payment. And the comment, the analysis, is that -- and, apparently, that's not going to happen in the next one year or the next five years. But to go from 7.3 to 10.1 is something like a 40 percent increase.

Do you have an estimate for how many years it would take for the empirically justified to exceed the current policy?

MS. BINKOWSKI: We do not have a specific estimate. We have looked at modeling different assumptions, and it depends on whether you think that the relative faster growth in outpatient services will continue to accelerate or abate some. So I have not put a specific time frame on it. [Inaudible].

MR. PYENSON: But, for example, what are -- a 5 percent per year trend would take a long time.

MS. BINKOWSKI: And outpatient has been growing faster than that.

MR. PYENSON: Okay. Or at a 10 percent -- I'm wondering what parameters you're thinking of for that.

MS. BINKOWSKI: Jeff?

DR. STENSLAND: Yeah, why don't -- if you want to talk about specific parameters, why don't we just send you a little example on how long it will take. It will probably take quite a few years before this happens. You know, we're definitely talking well more than five, but not infinite.

MR. PYENSON: Okay. It's a fairly large range. Thank you, Jeff and Alison. My comment, I agree with Betty and Brian and others that this is a platform for important future work, and I wanted to identify one aspect of that that I think we might want to take on more quickly, which is that since we have a segment of money that's attributed to Medicare Advantage, that we think about having Medicare Advantage play a role in the training of future doctors. That has the advantage of an alignment of interests with primary care, which is really fundamental to many Medicare Advantage plans and to have a -- reflect, as Betty said, a world that's different today and is pretty soon going to be half of Medicare's beneficiaries. So for future work, I would look for some change that would move the money into programs that Medicare Advantage could somehow direct or take responsibility for, and maybe that's not just a

Medicare Advantage topic but a CMMI topic as well.

Thank you.

MS. KELLEY: Pat.

MS. WANG: I'm sorry. Did you say my name? I couldn't --

MS. KELLEY: Yes, I'm sorry. It's your turn, Pat.

MS. WANG: Oh, thank you. Thank you. I appreciate it.

The table that Larry pointed out on Slide 6, which is the impact analysis by categories, page 27 of the chapter gives that in more detail. And while the aggregate numbers, folks can kind of say it's, you know, more or less there, I am kind of concerned about impacts, you know, at the tails of that distribution, particularly for hospitals serving the highest proportion of low-income patients, as well as hospitals with the highest resident-to-bed ratios, like at the 5th percentile there are hospitals that are going to have pretty big hits in total fee-for-service payments.

For something like this, given Medicare margins, I think we need to signal something in the paper. You

know, you've mentioned it, about additional things that CMS could do, but if anything I would like to stress that, because, in particular, for hospitals that are treating a lot of vulnerable patients, like this is their workforce, and this is their future workforce, the residents that they train are more likely to stay there and provide care. It's like the meaning of life. It's like their blood. Wayne would be able to address this more.

And so there is a lot at stake here, and so don't think that the aggregate numbers, the aggregate intent is really telling the whole story, so I guess I'd like to see some more attention paid to the importance of trying to figure out how to get that right.

To Larry's question about unintended consequences, I'll raise one that you could think is good or bad. Based on my understanding of where residents train, it's really less about following money and following the requirements of residency review committees. That's what drives this, and where the money comes through is almost a disconnected source.

The one thing that I do want to note, though, is shifting to outpatient takes the financial pressure off of

having an inpatient admission in order to collect your IME. Spreading that to an outpatient setting, an observation unit -- you know, I'm not going to admit this person, I'm going to lean towards putting them in an observation unit -- today you do that, you're out your IME. I mean, hospitals deal with this, but one of the benefits, unintended consequences, I can see from this is it kind of spreads the payment mechanism with money that gets calculated by these formulas, and I think anything that kind of takes a little pressure off of decision to admit or pressure to admit, then pressure to like just count those inpatient admissions is a good thing.

You know, I'm sure you're aware that in the Medicare Advantage world, if somebody gets admitted and that admission is later found to not be medically necessary and it is downgraded or reversed, the IME payment still gets made to the hospital.

So, on the plus side, it's appropriate because people were spending resources. On the negative side, there's no strong incentive for a hospital to figure out alternatives to admission in a situation like that. It creates a strange incentive. So I see an unintended

consequence of this that I think could be beneficial to spread the mechanism for payment to more settings than just inpatient.

The final thing I want to say is that on page 33, I feel very strongly that this should not be borne by Part B and be reflected ultimately in people's Part B premiums. I know it's not quite a precise but it feels sort of like the equivalent of regressive taxation. Part A is a general taxpayer program. It's supporting IME today. It's mentioned in here, and I really appreciate it. I'd love us to put more of a thumb on the scale there, to say that Part A should continue to pay for this, because I really would hate to see a proposal like this ripple through to Part B premiums. You know, training of the nation's physicians is a benefit that is enjoyed by everybody in the nation, not just Medicare beneficiaries who, you know, pay Part B premiums, and I think it should be borne through a broader base of taxation. Thanks.

MS. KELLEY: Jon Perlin.

DR. PERLIN: I realize the time is getting short so I will be very brief. First I have three questions, and the first are kind of linked. At the point where empirical

justification crosses budget neutrality, I wonder if the effects are functionally or effectively the same under different categories of hospitals. I'm reflecting the concerns, the questions that were raised about the way the differences stack in an urban, teaching, safety net hospital as an example.

With that in mind, my second question is that on Slides 2 and 3 we go to pains to say that we want this to reflect the settings that reflect empirical costs maintaining budget neutrality. But our draft recommendation is much more terse than that and doesn't offer that guidance. And, you know, I wonder about that discrepancy. In other words, I think we should stipulate that very clearly.

And the third is something I may not have fully appreciate until this discussion, but in thinking about the broader incentive to move to higher level forms of value-based payment, alternative payment models, in terms of thinking about driving to outpatient, if you were a health system hospital hosting a teaching program, and you really wanted to do that, you actually would want to engage, perhaps even acquire -- now, I realize the avarice is the

consolidation, but the reality is you need to create that system-ness, that network to be able to do that. And would that not create some complexity in terms of bidding against ourselves?

So thanks.

MS. KELLEY: I have Wayne next.

DR. RILEY: Yes, thank you. Mr. Chairman and Commissioners, you know, I have spent most of my academic career in training in Houston, Texas, in a safety net public hospital, overseeing a storied one in Nashville, Tennessee, and now here I am in New York, with a very large GME program of 1,300 residents. And I can tell you, throughout my whole career, I have never made a decision, or have I ever seen a decision made about resident slots based on GME funding. And as Pat just mentioned, the biggest headwind we have all had as medical educators, to put more residents in outpatient settings, is the residency review committees and the ACGME very strict guidelines.

So again, I just want to make sure Commissioners know, we don't make decisions based on Medicare not sending residents into outpatient settings. It's really more complex than that, from a pedagogic point of view.

You know, I'm mindful of the fact, you know, the hay is out of the barn, if you will, on empirical justification, because there is intellectual empiric support for it. But as Jeff said, this is going to be five to ten years that, as a Commission, we need to make sure, and I harken back to Larry and Pat, unintended consequences that could have a deleterious effect on physician supply. And Brian raised the whole issue of rural. Brian, we face the same thing here in central Brooklyn. You know, it's tough recruiting doctors into heavily minority, dual-eligible, low-income, working class populations, very similar to rural, in some respects.

So again, I understand the empiric justification thrust, but as a Commission I would implore us to make sure, as Jeff mentioned, that over the next five to ten -- it is not five to infinity, it's five to ten years -- we should, you know, think about this. And I understand, Chairman, that we are not likely to return to IME in the next two years as a discussion topic, but at some point a commission will have to delve down deep and make sure that some of these unintended consequences that we have all heard about have not come to pass.

DR. CHERNEW: So I think Larry has a comment, but I will say, Wayne, first, thank you very much for your comments, and having someone with your experience on the Commission is really valuable, and I appreciate the comments you've given offline as well. So I'm really grateful for your contribution.

I will say that the general sense that I have, and if you look through the chapter I think it's pretty well justified, that the payment rates right now are quite above empirically justified, and if we took standard MedPAC approach of going right to empirically justified rates, we would be taking a lot of money out of the system and we would be having a discussion right now about the consequences of that, that I think would be quite concerning. So in many ways I view this as more timid, although I know, having talked to all of you, that point might not be universally shared.

The other thing I will say, which Brian said in the very beginning, as care moves to outpatient we need to think about how to balance that platform, which this tries to get the flexibility to do. In fact, I will add, over all of the long run, this will likely put more money in the

system than if we just stop with the status quo, because of the relative growth in outpatient, for example.

So that's sort of where we're going, and I very much appreciate your concerns, and a whole slew of unintended consequences, ranging from Larry's comment -- I think he was second to your comment now -- and I hope that as we go to the chapter that becomes clear, and we engage with both staff and CMS that becomes clear. But I do appreciate that notion and I just want to say, our goal here is not to pull money away from the organizations that are training our nation's physicians. I think that's clear. And so we are trying to slowly get to empirically justified, which I think generally is where we go across all of our payment models and do that in a way that minimizes the consequences in some of the places that we think about. But the recommendation is, I think, as Larry pointed out in his second-to-last comment, is more flexible to allow those things to be taken into consideration.

I know Larry has a comment. Jim, do you want to add anything before Larry says something? That's a no.

Larry, I think you had a final comment before we get to the vote.

DR. CASALINO: Yeah, just extremely quickly, but I think this is worth bringing up because otherwise I think the public may not realize it. So there wasn't really room for this on the slides, and at the moment the public doesn't have access to the chapter. It's kind of buried here, but on page 32, this is for people who are concerned that certain hospitals, for example, hospitals that take care of a lot of low-SES people, are really going to get hurt. And so we do make a comment on page 32, where we say, in addition, while we revised policy, blah-blah-blah, for a majority of hospitals a phase-in could be implemented for the subset of hospitals that would see more substantial changes. And I'm not going to go on and read it, but then the chapter suggests several ways that this phase-in could happen, or other ways that hospitals that really get hit hard by this, and that we might not want to see hit hard, for whatever reasons, could be given some, let's just say, special treatment.

So I just want to make the point that the chapter does not disregard that concern, and we actually did make some suggestions for how it might be dealt with, and that's in there, and people will see it in June.

DR. CHERNEW: Thank you, Larry. And let me just add one more thing. This is not the only policy level we have to support certain types of hospitals. In dealing with issues of disparities and inequities and a range of issues that are very important to me, and providers that serve some of those populations, figuring out how to support them is very high on the list of things that I worry about. It's not clear that you want to support organizations always with above empirically justified rates for a various particular type of service.

And so showing the transition, and the point that you raised, Larry, is important, but I think understand there's a lot of levers to support different types of organizations doing different things, and we are going to have to continue to think through that, and it's not simply going to show up in a chapter related to IME. This will be a general concern we have about access to care in populations that are very important, to make sure that they have adequate supply of physicians. That is more than just rural. Rural is certainly one important area, but there are a range of other types of area that we are concerned about. And when I think about this I think about it much

more broadly than just the IME chapter.

So, I'm going to pause for a second and see if anyone else wants to say something. We are a bit over time.

Okay. We'll go to Dana to take us through the vote. Dana?

MS. KELLEY: Okay, on the recommendation that Congress should require CMS to transition to empirically justified IME adjustments, both inpatient and outpatient Medicare payments. Voting yes or no. Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Karen DeSalvo, are you back with us?

DR. DeSALVO: I am. Yes on the vote.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: I'm going to abstain.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne? Wayne?

DR. RILEY: I'm sorry. I abstain.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: And Dana Safran is not present.

DR. CHERNEW: Great. All right. Thanks, everybody. I appreciate your comments and your efforts on

this chapter.

I think we are now going to move on to our chapter on Medicare vaccine coverage, so I think I'm turning it over to Nancy, Nancy Ray.

MS. RAY: Yes. Thank you. Good afternoon. The audience can download a PDF version of the slides on the righthand side of the screen.

Today we are going to continue our discussion from the September, January, and March meetings about policies that would improve Medicare coverage and payment for preventive vaccines. During the March meeting, there was good consensus among Commissioners for the draft recommendation. The revised chapter that we sent you addresses items raised by Commissioners during the March meeting, including updating the section on vaccine hesitancy as well as comments from the September and January meetings. The goal for today's session will be to solicit feedback on the Chair's final draft recommendation for you to vote on and publication of this work in the June 2021 report. Today's presentation is an abbreviated version of what Kim and I presented at the March meeting.

Medicare's coverage of vaccines and

administration of the vaccines is split between Part B and D. Part B covers preventive vaccines that are specifically named in the statute, that is flu, pneumococcal, hepatitis B, and COVID-19. Part D covers all commercially available preventive vaccines not covered by Part B. Shingles accounts for the vast majority of Part D vaccine doses.

With the exception of COVID-19, Part B preventive vaccines are paid according to the product's average wholesale price or reasonable cost, which Kim will talk more about shortly. Part D payment is based on the plan's negotiated rate. Part B-covered preventive vaccines and the vaccines' administration are not subject to cost-sharing. By contrast, Part D plans are permitted to charge cost-sharing for vaccines and the associated administration. These amounts vary by plan and benefit phase.

Part B vaccines are administered in a variety of settings. Mass immunizers such as pharmacies and physician offices are the most common sites, but other providers listed on this slide also bill. By contrast, Part D vaccines are mostly administered in pharmacies.

In June 2007, the Commission recommended that all

Medicare vaccine coverage be moved to Part B. One of the factors motivating that recommendation were concerns that physicians would have difficulty billing Part D plans and concerns that patients would have to pay for vaccines up front and seek reimbursement from plans afterwards, potentially deterring access.

Since then steps have been taken to lessen these billing issues under Part D. However, there continues to be strong rationale for moving coverage to Part B.

Moving all vaccine coverage to Part B would promote wider access to vaccines. More beneficiaries have Part B coverage than Part D coverage. Part B vaccines are administered in a wider variety of settings than Part D vaccines.

It may also be less confusing to beneficiaries and providers to have all vaccine coverage under one part instead of split across Parts B and D.

No Part B cost sharing for preventive vaccines and the vaccine's administration would ensure cost is not an access barrier for beneficiaries.

Kim will now discuss payment issues with you.

MS. NEUMAN: When Part B pays for a preventive

vaccine, in most cases it pays a rate of 95 percent of the average wholesale price, except for certain providers like hospitals that are paid reasonable cost.

Note that when the federal government directly purchases a vaccine like for COVID-19, Medicare does not pay for the vaccine, just an administration fee.

There is concern about Medicare Part B's payment method for preventive vaccines. AWP is akin to a sticker price and does not reflect market prices.

Moving to payment based on wholesale acquisition cost, or WAC, or average sales price, referred to as "ASP," would improve Medicare Part B payment for preventive vaccines.

Paying for Part B vaccines at a rate of 103 percent of WAC would moderately reduce payment rates to a level that should be accessible to all providers.

Although WAC is a better measure of drug prices than AWP, it does not reflect discounts or rebates. Ultimately a payment rate based on ASP might be most appropriate, as it would reflect the average actual market price.

However, it would be helpful to have more data

before considering an ASP-based payment for several reasons: With vaccines, there is uncertainty about how the two-quarter lag in ASP data would affect Medicare payment rates, especially given the seasonality of the influenza vaccine.

Because ASP is an average, we do not know how much vaccines acquisition prices vary across providers. Understanding that price variation could help inform whether 106 percent of ASP or an alternate add-on to ASP would be appropriate.

So this brings us to the draft recommendation. It reads: The Congress should: cover all appropriate preventive vaccines and their administration under Part B instead of Part D without cost-sharing; and modify Medicare's payment rate for Part B-covered preventive vaccines to be 103 percent of wholesale acquisition cost, and require vaccine manufacturers to report average sales price data to CMS for analysis.

The first part of the draft recommendation is intended to improve access to preventive vaccines by moving all coverage to Part B and eliminating cost sharing. This is similar to the Commission's 2007 recommendation, except

that the 2007 recommendation did not address cost sharing.

The second part of the draft recommendation is intended to improve payment accuracy for Part B vaccines by immediately modifying the payment rate to 103 percent of WAC and creating the knowledge base to consider an ASP-based payment rate in the future.

The implications of the draft recommendation are: In terms of spending, it is expected to increase Medicare program spending overall by between $250 million and $750 million over one year and between $1 billion and $5 billion over five years.

Underlying this overall effect are a couple dynamics. On the one hand, by moving vaccines from Part D to B and eliminating cost sharing, the draft recommendation would increase Medicare spending. On the other hand, by paying for vaccines based on 103 percent of WAC instead of a higher rate, the draft recommendation would reduce Medicare program spending.

In terms of implications for beneficiaries and providers, we expect that this policy would improve beneficiary access to vaccines because more beneficiaries have coverage under B than D and because beneficiaries

would face no cost sharing for vaccines under B.

In terms of providers, covering all appropriate preventive vaccines under Part B would facilitate the administration of vaccines by a wide variety of providers. We do not expect the draft recommendation to adversely affect providers' willingness or ability to furnish vaccines.

So that brings us back to the end of the presentation, and we turn it back to Mike.

DR. CHERNEW: Great. Thank you. Obviously, there is not a year in MedPAC where vaccines are more important. That said, Dana, I'm going to turn it to you to go through the queue.

MS. KELLEY: All right. I have Jonathan Jaffery first.

DR. JAFFERY: Thank you, and thanks, Kim and Nancy. This is a great chapter. I want to start off by saying I'm supportive, fully supportive of the draft recommendations. Like Mike just said, vaccines are pretty heavy on all our minds right now, including, I think, issues around equity, and we address some of that in the chapter through hesitancy discussions and things like that.

But my question is actually, as I was reading the chapter, I started to think about some of the barriers we have and obstacles to understanding some of that equity due to maybe some lack of data, or at least that's my perception, and I wonder if you know how many states have vaccine registries. And I guess depending on the answer to that, it might help policymakers think through different types of approaches to ultimately try and get better data here nationwide and then ultimately try and address -- maybe through some other process sort of beyond the scope of this chapter's work, but for the future, how to address some of those equity and hesitancy -- some of the equity issues.

MS. RAY: I don't have an answer for that. That's a good question. Kim?

DR. JAFFERY: Okay. Thanks.

MS. NEUMAN: No, I don't either.

DR. JAFFERY: Thanks.

MS. KELLEY: Bruce?

MR. PYENSON: Kim and Nancy, thank you very much for terrific work. I wonder if you could discuss for a little bit why -- what the challenge would be to moving

directly to an ASP basis and whether -- that's one question. And second is whether we should put something about -- rather than -- in the second bullet, rather than report average sales price to CMS for analysis, say something like report average sales price to CMS for implementation.

MS. NEUMAN: So the paper includes a discussion of some of the issues that could use some additional information in terms of thinking about what the implications would be of moving to an ASP-based payment. And these are -- particularly the first issue that I'll mention is a particular issue related to vaccines. And so it has to do with the lag in the ASP payment rate, so the way ASP payment rates work is that data for the first quarter of the year is used to set the payment rate for the third quarter of the year. There is a two-quarter lag in the payment rates. And with vaccines, there's seasonality that occurs, for example, with the influenza vaccine. And so there's a question of how that seasonality would play out, for example, given this lag.

And so if CMS obtained ASP data, they could look at whether they see variance in ASP as a result of this

seasonality, that one would possibly want to take into account if they were thinking about setting an ASP-based payment amount.

MR. PYENSON: Okay. Thank you. And maybe the second part of that is a comment rather than a question. I would like to see in the draft recommendation, rather than ASP price data being used for analysis, being used for payment. So the issue of seasonality is important, but that ASP is less than WAC, and it works for lots of Part B drugs. So I think the goal or the intent -- and I think this is the intent we have -- is that eventually vaccines would be moved to an ASP basis.

DR. CHERNEW: Bruce?

MR. PYENSON: Mike?

DR. CHERNEW: Yeah, so I appreciate your perspective. We haven't done a lot of the analysis yet to figure out where we're going, so we're simply not in a position where we're going to change, based on where the chapter is, how the recommendation goes, if that's what you're discussing. I think certainly getting the data will allow us and future people to understand what should happen, but we're not -- you know, without that data, we

haven't yet done the analysis to make a recommendation based on that. So the recommendation is as the recommendation is, I suppose. I appreciate your comment and will think through the wording around that in the chapter. I do think the discussion there is valuable. But that's where we are.

MR. PYENSON: Thank you.

DR. PAUL GINSBURG: Yeah, if I could get in here, I was thinking that it seems strange the recommendation just say "should require to report" without giving any inkling if this is really for, you know, MedPAC and CMS and the Congress to contemplate, you know, using ASC in the future. So we're not going to commit ourselves to, but in a sense, that's the reason we want the data, to see if it could actually be employed to work in this.

You know, maybe it doesn't have to be the wording of the recommendation, but the script with the analysis below it to say, you know, that's what it's for; you know, we don't know if it's going to work, but we'd like to collect the data so we could find out.

DR. CHERNEW: And I think the chapter was meant to imply that. We'll have to look back and see the extent

to which that's actually true. But that was certainly intended to be the tone in the discussion. Again, I'll turn it to Nancy and Kim on that, but I think that should be -- I wish I could remember, there's so many chapters. I believe it's explicit. It's certainly implicit. But, Kim or Nancy, do you have any comments?

MS. RAY: We will make sure that that rings out.

MS. KELLEY: I think Jaewon had a comment.

DR. RYU: Yeah, and this is a really minor point, and let me start by saying I also agree with the draft recommendation. A minor point also related to, you know, what is explicit or maybe not so explicit in the chapter. But you referenced the implications, the spending implications, as a result of the recommendations. It's a net -- anticipated to be a net increase in program spending. And part of that is the cost-share dynamic; part of that is, you know, offset partially with the 103 percent WAC instead of the current approach.

I don't think it's modelable, but I think it is worth a mention in the chapter perhaps, that there is -- you know, if you believe in the vaccine, there should be an offset of some sort in the cost of care, and I think it's

worth mentioning without, you know, trying to model something that may be very difficult, if not impossible to model, but just the mention of it I think is worth considering.

DR. CHERNEW: Jon? Well, you're in the queue, so, Dana?

MS. KELLEY: Our queue is now -- oh, no, I'm sorry. Jon Perlin has jumped into --

DR. CHERNEW: There you go.

DR. PERLIN: This is a really tough one, but I want to agree with Jaewon, because I wondered the same thing about the offset. Do we or do we not believe in preventive care based on the science? I know when I was leading VA it was difficult because, you know, everything was scored on a one-year return in terms of the ROI, but actually we published at VA the ASP, and this is correlative, not causal, to be sure, but as the rates of immunization increased, the rates of hospitalization for community-acquired pneumonia and the like decreased. So there's precedent on that.

This is one of the areas where, you know, taking the longer view is complex in terms of mathematics and

modeling, but would be very consistent with the fundamental science, and there are incidental examples that demonstrate some covariants. Thanks.

MS. KELLEY: I believe that is the end of the queue, Mike.

DR. CHERNEW: Perfect, and we are now back exactly right on time. So I think, Dana, if we could go through the roll call for the vote.

MS. KELLEY: Okay. On the recommendation that preventive vaccines should be covered under Part B instead of Part D without beneficiary cost sharing and to modify Medicare's payment rate for Part B-covered vaccines, voting yes or no, Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: And Dana Safran is not present.

DR. CHERNEW: Okay. So that brings us to our last chapter for the day, which is on the OPPS system for separately payable drugs, and for this, I am turning it over to Dan. Dan?

DR. ZABINSKI: Yes, good afternoon. Okay. To start for the broader audience, PDF versions of the slides for this presentation are available on the Webinar control panel on the right side of your screen.

At the March 2021 meeting, we discussed the system of drug payment in the hospital outpatient prospective payment system, or OPPS, and how that system could be improved and included two draft recommendations.

In response to Commissioners' comments, we have updated our analysis, and now your paper includes a schematic of how drug payment policy would work if our draft recommendations are implemented and also a discussion of how to effectively price new biosimilars which includes use of consolidated billing from a June 2017 recommendation.

Also, we anticipate doing more analysis on drug payment in fee-for-service Medicare overall, and nothing

we're recommending today precludes us from recommending further changes to Medicare drug payment policies.

Finally, like to thank Kim Neuman and Nancy Ray for their guidance and assistance.

Under the OPPS, many covered drugs are ancillary supplies to primary services, but other drugs are not ancillary and are the reason that patients go to a hospital outpatient department for a visit.

In general, these drugs that are the reason for a visit are those in which the only services provided with the drug is the drug administration. All other drugs are supplies to a service.

Under the OPPS, most, but not all, drugs that are supplies to a service have costs that are packaged into the payment rate of the related service. Also, most, but not all, drugs that are the reason for a visit are paid separately from any related service.

The importance of these separately payable drugs in the OPPS has increased, as program spending on these drugs rose rapidly from $5.1 billion in 2011 to $14.8 billion in 2019.

The OPPS has two policies for separately payable

drugs. One is the pass-through policy, and the other is the policy for separately payable non-pass-through drugs.

These two policies have different criteria for eligibility. For a drug to be eligible for pass-through payments it must be new to the market and have a cost that exceeds three thresholds that are related to the payment rate of the applicable primary service. And drugs can have pass-through status for a limited time of two to three years.

The Congress created the pass-through policy because cost and use data for new drugs are not available to accurately reflect their costs in the payment rates for the related primary service. And the purpose of the pass-through policy is to provide adequate separate payment and encourage the use of new drugs while the necessary cost and use data are collected.

For a drug to be eligible for the separately payable non-pass-through policy, it must not be a pass-through drug because this program is for established drugs, not new drugs; and it must have a cost per day that exceeds a threshold, which is set at $130 for 2021, but CMS updates that threshold for drug price inflation each year.

CMS has established that drugs that are supplies cannot be separately payable non-pass-through drugs, so this policy includes only drugs that are the reason for a visit.

Finally, there is no specified time limit for these drugs to have this status.

And we also have concerns about the setup of these policies. One concern is that both the pass-through and the SPNPT policies include drugs that are the reason for a visit. A small issue is that this makes administration of the OPPS system of drug payment more complex than it needs to be. And a more substantive issue is that for hospitals that obtain their drugs through the 340B drug pricing program, there is financial advantage to using some pass-through drugs rather than similar SPNPT drugs because of differences in pricing policies for pass-through versus SPNPT policies that tend to result in higher payment rates for the pass-through drugs, and this gives the 340B providers incentive to use expensive drugs when less costly similar drugs are available.

We also have a couple of concerns specific to the pass-through policy. One is that it is not restricted to

drugs that are supplies to a service, and the second is that it does not require a drug to be clinically superior to similar drugs that are already on the market. This lack of a clinical superiority requirement is especially important. Without one, Medicare can make additional separate payments for a new and potentially much higher-cost drug that is no more effective than a similar competing drug that is already on the market.

In response to the concerns that we have about the drug payment policies in the OPPS, we have identified changes that could be made to improve them. On this slide, we have the eligibility criteria that would occur for the pass-through and SPNPT policies if these changes are implemented. I will discuss only the new or modified criteria, which are bolded in yellow.

For the pass-through policy, it would be restricted to new drugs that are supplies to a service, which means the policy would exclude drugs that are the reason for a visit. In addition, a drug would have to show clinical superiority over similar drugs that are used in the same primary service. Making these two changes to the pass-through policy would raise the bar for drugs to

qualify for pass-through payments beyond simply being high cost. Also, manufacturers would have incentive to devote resources to develop drugs that offer better clinical performance.

For the SPNPT policy, there would be an explicit requirement that a drug would have to be the reason for a visit.

Also, the policy would be expanded to include both new and established drugs that are the reason for a visit. Currently, these new drugs are paid separately under the pass-through policy.

Making these changes to the SPNPT policy would mitigate the financial benefit for 340B providers to use some pass-through drugs over similar SPNPT drugs.

In light of our discussion, we have two draft recommendations for the Commission's consideration. The first is that the Congress should direct the Secretary to modify the pass-through drug policy in the hospital outpatient prospective payment system so that it includes only drugs and biologics that function as supplies to a service and applies only to drugs and biologics that are clinically superior to their packaged analogs.

The second recommendation is the Secretary should specify that the SPNPT policy in the hospital outpatient prospective payment system applies only to drugs and biologics that are the reason for a visit and meet the defined cost thresholds.

The implications of these two draft recommendations include, for spending, we anticipate no direct effect on program spending for over one year or over five years due to budget neutrality requirements in the hospital outpatient payment system. But over the longer term, we expect savings from the smaller pass-through policy giving providers incentive to alter their drug choices, and we expect the inflationary effects of current policies for separately payable drugs to be mitigated, especially for drugs that are supplies.

For providers, they could change their drug choices within groups of clinically similar drugs. However, we anticipate no effect on beneficiaries' access to needed drugs, and beneficiaries may benefit from improved efficacy of drugs used with outpatient services.

And now I turn things back to the Commission for discussion and voting.

DR. CHERNEW: Thank you very much, Dan. Let me pause for a minute to see, Dana, do we have folks in the queue?

MS. KELLEY: No. There are no questions.

DR. CHERNEW: Great job, Dan. I will just add, then, that --

MS. KELLEY: Bruce has a question.

DR. CHERNEW: Bruce, go ahead.

MR. PYENSON: Thank you. I appreciate the comments in the chapter referring to our 2017 recommendation on biosimilars. And I know, from time to time, MedPAC has reiterated older recommendations in its newer recommendations, and I'm wondering if this is an opportunity where that is appropriate on the biosimilars. And, Mike, I welcome, or Jim, your thoughts on doing that or not. Obviously, we didn't do that in this draft.

DR. CHERNEW: You know, as we've said in the past, my general reaction is we are voting on the recommendations that are in front of us now, and the recommendations that we've made in the past, with a different set of Commissioners and different levels of analysis. So while all those recommendations stand, and I

think we count them a lot, I believe it is in the March chapter, Jim, where we give all the recommendations that are made, and when they are particularly relevant we certainly call them out in the chapters, but we are not -- I don't know what the word is -- we are not asking now for a vote to endorse those past things. And so I think we will look back to make sure that people understand what the particular relevant recommendations are, but our intent is not to use this vote or use the chapter to reiterate or push recommendations in the past. That is a broader policy thing than it is anything explicit about this chapter or these recommendations.

Do you want to add anything to that, Jim?

DR. MATHEWS: If I could, please. So I agree with Mike, what you just said, but I would also point out that the reason we are invoking the 2017 recommendation here is to make the point that while we are defining two different categories of drugs that are separately payable under the OPPS, that does not preclude us from revisiting this notion of consolidated billing codes, you know -- I'm losing a little bit of articulation myself at this point of the day. But it wouldn't necessarily be that each

individual pharmaceutical product warrants separately payable status, but at a future point in time, if we were using consolidated billing codes, all of the products under code, collectively, would be a separately payable code, if that makes sense.

And so where this will become more germane is, you know, as the paper alludes at its conclusion, and as we have been discussing throughout this cycle, there is some interest in us pursuing work over the next cycle on how Medicare should deal with expensive new things, expensive new technologies, expensive new therapies, and this notion of consolidated billing codes might be something we contemplate more directly in that context, along with other ideas that we would start to put on the table.

So I think it would be much more directly relevant to a future body of work.

DR. CHERNEW: Thank you, and we will be contemplating that future body of work, although nothing is decided as of yet. The core point here, I think, is there's a lot of recommendations from the past, and as a general rule they're included when they're relevant specifically to the material that is being presented in the

chapter, in the way things might interact. And as Pat raised in the Medicare Advantage chapter, for example, we are pondering that in a bunch of ways.

So again, I'm going to pause for a second to see if anyone wants to add something.

[Pause.]

DR. CHERNEW: Okay. Dana, why don't you take us to the roll call.

MS. KELLEY: Okay, for the first draft recommendation, that the Congress should direct the Secretary to modify the pass-through drug policy and the hospital OPPS so that it includes only drugs and biologics that function as supplies to a service and applies only to drugs and biologics that are clinically superior to their packaged analogs.

Voting yes or no. Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: And Dana Safran is not present.

Moving to the second recommendation, that the Secretary should specify that the SPNPT policy in the hospital OPPS applies only to drugs and biologics that are the reason for a visit and meet a defined cost threshold.

Voting yes or no. Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Karen?

DR. DeSALVO: Yes.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Yes.

MS. KELLEY: Bruce?

MR. PYENSON: Yes.

MS. KELLEY: Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: And Dana Safran is not present. Go ahead, Mike.

DR. CHERNEW: Dana Safran is not present. She will be recorded as such.

So first to my fellow Commissioners, thank you very much for all your efforts and your diligence today. As always, at the end of each half day I want to remind our audience that they are strongly encouraged to reach out to us with their comments. There are many ways to engage, by sending letters, messages. I think you know where to reach us, and we very much appreciate that.

We are going to be signing off now. I'll pause for a second to see if anyone has any closing comments.

[Pause.]

DR. CHERNEW: And hearing none, I thank you all for joining us, the public for joining us, and again, the Commissioners and the staff for all of their outstanding work. And we will reconvene tomorrow morning at, I believe it's 9:30, when we will talk about private equity in health care.

So again, thank you all, and we will see you tomorrow morning.

[Whereupon, at 4:12 p.m., the Commission was recessed, to reconvene at 9:30 a.m. on Friday, April 2, 2021.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Friday, April 2, 2021
9:31 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
PAUL GINSBURG, PhD, Vice Chair
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
KAREN B. DeSALVO, MD, MPH, Msc
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DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
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P R O C E E D I N G S

[9:31 a.m.]

DR. CHERNEW: Good morning, everybody, and welcome to the Friday morning MedPAC session. This will be our last session for this cycle, and we have a particularly good one. We're going to start with a topic of great interest.

For those of you listening, you don't yet get to see the amazing chapter that goes behind this material, so set some time aside in June so you'll be able to read it. It is really exceptional. And I'm going to let Eric start with what will be a brief description of really an exceptional body of work on a really important topic. Eric.

MR. ROLLINS: Thanks, Mike. Good morning. I'm going to start today's presentations by talking about private equity and the Medicare program. Before I begin, I'd like to remind the audience that they can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen. I'd also like to thank Bhavya Sukhavasi for her help on this project.

Last year, the Chair of the Committee on Ways and Means asked the Commission to look at the role that private equity plays in Medicare. The request did not ask the Commission to make any recommendations. We have focused on answering the questions that were included in the request and are not making any value judgment about the relative benefits or drawbacks of private equity. We discussed our analytic work plan for this project at the September 2020 public meeting, and we've come back to you today to share our findings. We will respond to the request with an informational chapter in our June 2021 report to the Congress.

The request asked the Commission to look at four specific issues, to the extent feasible. First, we were asked to look at the current gaps in the data that CMS collects on provider ownership that may make it difficult to track private equity investments in Medicare providers. Second, we were asked to examine the business models that PE firms use when they invest in the health care sector and how those models vary across health care settings. Third, we were asked to examine the effects that PE investment has on Medicare costs, the beneficiary experience, and the

provider experience. And, finally, we were asked to assess the extent to which PE firms have invested in companies that participate in the Medicare Advantage program and whether it is possible to evaluate the effect of those investments on Medicare costs.

Before we get into the heart of the presentation, we thought it would be helpful to specify what we mean by "private equity." Broadly speaking, the term refers to any situation where investors buy an ownership stake in a company or other financial asset that isn't publicly traded. The term generates confusion because it covers a wide range of investment activities, such as venture capital funds for startup companies, growth capital funds for new companies that need money to expand their operations, buyout funds that acquire established companies, and hedge funds that invest in a wide range of assets.

Within the health care sector, the growing prominence of PE firms in recent years largely reflects the actions of buyout funds. As a result, we focused primarily on those funds in responding to the congressional request and will use the term "private equity" to refer to them

unless noted otherwise.

Now I'm going to briefly review the typical structure of a private equity investment fund. The graphic on this slide is illustrative and tries to highlight some of the most important features. Starting with the two rectangles at the top, a private equity firm raises money from a variety of outside investors and pools that money into a private equity investment fund, shown in the middle in the oval. The outside investors provide almost all of the capital, while the PE firm acts as the fund's general partner and decides how its money will be invested. Most funds operate for a limited period of time, usually around ten years.

During that time, the private equity fund acquires several different companies, which are known as "portfolio companies" and are shown in the circles at the bottom. Since the PE firm must liquidate its investments by the end of the fund's ten-year life span, the fund owns most portfolio companies for a relatively short period of time, usually between three and seven years. During this time, the PE firm tries to make its portfolio companies more valuable through steps such as making them more

efficient and reshaping their business strategy. The PE firm then sells the companies to other purchasers. The dotted lines on the outside show how profits are shared and how the PE firm is paid. The PE firm receives 20 percent of any profits from the sale of the portfolio companies, plus an annual management fee that equals 2 percent of the amount in the investment fund. The outside investors receive the other 80 percent of the profits.

I'll now turn to the first issue discussed in the request, the gaps in Medicare data on provider ownership that make it difficult to track PE investments.

CMS maintains enrollment and change of ownership, or CHOW, data in the Provider Enrollment, Chain, and Ownership System, or PECOS. CMS uses PECOS primarily to support Medicare payment and program integrity, but also uses it in a more limited way in consumer lookup tools like Medicare's Care Compare website.

When Part A providers and Part B suppliers apply to enroll in Medicare, they provide information about every individual or organization that has a direct or indirect ownership stake of 5 percent or more or that exercises managerial control. This includes organizations that hold

provider mortgages or contracts with management services organizations that have managerial control. The Medicare Administrative Contractors, or MACs, review and verify these submissions, and the CMS regional offices ultimately decide whether to issue a Medicare number to the provider.

When a provider's ownership changes, for example, due to an acquisition, Part A providers and certain Part B suppliers (such as ambulatory surgical centers that are subject to survey and certification) may need to update their PECOS data through the CHOW process. Whether or not CMS considers a transaction a CHOW depends on the legal structures of the companies and the deal. If the transaction is a CHOW, the buyer and seller submit information about the deal, and the CMS regional offices make an approval decision. This usually results in CMS reassigning the seller's Medicare number to the buyer. Other Part B suppliers such as physician group practices do not go through the CHOW process, but they still have to update their data. One key difference is that the buyer in these transactions must newly enroll and get their own Medicare number. As a result, PECOS has change of ownership data for all Part A providers and certain Part B

suppliers, but not for suppliers such as group practices.

When we talked about private equity last September, we told you that previous studies had found that PE-owned providers had complex organizational structures, which made it difficult to use PECOS to determine when providers have common ownership. This has been a perennial problem, for example, with identifying the owners of nursing home chains that provide substandard care. What we have come to appreciate is that many health care providers and suppliers -- whether owned by PE or not -- have structured themselves in complex ways to limit their liability. One person we interviewed called this the "taxicab" model, where each cab is registered as its own limited liability company to prevent a plaintiff from suing to win the entire fleet. Your mailing materials have a couple of text boxes with examples. When the MACs review ownership information, they may not know when a provider's submission is incomplete. It's hard to verify data when you don't know what you're looking for, and providers may not volunteer more detailed information unless they're asked directly.

We looked at PECOS data for providers and

suppliers that we knew from other sources have PE owners. Some of those providers had extensive entries that clearly showed PE fund ownership as well as the names of individual employees of PE firms who sat on boards with managerial control. For other providers, PE ownership was not clear or not evident at all. We did not try to do a systematic inventory of every instance where we could identify PE ownership. That being said, for the cases we examined, it wasn't clear to us that the PECOS data for PE-owned providers were more or less complete than the data submitted by providers that do not have PE ownership.

Let's move now to the second issue, the business models that PE firms use when they invest in the health care sector.

For this part of the request, we focused on three types of providers that play major roles in caring for Medicare beneficiaries: hospitals, nursing homes, and physician practices. We used a variety of data sources to estimate the share of providers in each sector that are owned by PE firms, but it's worth noting that we did not use PECOS data. We found that PE firms have invested in each sector, but their presence is relatively limited.

For hospitals, we conducted our own analysis and found that less than 4 percent of hospitals (not including critical access hospitals) were PE-owned at the start of 2020. Only about a quarter of all hospitals are for-profit, but there have been some prominent PE acquisitions in the past. There has been relatively little PE activity in this sector recently, and we expect that new PE investment in the sector will be limited for the next few years.

For nursing homes, we assessed PE ownership using the research literature, which indicates that about 11 percent of facilities are PE-owned. Unlike hospitals, the majority of nursing homes are for-profit, and PE firms have been investing in the sector for more than 20 years. As with hospitals, PE firms appear to have made relatively few new investments in this sector in recent years, and their overall interest in nursing homes may be waning.

As for physicians, we do not know how many practices are owned by PE firms. One study found that private equity acquired about 2 percent of physician practices between 2013 and 2016, but that figure does not account for practices that were acquired in other years.

PE investment varies by specialty but has been on the rise, and overall PE interest in the sector appears to be high.

We identified a variety of strategies that PE firms use to make the providers they have acquired more profitable. Some strategies focus on increasing revenues, such as providing more services, providing more profitable services, and using multiple acquisitions to develop greater market power and obtain higher commercial rates. Other strategies focus on reducing costs, such as consolidating providers to benefit from economies of scale and reducing labor costs. Your mailing materials provide more detailed examples that we can discuss on question. We would like to note that these strategies are not unique to PE-owned providers and are also used by other for-profit providers.

At the same time, PE firms may also use strategies to generate profits that may increase providers' costs. For example, providers that PE firms acquire through leveraged buyouts are typically required to spend more on debt service. PE firms may also sell a provider's real estate to another company and have the provider sign a long-term lease, making the provider responsible for the

lease payments. PE firms may also require nursing homes to buy goods and services from other companies that the PE firm owns, a practice known as "related party transactions." This strategy may increase costs if the prices charged by the other companies exceed market rates. Finally, PE firms often require their nursing homes and physician practices to pay monitoring or management fees.

Now I'm going to discuss the third issue, the effects of PE ownership on Medicare costs, beneficiaries, and providers. Although the involvement of private equity in health care has been in the news a fair amount in the last few years, we focused here on summarizing the empirical evidence that we have available. As you'll see, the amount of research that has been done on this issue varies significantly across the three sectors.

For hospitals, the empirical literature is relatively thin and focuses on a small number of high-profile deals. One recent study by Bruch and others found that hospitals tended to increase their charges after being acquired by PE firms, and the effects on quality metrics were mixed.

We supplemented that literature with findings

from our own cross-sectional analysis of PE-owned hospitals. Our analysis focused on traditional acute-care hospitals and did not include critical access hospitals. We found that costs per discharge and patient satisfaction were slightly lower for PE-owned hospitals compared to other for-profit hospitals and materially lower compared to nonprofit hospitals. However, there was also a lot of overlap in the performance of the hospitals in these three ownership categories, which suggests that the effects of different types of ownership are not a dominant factor in hospital performance.

For nursing homes, there's a longer history of PE ownership and a more extensive literature on its effects, but most studies are somewhat dated and use data from the 2000-2010 period. Those studies have mixed findings on the effects of PE ownership on quality and financial outcomes, and not all of the studies control for differences in the types of facilities that PE firms acquire or in the types of patients they serve.

However, there are two working papers that have come out recently and use more current data, although they haven't yet gone through peer review. One paper, by Gandhi

and colleagues, found that PE ownership led to an increase in staffing at nursing homes in highly competitive markets and a reduction in staffing in less competitive markets. The other paper, by Gupta and colleagues, found that PE ownership led to higher mortality for Medicare skilled nursing patients and higher spending per episode of care. The paper also found that PE ownership had no effects on a facility's net income, overall revenue, or overall costs. However, spending for management fees, lease payments, and interest payments all increased.

For physician practices, we are not aware of any empirical studies on the effects of PE ownership on spending and quality, and the available research largely relies on interviews with physicians about their experiences. We reviewed the studies that have been done to date and conducted some interviews of our own with physicians.

These interviews suggest that provider experiences with private equity vary widely, with some finding PE ownership highly disruptive and others finding it useful. Some physicians have said that the pressure that some PE firms apply to clinicians to increase revenue

by performing more procedures and ancillary services (such as imaging) could lead to higher spending.

That brings us to the last issue we were asked to examine, the extent of PE involvement in companies that participate in the MA program. We looked at two types of PE involvement: one, investment in plan sponsors, which are the health insurers that offer MA plans, and, two, investment in related companies that work for plan sponsors.

We found that very few plan sponsors are owned by PE firms. At the start of this year, only 6 out of 309 parent companies were owned by PE firms, and the plans they offered accounted for 1.7 percent of total plan enrollment. We also found that some plan sponsors have received other types of PE funding, primarily venture capital. These companies accounted for another 1 percent of total plan enrollment. Many of these investments appear to be targeted at three types of plan sponsors: startup health insurers that focus on MA and/or the ACA's health insurance exchanges; provider-sponsored institutional special needs plans, which are specialized MA plans that serve beneficiaries living in nursing homes; and, finally, the

Program of All-Inclusive Care for the Elderly, or PACE, which largely serves frail elderly beneficiaries who still live in the community.

PE firms have also invested in an array of companies that perform various functions for plan sponsors. For example, several companies focus on delivering primary care, either through their own network of clinics, through joint ventures with group practices, or through making house calls to patients. Other companies provide care management and are often focused on specific services, such as post-acute care, or specific groups of enrollees, such as those with kidney disease. Another set of companies help plan sponsors collect medical diagnosis codes for enrollees, which play an important role in determining payment rates for plans under the MA risk adjustment system.

Many of these related companies are paid using some type of value-based contract where the company bears some degree of financial risk for an enrollee's overall spending.

That brings us to the end of the presentation. We'd like to get your feedback on the draft chapter that we

included in your mailing materials, and like I said, the chapter will appear in our June 2021 report. We'll be happy to take your questions, and now I'll turn it back to Mike.

DR. CHERNEW: Eric, thanks. That was actually phenomenal. I know we're going to jump into Round 1 now. This is a chapter for the June '21 report. I would just say to all of those listening, we are not yet sure how far and in which directions we will push work like this, but certainly understanding the changing and complex organization of the delivery system and how it's financed in Medicare, in the health care system, is of importance to Medicare overall. So one way or another, I think the ideas and the findings in this work will find their way into what MedPAC does going forward.

But with that said, Dana, can we start Round 1 questions?

MS. KELLEY: Yes. I have Bruce first.

MR. PYENSON: Thank you. I want to echo Mike's appreciation of this work. The question I have is beneficiary rights to know ownership of the provider they're going to, and whether there is any sense of that in

the Medicare program. Certainly we heard some things around that kind of patient right around surprise billing, and the informed consent of patients is longstanding. And MedPAC has said that patients deserve to have information about the quality of the provider.

Is there any angle in the Medicare program that patients, beneficiaries deserve to know who owns the provider they're going to?

MR. ROLLINS: Ariel, do you want to talk about that recommendation we have from, I think it was a few years ago now?

MR. WINTER: Yeah. We did a recommendation in 2009, that the Secretary should collect information on physician ownership of any provider that bills Medicare, whether it's a hospital, ASC, or some other kind, and that information should be made available on a public website. But that recommendation was never adopted.

In the ACA, there is a provision that requires physician-owned specialty hospitals to report to CMS the physicians who invest in the hospital, but that has not been enforced since, I think, 2015. CMS has put that reporting requirement on hold. And in any case, I don't

think that information was made available to the public or to enrollees.

So that's all I'm aware of in terms of Medicare.

MS. KELLEY: Okay. Paul has a Round 1 question.

Oh, I'm sorry. Can I interrupt for a second? I think David Grabowski had something on this issue.

DR. GRABOWSKI: Yeah, just to follow up on Ariel's point there. I also think for nursing homes under the ACA they were required to report this publicly, Bruce. So if you go on NursingHomeCompare you can see the PECOS information, anyone with over a 5 percent ownership stake. I think the ACA required nursing homes to now report this. We can talk more about how useful that has been. I also think they have to post it somewhere in the building, how useful that is as well. But there were requirements for nursing homes as well, under the ACA. Thanks.

MR. PYENSON: Thank you.

MS. KELLEY: Thanks. Go ahead, Paul.

DR. PAUL GINSBURG: Sure. My question is, is there evidence of private investment directly and health care providers not going through the buyout fund structure you portrayed with the limited and general partners and the

sharing of temporary funds. In a sense, are there any very large investors that just directly -- rather than going through a PE funds -- purchase ownership in health care providers?

MR. ROLLINS: Well, I think we were highlighting, you know, for example, in the Medicare Advantage sector there are a number of -- again, to some extent they are partially providers, so you have companies like an Oak Street, which operates its own network of primary care clinics, that has private equity investment. It's not a buyout. This is a new company, it's a startup, and so they received venture capital funding as opposed to sort of a buyout of an existing entity. So, you know, those activities do go on in certain instances.

DR. PAUL GINSBURG: Okay. Thanks.

MS. KELLEY: I think that the end of Round 1 except for your question, Mike.

DR. CHERNEW: Yeah. So I have a few quick questions, because there's so much in this space that I don't know. The first one is, is there a large number of ever-changing private equity firms, or is there a relatively discrete number of large private equity firms

that kind of are stable, and you could ask what these organizations are doing?

MR. ROLLINS: Others could jump in. I would actually say, to some extent, both of those statements are true. There are a very large number of private equity firms. They vary in the amount of assets they have under management. They vary in their investment strategies with sectors they specialize in. There are private equity firms that do nothing but technology. There are private equity firms that do nothing but health care.

That being said, you know, there are a number of very large firms, you know, that operate on a much larger scale than some of your smaller, sort of what they call mid-market PE firms.

DR. CHERNEW: My second related question is, a lot of the evidence that you summarized is very important, but I can say this as a researcher. Research tends to look at averages, the nature of how statistical models work, so we tend to look at averages. Is there any sense in some of this work about what the variation is? My belief is there's probably some things that we might like a lot and some things that we might not like very much, and we tend

to draw an average conclusion. Did we get any sense of what that range might be? I'm a little worried about broad generalizations, and maybe the literature might help.

MR. ROLLINS: Jeff and Kathryn, I think to the extent we have literature it is on hospitals and nursing homes, so maybe the two of you could start on that one.

MS. LINEHAN: I think you are right that most of the literature is looking at averages and trying to determine the effect of PE ownership. There are a lot of press accounts of PE-owned nursing homes and things that have happened in those facilities, and there are a few case studies in the literature. But I don't think the literature is going to capture the variation.

I mean, there's that Gandhi paper that kind of looked at the heterogeneity, depending on the competitiveness of the market, that tried to get at some of the difference in response.

DR. CHERNEW: Right. I understand. So that's really useful, because again, I think we are going to have to be careful as we think through this, so be careful of certain types of generalizations around the finding of things, particularly given Paul's questions.

But I think we'll continue this discussion as time goes on, but we should move on to Round 2. So, Dana, do you want to start with Round 2?

MS. KELLEY: While you were speaking we had a few more Round 1 questions pop up. I think Larry had a point that he wanted to address on something you said, Mike.

DR. CASALINO: Oh yeah, just briefly. Mike, I think the staff gave pretty good answers, but the number of private equity firms in health care, and even in the part of health care we're talking about, is large. It's not like 10 or 20 or 30. You can't just identify them and go from there to figure out what's going on. It's large and ever-changing. They tend to vary by size in what they invest in. For example, for physician practices, it tends to be mid-market-sized firms or even smaller.

And they also vary in whether they are specialized or not. So there are private equity firms that just specialize in acquiring physician practices. And they will say, and some of the practices say that they really understand what's going on in physician practices and, therefore, they really can provide value. And that may be true, as opposed to they'll contrast other private equity

firms that invest in lots of areas that may not really know what they're doing with practices but just have the money to invest. That's important.

And I think one point that's in the chapter didn't come out understandably in the presentation. There's so much money sloshing around right now, looking for a place to invest, so-called dry powder, as the report calls it, and that's really driven up the price for physician practices and possibly for nursing homes as well.

And I think, you know, the averages and extremes are important. Again, if you talk to the private equity people themselves they all say, like any other area, there are good actors and bad actors, and there are some that really add value and there are some that they are possibly pretty awful things. And how to deal with that, because that's true, of course, in every sector and for nonprofits and for-profits as well as PE firms. But I think it's important to keep in mind that it's not one size fits all in any way.

DR. CHERNEW: Thanks, Larry.

MS. KELLEY: Marge, you had a Round 1 question?

MS. MARJORIE GINSBURG: Yes. I just wanted a

little bit more about the corporate practice of medicine laws that the chapter referenced, and I know California has got one. Is there any effect on PE if there are laws in the state about the corporate practice of medicine, or is this issue really not related at all?

MR. WINTER: Rachel, do you want to take this?

DR. SCHMIDT: Sure. It's actually very important because the differences in corporate practice of medicine laws from state to state directly affect how the PE investments happen, how it's structured, its interaction with the physician practice. And so that's why we have a diagram in the chapter discussing how there's usually a management services organization in which the private equity fund will have dominant ownership, but they don't own the clinical practice per se. But they also have representation on maybe a board of directors that helps to guide how the practice is at least managed and some say can be more influential than that. So it's highly important.

DR. CASALINO: Dana, may I comment on that?

MS. KELLEY: Of course.

DR. CASALINO: You know, over the years I spent a fair amount of time looking at corporate practice of

medicine laws, where some states have it, some don't, and they vary. But I think it's fairly generally accepted that in no case do they prevent a private equity firm or a hospital or a health insurer from essentially buying a physician practice. What they do is make it necessary to have more -- there's generally a lot of money for lawyers, and they make it necessary to have more complicated structures. But I think it's generally conceded that if their practice was to prevent the corporate practice of medicine I think it's pretty well agreed that they haven't really done that.

MS. KELLEY: Okay. So I think we've reached the end of Round 1, and we can go to Round 2 with Brian first.

DR. DeBUSK: First of all, thanks to the staff for an excellent chapter. I think you've managed to address a very difficult topic really well, and I do think, and you can see from some of the Round 1 questions, that I think this has uncovered a more foundational issue than private equity per se.

First of all, I completely agree with Bruce's comments and some of the earlier Commission work and some of the ACA work. You know, I think across a broad series

of payment areas I think beneficiaries should have the right to be able to identify their provider. So I think maybe that's a principle that we could incorporate into some future work, because I think that's something that could apply to all payment areas.

But the other thing that really stood out in this chapter for me was how this meshes with some of our work in vertical integration, because I think there's an incredible loss of transparency when you have this degree of intertwined ownership and, you know, one group is leasing the facility of a nursing home to another.

I think it creates some real challenges with transfer pricing and how that pricing appears on the cost reports. And as we all know; the underpinning of Medicare's administered rates is based on the payment adequacy framework. Well, payment adequacy relies on cost reporting, it measures access to capital, industry structure, entities entering and exiting the payment area. But with vertical integration, we lose visibility into most, if not all, of that information.

So again, this was a very fascinating report, very eye-opening, but I hope it leads to some further work

around transparency and vertical integration and what Medicare can do to make sure that it's working with good information. Thank you.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Good morning, and let me thank Eric, Jeff, Rachel, and Ariel. I thought this was an absolutely brilliant paper, and obviously one generated by a congressional request. But I think, one, it has reasons it is of interest to CMS and ergo to MedPAC as well.

My first is a sort of editorial comment, that I know the focus is normally on private equity, but there's no magic in private equity. It's just a form of capitalization. It doesn't mean that it's not of interest, but I want to sharpen why I believe CMS and MedPAC might have an interest here, and along those lines, why I think there a difference between investment in institutions, hospitals and nursing homes, versus investment in individuals, on physicians and advanced practitioners.

I think that divides into really two issues that are the crux of the matter. The first is that when the corporate governance structure is entirely dissociated from clinical governance structure it means that corporate

decisions about things like staffing, the quality of the providers, the types of providers may or may not be adequately clinically informed, and that gets at our interest in quality, as well as, to a certain degree, access.

The second issue at the heart of the matter, I believe, is there are situations where there's an inherent imbalance of power between the corporate and the clinical. So think about it. Investment in a hospital, a nursing home, a health system, there's pretty significant countervailing power. If a hospital is not functional, then the investment fails. Not true for physicians or advanced practice professionals. Each unit, in that situation, we're talking about a human, is essentially dispensable.

So why is that important? Well, think about the number of derivative effects when this occurs, that drives consolidation of practices in a variety of ways and impacts the staffing and cost structure for hospitals. And this is where I believe that CMS and MedPAC have interests.

Okay. The hospital is required to staff 24/7. What does it need to do that today? Well, it typically

engages with hospitalists and advanced practitioners, specialty coverage so that you can meet your EMTALA requirements, ER, and call for all the esoteric coverage.

Now think about the revenues and cost structure of a consolidated practice. The revenues are coming in when the patients come in. That's kind of during the daytime, and that's kind of biased towards weekends. And that means that your only incurring revenues five of seven days, you know, during mostly the daylight hours. On the other hand, you're paying for coverage throughout.

What I'm saying is that that model doesn't provide enough revenue to actually meet the compensation requirements, and that means that particularly when there are periods of volume volatility -- you know, and COVID certainly exposed that -- there's also revenue volatility. And that means that return on investment situations, the hospitals are obligated to subsidize, and those subsidy costs are increasing.

Okay, so even more sharply on why MedPAC and CMS have interest in this. The call and coverage costs are an escalating fixed cost, and second, that the hospitals become price takers to a breaking point, and not

surprisingly the employed physicians that are practitioners are also price takers as well. And this is amplified if the investor-owned physician group is the only provider of a certain type of services in a market, for example, emergency services, hospital services, anesthesia services, et cetera.

And so there's a fourth point that references one major concern, is that the dissociated corporate and clinical governance can yield decisions that are not in the best clinical interest of the patient. They are not ultimately decisions that are made by the caregiver, physicians, and others.

So what is the recourse? Well, the only recourse then is for the hospital or health system to do their own hiring, and that further drives the consolidation. And, you know, just to be really clear on this, I thought the point that was made about only 2 percent of practices in the literature -- remember, these investors are not shopping Wednesdays and Tuesdays. They are shopping more at the wholesale store, already buying consolidated practices, and this is a sort of a consolidation of consolidation.

And then what happens at a very practical level is that a degree of discomfort in this sort of circumstance, those who can, physicians, exit from the market, and that, in turn, also impacts the access.

So I think there are a cascade of scenarios that are really consistent with the issues that we have been discussing, and it's not related to private equity but rather this dissociation between corporate and clinical governance and something that conveys when there is an imbalance of power without countervailing pressure that happens to be more unique to the physician staffing and APP staffing than to the institutional relationship.

Thanks so much, again, for an absolutely brilliant and thoughtful chapter.

MS. KELLEY: Bruce, you're next.

MR. PYENSON: Thank you. I'd like to echo the compliments on the content of both Jonathan and Brian. I wanted to address one item with respect to Medicare Advantage that I think may paint a useful approach going forward.

Medicare Advantage, as more broadly the insurance industry, has for decades been required to disclose

ownership in a lot of detail, health insurers through the National Association of Insurance Commissioners, Orange Blank, as it's called, and Medicare Advantage plans through the bid production tool that has to disclose related entities in their bids. So from a reporting standpoint, the insurance industry perhaps is ahead of -- the insurance industry with respect to reporting ownership and investments and relationships is perhaps ahead of the regulatory structures that are used for providers as regulated by Medicare and others.

So I think that's worth looking at, in particular as Medicare Advantage is approaching half of the Medicare enrollees as a model, certainly a model that can be improved upon while many providers are relatively small compared to insurers. The reporting requirements for insurance have been around for decades, and many insurers routinely fill these out that were much smaller in scale than many of the provider systems.

So I'd like to suggest that a look at some of that reporting as a different approach, of course, insurers have financial liability for the policies and their obligations. And that's perhaps another concept that we

could think about with respect to providers and the stability and obligations of providers that get seen and could be seen in a lot of ways in the insurance industry with surplus capital requirements.

I did want to take up on Brian's point that this chapter touches a lot of the issues that MedPAC has addressed, and he mentioned the vertical consolidation. I'd like to mention another one, which is the challenges that providers faced with COVID and having the stability and the strength and things like adequate personal protective equipment for their staff. And to the extent that there has been a push for the provider world to operate on thin margins, on as thin a supply chain as possible, and as thin a workforce as possible, we've seen the consequences of it. So I think some of the economic theory that says private equity is good because it squeezes out inefficiencies, there's another side to that. And I think we've seen it with the public health emergency.

Thank you.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Thank you. Echoing my fellow Commissioners, this is a fabulous chapter. I just learned

a tremendous amount, so I really appreciate all the hard work that went into it.

I just wanted to bring up one thing that, as I was reading through it, came out sort of throughout -- one piece -- I guess it's part of the tone for one particular area that came out. There's a quote on page 69, but it's also sort of throughout, that talks about the fact that private equity may consolidate providers for the creation of market power, and that could impact the negotiation of higher payments, which I'm not questioning that. The tone, though, talks about how this is limited relevance to Medicare, and I get the point that it's because, you know, obviously Medicare sets its own payment rates by and large, but I guess my takeaway to that as I kept reading through it was it seemed a little bit off that -- because it feels like there's a lot of places where the impact of that, as we've talked about many times, could have some significant relevance for the Medicare program, and, in fact, Jon spoke quite eloquently a few minutes ago about some of the cascading events that could have -- could impact not only utilization but access and equity issues and things like that. So I wonder if there's a different way to think

about phrasing that, even if we just talked about it having a limited impact on Medicare pricing.

So that's really my only extra comment, and, again, otherwise this is, I think, just a fabulous chapter, so thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Great, thanks, Dana, and thanks to Eric and the team. Let me echo the other Commissioners. This is fabulous work. I'm really pleased that the Congress asked us to undertake this area of work. I think this is exactly the kind of issue MedPAC should be focusing on.

I'm going to focus my remarks around, not surprisingly, nursing homes and private equity. Eric mentioned during the presentation that interest in -- private equity interest in nursing homes may be waning a bit. I'd largely agree with that, Eric, although I will note, since you last presented on this issue, the largest nursing home in the country, Genesis, is now being acquired by a private equity firm. We are seeing a continued presence here. So I want to temper that somewhat in thinking that -- I don't think we're going to see an

explosion in PE in the coming years, but I don't think this is going anywhere. And, indeed, as I mentioned last time we discussed this, we often see private equity firms selling to other private equity firms and nursing homes, so these aren't going to back to kind of publicly owned companies. There's one of the major chains that's on their third private equity owner currently.

In my mind, when thinking about this issue, it's really about transparency and accountability, and I wouldn't just apply that to private equity. I think private equity is part of this issue, but it's a broader issue in terms of ownership. We want to know who is the owner, who is accountable to Medicare as a payer and to our beneficiaries as patients. We had hoped that the PECOS data, as Eric described it, would fill this gap, that it would let us know who is the owner. And I think these data have largely failed.

As I noted earlier in response to Bruce's question, you now can see, if you go on Nursing Home Compare, what entities have at least a 5 percent ownership stake in a nursing home. But I don't think the -- you can't tell whether or not there's a private equity owner,

for example, and there's a lot of sort of opaqueness to those data.

So I think as one area that we want to continue to push -- and this is broader than private equity. Can we get a better understanding of ownership and ensuring that we know who's accountable for Medicare dollars and overall quality for our beneficiaries? So how do we improve the PECOS data? And if it's not improving the PECOS data, is there another system or way to ensure greater transparency?

The other issue I wanted to raise in relation to transparency is really around the cost reports. Eric, you noted during your remarks that there's potential in the nursing home area for these related-party transactions where private equity groups kind of contract and basically siphon dollars away from direct care to these other entities. And are we adequately able to track that? Does that suggest that maybe our calculation of margins for Medicare overall may in some way be compromised? And I think this is something -- once again, it's not just -- I guess related-party transactions are a private equity issue, but this is a broader issue about kind of how much we can trust our calculations in terms of our margins. And

I think with PE, this is an area where there's real potential for gaming on the part of these owners.

A final comment. I just wanted to touch on the literature. I think the two big issues here in thinking about what's the impact of private equity on overall quality and Medicare spending, the big issue here in selection. Are these nursing homes different in terms of who's being acquired by these private equity groups? And then are they caring for a different mix of patients?

I will send you, Eric and team, some additional comments. I don't want to take everyone through a kind of weedsy set of comments on selection, but it's my sense that some of the papers do a better job than others of addressing this issue, both who's acquired and kind of the mix of patients that they're actually caring for.

The other big issue in my mind is what are the outcomes they're looking at, and I think the splashy headline of late with private equity has been around that big mortality effect in the Gupta paper. I have some real concerns about whether mortality is the right measure to be thinking about here. It's not a measure we use as a Commission in terms of thinking about post-acute quality.

It's not a measure that's reported on on Nursing Home Compare. I think it says a lot more about which types of patients are being admitted, how much they're using hospice, for example, is post-acute basically a substitute? Are they caring for these patients longer? So I just don't want us to be distracted by one measure. That's not to defend private equity, but only that we need to take a real critical eye towards sort of the quality of the data and what measures are being utilized in those studies.

Overall, once again, really great work, Eric and team, and I'm really excited this will be part of our June report. And I hope this is a springboard to future efforts in this area. So I'll stop there and say thanks.

MS. KELLEY: Okay. I have Dana next.

DR. SAFRAN: Thank you. So I'll just start by adding my huge compliments to Eric and his team. This is a tremendously clear and compelling chapter on a very complex topic, so thank you for being so illuminating and thorough.

I have just three areas of comments that I would make. The first is that, you know, you highlight, I think, some really important regulatory issues that make health care different with respect to PE. And I think the chapter

will benefit from some way of just calling that out explicitly and sort of naming, you know, that there are these regulatory issues.

In particular, you know, it really struck me on page 44 when you talked about the fact that, you know, the smaller-size deals in health care don't typically trigger FTC reporting, but are still enough that within markets they really can wreak havoc on competitiveness.

That was such an important point and I think should be, you know, one of the things to just call out as different and differentiating about PE and the need for some regulatory attention in health care.

A second that you name and I was unaware of before but I found really striking was the in-office ancillary services exception to the Stark law, and I think just, you know, if you have kind of an introductory paragraph about specific regulatory issues that need attention in health care, I think that would be on my list.

And then the third, which, you know, David just talked about quite a bit and that you do a very nice job of in the chapter, are the issues around data and just the incredible challenges in understanding ownership and the

complexity. The additional point I would make that I haven't heard made is how that ties to our really incredible challenges understanding the impact of PE on cost or quality in health care. You know, you cite what I find to be and I think you've described to be very mixed evidence, but also it seems that it's tremendously challenging to develop the evidence because there's no good visibility into these ownership issues. So I think that's worth calling out explicitly.

The second category of things I would just mention is the handling around physician practices I think is really very well done, but in two different sections, one on page 36 and then on page 56, you do mention that others besides PE are playing a role. So on 36, you know, you're talking about the role of hospital system acquisition, the role of insurer acquisition. And it would really be helpful, I think, to the chapter to have just a little bit more about what we know about the differences between those categories of ownership relative to PE ownership, if anything is known. And, similarly, on 56 where you're talking about provider support organizations that are kind of the shelter from the storm, some non-PE

and some PE, helpful, you know, anything we can say to kind of characterize differences in how these different types of ownership play out in the results that are being had.

And then, finally, what I'll characterize as just a couple of small comments but hopefully helpful ones. I really appreciated and learned a lot from the typology that you built out at the beginning of the chapter around four different kinds of private equity. But I then have to admit that I found it confusing in the chapter to then use the broad term "private equity" to really refer to just one of those four categories. You know, I won't ask you to explain like why you made that choice, but I'd ask you to consider, you know, referring to that category by its name, you know, the sort of buyout aspect of what you're talking about through most of the chapter. I think it would be helpful to just call it that. So I share that for what it's worth.

And then, finally, I think that where you talk about the role post-COVID of private equity, I think in the SNF section it was really very clear, clearly explained why there's waning interest of private equity in SNF. I found the explanation in the hospital which preceded that a

little less clear, and so I would just ask you to take another look at, you know, what we can say about post-COVID what's your explanation for less PE interest in hospitals. But, overall, just tremendous, tremendous work. I really appreciate it, learned a lot, and I think this makes a very important contribution to the June chapter. So thanks for the great work.

MS. KELLEY: Larry?

DR. CASALINO: Thanks, Dana. So I'll talk briefly about two things: first, suggestions for the chapter; and, secondly, ask a question of whether -- what are the pros and cons of MedPAC taking up this topic for further work.

In terms of the chapter, as others have said, it's absolutely terrific, and I'll just say it in a slightly different way. One sign of how good it is to me is that I have to keep telling myself, "I cannot give this to anybody until it's published. I cannot give it to anybody until it's published," because, you know, the faculty and staff that I work with would love to have it, as would a lot of people in the country, and probably people on Zoom today. It provides such a lucid explanation

of private equity in health care, which is a complicated topic. So terrific work, and really an all-star team doing it.

So that said, the other thing I'd say about the chapter is it's very balanced and I think it addresses the existing literature such as it is, which is helpful. But there are some things I might consider modifying. Some are minor and some are a little bit more important in my mind.

One is I think it might be useful to put a little more emphasis on the fact that probably because of the lack of transparency and ownership and the difficulty of figuring out who owns what, we have a very bright post-doc, and highly motivated, who spent the last two years, 90 percent of his time, really, just trying to build data sets of private equity acquisitions. It's a complicated topic. It requires high motivation and a lot of time. And even so, I'm sure that we have undercounts, so just maybe a little more emphasis on the fact that, although I agree that it's not like private equity is anywhere near dominating many of the sectors that you talked about, there probably is some undercounting of acquisitions or investments.

You might address also, jut briefly but explicitly, whether private equity behavior might be expected, on average, to be different from that of other for-profits, because I don't think the chapter really says too much about that. And, you know, I mean, the obvious different is private equity has a very short time horizon. It wants to buy something and work with it and sell it in three to seven years, and seven would be a long time, generally speaking. And that may generate, it could generate an intensity of incentive-induced behavior that goes beyond the average for-profit.

And again, the private equity firms promise their investors, or they tell their investors that they'll give them way above market returns, and so somehow they have to generate those returns out of organizations that haven't been generating that kind of margin previously.

I think a bigger point -- and excuse me, I'll try not to be too lengthy here -- I think a bigger point is that on page 69 you say -- actually, this is a related point -- the lack of more definitive findings in the research suggests that the behavior of PE-owned providers may not differ significantly from the behavior of other

for-profit providers. I'm not sure that really follows. There isn't that much research. It's not definitive. To me, that means we don't know whether the behavior differs significantly or not, and I think it's going a step too far to say that it doesn't, or may not differ significantly, since we don't have much research one way or the other.

And then I think some of the other Commissioners -- it's interesting to me to see how many Commissioners seem to want to continue some form of this work. There's a couple of places in the chapter where it says, for example, this approach has little direct impact on Medicare beneficiaries or spending, because Medicare prices are set administratively rather than negotiated. So it's certainly true that the consolidation, as in other areas, is not a worry for Medicare because of administrative prices, in terms of prices, but it certainly could affect beneficiaries, right? If consolidation affects quality or patient experience or total costs as consolidation is thought to do in Medicare as elsewhere, and then certainly private equity consolidation would have an effect. And there could be higher utilization. There could be more ambulatory care admissions, more ED visits, more use of

surgery and dermatology when it may not be necessary, and so on. It could be. I'm not saying there isn't.

So I think to say that Medicare doesn't need to worry about this so much because it used administered prices I think misses all the area of quality, utilization, total cost, patient experience, that need to be looked into.

And it's not just a matter of consolidation. It's also the question that does private equity behave differently, on average, in a way that has an impact on beneficiaries and on the program, compared to other for-profit or nonprofit, and we don't, I think, know the answer to that. And there's another page, page 47 also, basically it does the same kind of thing, where it says since Medicare has administered prices it's no big deal.

The only other thing I think maybe could be in the chapter that isn't is David mentioned accountability, and that is a potentially important issue. It's obviously important for anybody who owns a health care organization. Private equity may be a little different in that private equity firms, as the chapter shows very eloquently, invests very, very little of their own money in acquisitions, maybe

5 percent of the cost of the acquisition.

So they do a leveraged buyout, invest very little money, they borrow the money for the rest of the acquisition, the put it on the organization, which could be a physician practice, and even a pretty small physician practice, to pay off that debt, the organization has a responsibility for the loan. They make money for a while from related party transactions or from charging fees to the organization that they have acquired for their management, possibly make money from the real estate that the organization owns, which is especially relevant for nursing homes and hospitals. And then they can just walk away, and they lose very little. I mean, obviously they would rather sell it for a lot more than they bought it for. That's how they generate above-average returns primarily. But nevertheless, they can just walk away without that much damage. They've only got 4 percent of their money in there. So I think accountability is something that in some way might be mentioned.

So that's just suggestions for the chapter. In terms of is this an important area? Clearly it's important, but it is something that MedPAC might want to

look into more? Is it really important enough for Medicare policy? And I think the arguments for, no, it isn't could be the argument, again, that consolidation doesn't affect administrated prices and could be that, you know, private equity doesn't have that large a market share in any of the delivery sectors yet. So those are big arguments against doing it, I guess.

I think arguments for doing it are implicit in the things I've just said, so I won't go over them again. But I'll just add that -- and several people talked about this -- ownership transparency, this issue is important for more than private equity, and ownership transparency might be something that MedPAC might want to take up, either in the context of looking for at private equity or consolidation or just on its own. And we might take it up perhaps with the intent of making a recommendation. You know, PECOS is not very useful, probably for reasons that the chapter details very well and have been alluded to today, some of them, and partly because researchers can't get at it, never mind the public. So it takes very special circumstances for researchers to get access. So insofar as PECOS, it is useful but it's not very available to people

who want to look into ownership.

So that's enough. I'll stop there. Thanks.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. I think I would echo what many folks have said already. This area strikes me as being one that's really difficult to do proper justice to, because it's so expansive, and I think someone earlier mentioned, you know, heterogeneity. I think Dana may have mentioned the typologies. To me, this is a tale of many, many cities, and it's really tough to capture each and every one, and I think some of them, as many folks are getting to, are flat out sort of concerning in terms of their models. But at the same time I don't think we can paint the broad brush here because there are many models powered by private equity and venture capital investments which I would argue are very good as well. So it truly does have this multidimensional dynamic to it, at least in my head.

I think one of the things, or observations I would make, for sure, transparency, I think, is one of the key themes that seems to cut across all of those areas. I think another is this reality that capital and scale are necessities to change or transform. I think that is a

reality, and while there are a lot of investment dollars out there looking for areas to invest in, I think the channels for accessing that capital are more limited than what people might think. You know, you have the public markets, you have the debt market, you have private equity, and maybe a couple others, but if you really want to take a business and scale it and transform and disrupt, I think it requires the level of investment that has created this niche where these investment vehicles have come into play.

I think the best example of this might be in the MA category, sort of the fourth topic, if you will, and specifically around value-based care models. So when you're talking and thinking about some of these emerging models, disruptors, if you will, that have come into play, specifically in primary care and maybe even in terms of taking care into the home, maybe it's also kidney care, but there are these areas where I think the models have really sparked some nice transformation, but it's required quite a bit of investment to do these kinds of models or to launch them at scale.

I wonder, and maybe this is one additional level of applicability, I think it does inform a little bit of

our thinking, perhaps, in the APM world. The level of investment needed to truly transform and build out these models, it's a lot of dollars. And so when we're talking about 2 percent of payments, or 4 percent, or 5 percent, whatever it is, at risk, that's probably not enough to power the kind of transformation, because here in the MA world, in this last category in this chapter we're seeing venture dollars, private equity dollars being needed in order to truly transform and introduce these new models of care.

And so to me that's the interesting area I'd love to see more on, but, you know, it truly is a little bit of a behemoth, and big shout-out to Eric, Rachel, and Ariel and team for distilling it in a way that actually made a lot of sense, so thank you.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Yeah, thanks. I can't resist piling on how superb this chapter and presentation were, and I think the discussion that we've had, the Commission, so far has been superb as well and very thoughtful. Like when David said, you know, the Ways and Means Committee picked the best place to go, and I think we are really

showing that.

You know, one of the reasons the chapter is so good is that it was such a challenging topic because of the diversity in the strategies that private equity uses. You know, I'm most familiar with the physician practice side of it, and, you know, there, if you look at emergency physician practices and anesthesia practices, you know, that's mostly about pursuing opportunities for surprise billing and, you know, a much easier road to consolidation than you find elsewhere. Then when you go to dermatology it's about volumes of discretionary procedures and getting further into self-pay things.

And I would say kind of what unifies private equity to me is, compared to typical owners of physician practices, which are the physicians that work there, private equity is more aggressive and more agile in pursuing profits, and also, as Larry mentioned, the short-term dimension, because they're only going to be in it for a few years. And the implication, from the Medicare program's part, is that there is going to be a need for more resources going into refining our payment systems. You know, the loopholes in our payment systems will be

exploited more rapidly when there are more agile and aggressive providers. And I think this is a question of limits of private equity, but I think that's one of the stories of our times, and I think the MA coding is a particular example of this, and I noted in the report about the start-ups getting into specializing in this.

You know, the other distinction I would like to make is that I'm really glad that the chapter spent almost all of its time on the buyout funds, because I think they are very different from the venture-funded start-ups that are funded, because I think the difference is that the -- and this gets to Jaewon's comment a minute ago, is that as far as transformation of the system, in a good way, you know, start-ups and substantial capital probably are very important to doing this. But my sense of the buyout funds is that mostly doing things a little better and a little more profitably than they are being done, rather than transforming, at least in a way that the system needs to go.

So, actually, the final point on that is that whereas most of the report is focused on buyout funds, towards the end it kind of got into more venture funds, and

I think that kind of weakened the chapter a little bit in losing its focus, and we might just want to think about whether we want to focus even more substantially on the buyout model, which is I think where so much of the controversy is now.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. I also wanted to make sure to echo the previous sentiments that this is a huge topic, a very complicated one, obviously, and you guys have done a fantastic job of creating something that's, as Larry and others have said, is a great way to actually summarize a lot of activity here.

So much of what I was going to say has been said in the time from when I raised my hand, so I'm going to try to be relatively brief here and just echo a couple of points.

I think one point that many folks -- Larry, David, others -- have mentioned is this point about transparency. And I think it's worth nothing here that at least in my time on the Commission this is probably the single issue where we have the least amount of data of the impact of private equity on beneficiaries, on the sector,

generally speaking, and certainly on the Medicare program. And I think, to some extent, it behooves us to call that out, that not only is there an extreme dearth of data here, but also, as Larry pointed out, as somebody who has worked with PECOS files, as a researcher and in other avenues, it's very hard to get to the bottom of this. It's very hard to actually understand what's going on, understand ownership to even then start to study what the impacts are.

And so I think it's important that we call that out, a little more emphatically if we can in the chapter, recognizing that we're not making recommendations here necessarily, but we can still, I think, very explicitly and clearly state that that is a big barrier for us to even understand what the impact is on the industry at large.

I also wanted to just quickly echo the comments that Jon Perlin and Jonathan Jaffery and others have made about the complexity here, and yet the impact, the financial impact on the Medicare program. I wanted to draw a quick analogy. So, for example, when we had done our work around consolidation, we had noted that consolidation doesn't necessarily, again, impact the "regulated prices of Medicare," but that it does impact the commercial prices,

which may have an impact on the cost structure, which may then, in turn, have an impact on Medicare prices too.

And so if we are analogously making that sort of connection on the consolidation piece, I think it behooves us, again, to call that out here, that to simply say that there's no impact on prices directly is probably doing a disservice, and I know that Jonathan, again, and others have made that point, but I just wanted to make sure that I echo that point and try to make sure that we can clarify those connections as part of our chapter here in June.

So that's basically what I wanted to say. Again, great, fantastic job. The chapter was really tremendous, and I also support ongoing work in this space, just given how much we have yet to unpack. Thanks.

MS. KELLEY: Sue.

MS. THOMPSON: Thank you, Dana, and I'm not sure that there's a lot left to be said for today, but I do want to join the chorus of my fellow Commissioners in recognizing the good work that the staff have done in this chapter, and I anticipate a lot more discussion by Commissioners going in years to come on this topic.

I did just want to call out the commentary that

Amol just noted, that had been made by Dr. Perlin and Dr. Jaffery. I thought Dr. Perlin's description of the cascading of issue for health care organization and staffing, and the access issues that are created simply by needing to meet the conditions of participation of Medicare. And in those access issues we create opportunities for private equity to come in and answer a need. And as Jonathan Jaffery pointed out, the impact this cascade has on access, which is impact on the beneficiary. If an emergency department isn't staffed, the beneficiary is the recipient of the impact of that shortfall.

And I think as we peel the layers of the onion, and thinking about private equity, private equity is a little bit of just one example of money that's out there. And if we think about our discussions when we do payment update meetings every year, we ask a question about adequacy of access. And yet look at the opportunities that are being created here for private equity, because we clearly have some access issues, and we're paying enormous amounts of money to meet those needs in order to staff the health system and the various emergency departments and anesthesia services, critical care operations. So are we

really in a situation of adequate access?

So next time you do the payment update meetings, I would encourage you to recall, it's not so simple as do we have access to hospitals, do we have access to physicians, do we have access to long-term care. There are deeper issues. And I suggest that in this discussion about private equity you will peel layers of the onion and being to better understand that those access issues are creating great opportunities or great issues, depending on which side of the coin you're looking at it.

But I think this is a great discussion. I think it's going to open up all kinds of other insights into the challenges, but also the opportunities that can be met. Thank you so much.

MS. KELLEY: Pat.

MS. WANG: Thank you, and, again, thanks to the staff. This was such a great paper. I learned so much, and it was so clearly written. And it's a very complicated topic, so kudos to you for exploring it, but also making it so accessible to a reader.

I just wanted to say a couple of things to the great comments that have been made by my fellow

Commissioners about the other things to think about on the impact of Medicare. Notwithstanding the existence of administered prices, the Medicare Advantage world really moves in more of a commercial marketplace in terms of negotiating rates. While administered prices sort of default rates as we think about them are there, the whole sort of raison d'etre for an insurance company is to develop a network, you know, to provide the care that they want, and in that network dynamic, the dynamic is much more similar to a commercial negotiation than it is to an administered pricing negotiation. And I think that you will find, if you talk to MA plans, that the negotiation dynamic, whether -- we're talking about PE right now. It changes. I'll just put it that way.

So I think that there is, given the penetration of MA, something to pay attention to in terms of impact on bids in relation to fee-for-service, for example. It could get distorted.

I wondered whether it was a fruitful avenue of inquiry to explore the degree of Medicare participation inside of, let's say, physician groups that may be acquired by a PE firm. In the commercial world, it's not uncommon

to find folks who have contracts with a plan at a certain rate, but you have other members of the group who are not participating that charge -- you know, things get referred, and then a payer winds up with a bill for charges.

I just would be curious whether -- to think about whether that is an avenue of exploration for the composition of PE-funded physician groups and what the implications would be.

The additional couple of points that I wanted to suggest about impacts on Medicare, you know, I think of PE obviously as finding sort of the inefficiencies in the health care system to sort of pull out and isolate and, you know, make more efficient and follow the business model that PE firms follow. They're not, for example, pulling out care to uninsured people who are severely mentally ill as the focus. In that effort, there is a certain unbundling, ambulatory care, ambulatory surgery, diagnostic radiology, that may be good from a consumer experience perspective when they're pulled out into freestanding provider types, but do have an effect, I think, on hospitals. And it might be a good thing for society. I'm not sort of saying one way or the other, but I think that

it does have a cascading effect when perhaps the more profitable lines of business that a hospital might rely on to cross-subsidize unprofitable lines of business, get sort of picked out and subject to freestanding competition. And I do think that PE has a role there. It's not really so much the buyout situation, but I think it is related to some of the activity with investments and physician groups who then start am surg centers, for example. And, again, the end result might or might not be better for consumers, but I think that it does have an impact on Medicare payment policy fundamentally because it could have an impact on the costs and the financial situation of the institutions that we -- whose payments we regulate.

And the final thing is -- and others have said this -- to the extent that PE is part of the dynamic that feeds consolidation of the health care system, that's sort of the uber question, right? Whether it is, after that three- to seven-year period of time, a physician group is being reabsorbed or employed into a hospital, which is now getting bigger, or purchased by a large insurance company, which is now owning more of the provider delivery system, there is an effect, there is an interesting effect of sort

of the natural evolution that feeds consolidation, and I guess that that raises a bigger -- maybe we should -- if you agree with it, it might be just something to note.

Thank you.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you. I just want to again thank the staff. This was absolutely brilliant, and for someone like me who hasn't thought much about this before, I just wanted to share that it illuminated many things that I've seen at the working surface of health care that I couldn't really understand before. So I think it's really an important contribution.

And I would just like to also acknowledge the Commissioners who added so much nuance and insight, and for the reasons that so many of you have identified, I think this is a very important conversation to go forward and related definitely within our responsibility to think about Medicare beneficiaries, particularly -- I mean, many issues, consolidation, but also the transparency, which certainly I think goes to many workers in the health care system who are also part of these forces and not really clearly understanding what's behind them.

So just my thanks for excellent work, and I look forward to continuing this conversation.

MS. KELLEY: Okay, Mike. We are back to you.

DR. CHERNEW: So thanks. I have tons of notes, and we're at time, so I will read a portion. This conversation was as rich as the chapter was and really a highlight of the meeting.

Just for folks, both the Commissioners and for folks listening, let me just give a few broad thoughts.

First of all, it's clear this is an important area with far-reaching implications that we'd like to continue to learn about, all else equal. It's clear that heterogeneity is a big deal, that this is an area where there's some really good things and probably some not so really good things going on, and that makes sort of actions challenging.

It's super clear to me that we're very interested in transparency in a whole range of ways. I agree with what you said, Larry, that making this broadly transparent to allow researchers and other people to look at it can actually be quite helpful, and I think that matters a lot.

It's also clear that the area is so big and so

complex with so many different facets that it's not an area that's at least transparent to me about exactly how we would go at what parts of it in which ways, which isn't necessarily a bad thing. It just means I need to learn and we need to keep thinking about that to make sure that we have something tangible to do as we think about this.

So at least in the meantime -- and this is more of a lower bar than upper bar -- I think it's important that we're aware of all these things in our normal course of business. Most importantly, I think, David, it might have been you -- someone mentioned what this means for margins. I know Brian has said things like this, and I think that -- and others are criticizing us because we don't pay so much relative to various margins. Understand that margins are not our only criteria, and, in fact, out of a whole range of problems, and this chapter certainly illustrates those problems with margins. So while we will continue to look at margins, they are one of many criteria we will use, and this conversation illustrates that. And so I hope that everybody listens and keeps that in mind when next year they yell at us for various ways in which we use margins.

The other thing I will say is -- and this is more of a personal view, and as I said, it's not my area, so I don't feel that strongly. I think it's really important that we try and minimize the opportunity for undesired behavior, whether they're financed by private equity or other for-profit financing mechanisms, or whether they're occurring by nonprofit terms in a bunch of ways. That is a lot easier aspirational thing to say than to do, but at the end of the day, what I think we care about is the behavior, both short-term behaviors and the behaviors of the long-run success or failure for beneficiaries. And I think we will continue to do that, and there are a lot of things we do in our normal course of business that have ramifications for that.

So this is certainly the beginning and a very rich -- of a conversation that is very, very rich, and I'm glad that we'll have the opportunity -- there's so much expertise around the -- I'd say "table." I'm going to say "GoToWebinar" just to make sure I get my attribution right -- to have this discussion. We will continue to keep this in mind as we go forward with the other things that we normally do, and, again, I will close by just giving a big

shout-out to all the staff that was involved in doing this and a real appreciation to the great depth of knowledge for all the Commissioners that know a lot more about this than I do.

So with that said, we are little over time, but I think we will end up being fine, and we are not going to transition. I think, Brian, you are going to take the reins to talk about clinical laboratory fee schedule payments. So deep breath.

MS. SAN SOUCIE: I'm going to go first, Mike.

DR. CHERNEW: Oh, Carolyn, I'm sorry. I just read the order of the slides. Wonderful. So, please, you're in control.

MS. SAN SOUCIE: Thank you. Good morning. In this presentation, Brian and I will discuss our work towards fulfilling a congressionally mandated report. The report's focus is on assessing the impact of recent changes to the Medicare clinical laboratory fee schedule's payment rates. The audience can download a PDF version of these slides in the handout section of the control panel on the right hand of the screen.

The Congress mandated that the Commission

investigate changes made to the clinical laboratory fee schedule by the Protecting Access to Medicare Act of 2014. One part of the mandate requires the Commission to examine the methodology that CMS used to set private payer-based rates for laboratory tests paid under Medicare fee-for-service, which we first presented to you in September.

Another part of the mandate requires the Commission to report on the least burdensome data collection process that would result in a representative and statistically valid data sample of private payer rates from all laboratory market segments. The report is due in June 2021.

We have four parts to our presentation today. First, we'll provide some historical background on the clinical laboratory fee schedule to set the stage for the changes made to the CLFS under PAMA.

Clinical laboratory tests analyze specimens from the body to diagnose health conditions and help guide treatments. For laboratory tests that are not bundled in institutional settings or paid under the physician fee schedule, Medicare predominantly pays for tests under the clinical laboratory fee schedule under Part B.

In 2019, Medicare spent over $7.5 billion on 428 million CLFS tests. These tests were almost entirely furnished by three types of laboratories: independent laboratories, hospital laboratories, and physician office laboratories.

Prior to 2018, Medicare's CLFS payment rates were set based on local, historical laboratory charges, updated for inflation, and capped at certain amounts.

CLFS payment rates were not adjusted to reflect laboratories' improvements in efficiency, changes in technology, or market conditions.

Because of how CLFS payment rates were set and updated over time, research suggested that Medicare's payment rates were excessive. A 2013 OIG report found that Medicare paid between 18 and 30 percent more than other insurers for 20 high-volume or high-expenditure laboratory tests.

PAMA required CMS to shift the basis for CLFS payment rates from historical laboratory charges to current private payer rates. CMS established criteria for reporting. Qualifying laboratories must report the payment rates they receive from private payers so that CMS can

establish new CLFS rates based on the volume-weighted median of the private payer rates. This new payment system began in 2018.

However, PAMA established a long phase-in of payment reductions to mitigate the impact on laboratories and to allow them time to adjust their operations. Because of delays, payment rate reductions resulting from private payer-based rates are expected to be fully phased in by 2025.

Next, we'll discuss results from the implementation of the first round of private payer-based rates.

The statute in PAMA required CMS to collect private payer rates from laboratories every three years to establish new CLFS rates based on the volume-weighted median of the private payer rates.

We estimate that Medicare CLFS payment rates will decrease by an average of 24 percent once private payer rates are fully phased in in 2025. Private payer-based rates reported by laboratories were lower than Medicare's 2017 average payment rates for most (but not all) laboratory tests. Counterintuitively, overall Medicare

spending went up after the first year of implementation, which Brian will discuss in depth later in the presentation.

The Commission found that reported private payer-based rates were lower than Medicare's 2017 average payment rates for about 77 percent of laboratory tests, but higher for about 23 percent of tests.

The transition to private payer-based rates resulted in much larger payment reductions for low-cost, routine tests compared to newer, more expensive tests. Once private payer-based rates are fully phased in, we find that routine, low-cost tests such as chemistry tests generally will have payment rate declines between 20 percent and 30 percent. On average, newer, more expensive tests tend to have smaller payment rate declines, such as those for molecular pathology tests, or even payment increases for some categories of tests, such as multi-analyte assays with algorithmic analyses.

In the first round of data reporting, independent laboratories were overrepresented while hospital and physician office laboratories were underrepresented.

Independent laboratories billed for 48 percent of

all CLFS tests in 2016, yet they made up 90 percent of the volume reported to CMS in the first round of data collection. In contrast, hospital and physician office laboratories billed for 29 percent and 22 percent of Medicare tests, respectively, but only accounted for 1 percent and 8 percent of the volume reported to CMS in the first round of data collection.

The reason that some stakeholders are concerned with the lack of reporting by hospital and physician office laboratories is that these laboratories tend to receive higher private payer rates.

Based on private payer rate data reported to CMS, we found that, relative to independent laboratories, hospital and physician office laboratories received 45 percent higher payment rates and 53 percent higher payment rates on average, respectively.

Since independent laboratories were overrepresented in the first round of data reporting, private payer-based rates were closer to the median of independent laboratories.

MR. O'DONNELL: Because of concerns about how payment rates were set, industry stakeholders have said

Medicare's new rates could create disruptions in access to laboratory tests. However, in aggregate, we found that utilization was stable after the implementation of private payer-based rates. From 2017 to 2019, average utilization of laboratory tests went from 12.8 to 12.9 tests per Medicare fee-for-service beneficiary.

These results suggest stable access, but as we note in your mailing materials, access trends should be monitored over a longer period as payment rate reductions continue to be phased in and as the effects of the coronavirus pandemic on the laboratory industry become more clear.

Additionally, while laboratory test utilization was stable overall and for routine tests, we saw sharp increases in the use of new, high-cost tests, which has important implications for Medicare spending.

Despite flat utilization and payment rate declines for many tests, Medicare spending actually increased from 2017 to 2019. Over that time, Medicare spending increased from $7.1 to over $7.5 billion. The increase was driven by technical changes under PAMA and the increased use of new, high-cost tests.

Looking at the figure on the slide, I use three categories of tests to explain key trends that underlie the aggregate growth in spending.

For the first category, chemistry tests, spending decreased by 14 percent, largely in line with expectations under PAMA. For the second category, panel tests, expected spending declines had not yet materialized as of 2019, because of unbundling and a generous phase-in of payment rate reductions under PAMA. The large spending increase for the third category, molecular pathology tests, is due to higher use of these tests.

So now I'm going to shift from talking about what has actually happened during the first round of data reporting to how private payer rates could be collected in the future. We worked with a third-party contractor, RTI International, to examine potential survey methodologies that could be used to collect private payer rates from a representative sample of laboratories. I'll give a brief overview of RTI's work in the next few slides. The full report will be published on our website concurrent with the Commission's June report to the Congress and was included in your mailing materials.

After I summarize RT's technical analysis, I'll then discuss the likely effects on spending of setting Medicare payment rates using a representative sample of laboratories.

RTI examined survey methodologies that could be used to collect a representative and statistically valid sample of independent, hospital outpatient, and physician office laboratories. We focused on these three types of laboratories because they furnished nearly all CLFS laboratory tests and as Carolyn discussed, the prices they receive from private payers varies considerably.

RTI evaluated multiple sampling techniques based on two criteria, first and foremost, the extent to which a survey could produce accurate estimates of private payer prices for each type of laboratory, and second, how many laboratories would be required to report data in order to generate accurate price estimates. Reducing the number of laboratories that are required to report their private payer data could be one benefit of a survey, given that industry stakeholders have said that reporting their private payer data to CMS is burdensome.

Using Medicare claims and private payer data to

simulate the results of a survey, RTI concluded that setting Medicare payment rates using a survey is feasible and could substantially reduce the reporting burden on laboratories. For their preferred methodology, RTI found that a survey could produce accurate estimates of private payer rates for independent, hospital outpatient, and physician office laboratories. In addition, even after requiring at least ten laboratories report data for each test, RTI found that a survey could reduce the number of laboratories that would be required to report private payer data by up to 70 percent.

These results suggest a survey is a viable tool to collect private payer data. However, the analysis should be considered a proof of concept, and further testing is warranted if policymakers want to implement a survey in the future.

In the next slide, I'll discuss the potential effects on Medicare spending of setting payment rates on a representative sample of laboratories.

To estimate the effect of setting Medicare's payment rates on a representative sample of laboratories, we ran multiple 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 relied on varying assumptions. Specifically, our narrow definition of hospital outpatient laboratories only includes tests furnished to non-patients. Our broader definition includes all hospital outpatient tests that were separately paid under the CLFS.

Using these assumptions and the private payer rates reported to CMS, we estimate that setting Medicare's payment rates on a representative sample of laboratories would increase program spending by 10 to 15 percent, relative to the spending that would result from CMS's current rates. The mailing materials discuss additional simulations and their effects on program spending.

While these estimates should not be considered precise point estimates, they demonstrate that going from rates that are largely based on independent laboratories, as Medicare's rates currently are, to rates that are based on data from a broader array of laboratories is likely to substantially increase Medicare spending.

In the last section of the presentation, we

summarize our main findings, highlight a couple of issues for policymakers, and discuss next steps.

So just a recap. As of 2018, Medicare relies on private payer data to set CLFS rates. As a result, payment rates for many tests declined substantially. Payment rates declines were not uniform across types of tests. Routine tests experienced larger price declines than new, high-cost tests. Independent laboratories were overrepresented in the first round of private payer data reporting and received substantially lower private payer rates compared to other laboratories. Some stakeholders are concerned that this resulted in payment rates that are too low, which could lead to access issues. However, we find no evidence of substantial changes in access in the first two years after CMS implemented private payer based-rates, but further monitoring is warranted.

Over the same period, Medicare spending increased due to the increase in the use of new, high-cost tests. In the future, conducting a survey to collect a representative sample of private payer rates is feasible and would reduce the burden of reporting for many laboratories. However, basing Medicare payment rates on a representative sample of

laboratories would increase spending.

Based on these findings, I'll now discuss two instances when basing Medicare payment rates for laboratory tests on a representative sample of private payer rates may be undesirable.

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. Instead, Medicare should set payment rates to ensure beneficiary access, while maintaining incentives on laboratories to make better use of taxpayer and beneficiary resources. One way to do this could be for Medicare to set payment rates based on private payer rates of relatively efficient laboratories, instead of all laboratories.

The second instance in which a complete reliance on private payer data might produce suboptimal Medicare payment rates is among new, high-cost tests, such as genetic tests. Private payers may have a limited ability to negotiate rates for these new, high-cost laboratory tests, which are often more complex and proprietary than more established tests.

Indeed, while the market for such tests is nascent and changing rapidly, our analyses suggest that private payers may not be able to negotiate lower prices for newer, more expensive tests in the same manner as they do for more routine tests.

In the future, the Commission will consider alternative ways to set payment rates for new, high-cost technologies, including certain pharmaceuticals, devices, and laboratory tests.

The staff seeks feedback on these materials we discussed today. Commissioner feedback will be incorporated into the final report that will be published in the Commission's June 2021 report to the Congress.

And with that I look forward to the discussion and I turn it back to Mike.

DR. CHERNEW: Thank you. There's a lot of material here. I think it illustrates a few points, some of which are actually thematic from the previous session. One of them is the challenges with getting data and the importance of data, and I think MedPAC is so analytically oriented I'd like that theme working through all of our presentations. And the other thing that I think is

important for folks listening to understand is we really are quite concerned with the administrative costs that are placed on providers in the system by doing [inaudible] ways. And so a lot of this work was started before I was in my current role, but I really do appreciate that orientation.

I think we at least one Round 1 question, so I'm going to turn it over to you, Dana, to go with the queue, and I'll say to my fellow Commissioners, jump in when you have things you want to add.

MS. KELLEY: Okay. I have Paul with a Round 1 question, and that's it, and then he also is first in line for Round 2, so we could just have Paul start with Round 1 and roll into 2, if you'd like.

DR. CHERNEW: We get a two-fer. Go on, Paul.

DR. PAUL GINSBURG: I'll do that. So for Round 1, which I just thought of, you had mentioned that the transition to what we have now, as far as based on private rates but with a sample that is much more representative of independence, that's a higher Medicare spending, and you said it was the cost of higher volume of some types of newer tests.

Have you calculated if the volume and mix of tests had remained the same, what the impact on the new rates would be?

MR. O'DONNELL: I think the short answer is no, but, you know, what would have happened is that spending would have gone down in the first couple of years. I think it would have gone down more modestly than some people had hoped, because of the technical issues associated with the transition, and then again the long phase-in. But certainly it would have gone down, and probably somewhat modestly, and then the increase in utilization of the newer, higher cost tests just swamped that small decline.

And, you know, we note in the paper too that the utilization increase, you know, there's a real utilization increase, but at least a part of that is due to the kind of widespread fraud and abuse in this sector.

DR. PAUL GINSBURG: Good. Thanks, Brian. I'm going to ask you another question now, and let me begin by saying that I learned an enormous amount from your draft chapter, and it was really well done and very, very informative.

You know, when I think of the big picture on

what's happening, you know, it was recognized that Medicare's administered prices for laboratory services, you know, based on very old cost data and not reflecting anything in the market, had led to rates being higher than what private payers were paying, and that was an obvious problem. But the way the legislation went about trying to substitute private data, you know, first of all it had this, to me, flaw of try to do a weighting of all types of providers -- high priced, low priced, depending on that. And whereas we didn't get the impact of it because we didn't get much response from the high-provided provides, you know, a more representative sample would bring them in, as you said, and this would likely lead to Medicare paying more.

To me, we have to either keep innovating on this administered pricing approach, and I guess the innovation would be having much stronger weighting for the lower-priced providers in this. Otherwise, Medicare becomes hostage of the leverage that is happening and affecting private insurers as well.

The other thing would be to start talking about ways of bringing competitive bidding into this, either with

or without reference pricing, as perhaps a much better long-term solution, and probably would really help on dealing with the newer tests, where there's less competition, at least in the private sector, that perhaps Medicare competitive bidding would be what really brings in the competition to these areas more difficult to penetrate.

So I'll stop now. I may have more thoughts later after I hear from my colleagues.

MS. KELLEY: Okay. I have Jon Perlin next.

DR. PERLIN: Thank you for a very thoughtful chapter. First of all, let me agree with Paul that the survey provides the information with reduced administrative burden makes all the sense in the world to the extent that it's representative, point one. Point two is that, you know, we've really got an apples-and-oranges situation here. We've got the high-volume tests that are broadly available in commercial labs and individual labs, and to clearly state the obvious, those commercial labs are highly consolidated, and those are basically commodities. But I want to point out a difference between when those commodities are available in the commercial labs versus hospitals or doctor offices.

The second is the proliferation of new, very expensive, low volume, highly complex molecular tests. That's a totally different kettle of fish and lumping these two together is just challenging. You know, when we were examining, in my organization, proliferation of these new low-volume, molecular tests, it was the order of, you know, tens of these a week. Some of them were actually new and some of them just new bundles around a particular disease or whatever, but extremely expensive.

So that drives me to my third point, having separated the two. You know, if you've got commodity-type lab tests that are available in commercial, independent labs, and they are highly consolidated, what's the big difference between getting that lab there and getting it in the hospital or a medical center, clinician's office? Well, it's the availability, the immediacy, and, by definition, it's lower volume.

So I think that commoditized bunch, you've got to think about including the hospital offices, because the tradeoff is, yes, they are more expensive. They are more expensive because they do lower volume. The utility, though, is the immediacy in answering a clinical question.

I don't have any data on this, but, theoretically that could mitigate additional hospitalizations or additional visits or whatever.

I wish I had clear insight into the new molecular tests, but I am just concerned that given the volatility in that area as emerging that it may be less possible to sort of lump it into this is how we're going to do it. Thanks.

MS. KELLEY: Mike, I think that's all of the questions and comments.

DR. CHERNEW: Okay. So I will make a comment while other folks ponder if they have other questions. Otherwise, we will get more of our Good Friday back.

There are, I think, two different threads here that are important. The first one is the distinction between the types of tests. I acknowledge that distinction and I think the chapter actually does a good job of making that distinction. They are combined together because they are lab tests but in many ways how we think about them, how we price them, what we do is, in fact, different, and I think, Jon, that was the theme. You're in a small box on my screen, but I think that was the theme of at least part of your comments, and I think that's right.

The second theme has to do with both the combination of the administrative costs and conceptually what we want to do. So I agree with what Paul had said, which is conceptually it's not 100 percent clear to me want to just use the average price, because some of the prices may be higher than they need to be. We want to do something, in my opinion, that's sort of more analogous to what we do for all of our approaches, which provides the reimbursement for an efficient provider, whatever that means. So there's always some data issues there that matter.

And relatedly -- and this is really sort of a question for Brian -- the chapter had some discussion about the challenges of using actual claims data, which I accept those challenges. I think the other theme, of course, is there's challenges in the survey, and maybe people are reporting doing a bunch of other things. Can you take a moment and talk about the concerns you have, or the major concerns you have with actually just using claims data in a variety of ways to do this, which you're about to reiterate some of the things in the chapter about the weaknesses, but I think it's useful to get some of that out in public, so

we understand the different options that were considered.

MR. O'DONNELL: Sure. So I think the option you're talking about, I was just relying on kind of the HCCI, they're the FAIR Health's of the world, these existing kind of private payer data warehouses. And so we did go and look at -- we used FAIR Health data. We did go analyze data from one of these large claims databases, and I think conceptually you could think that it's kind of get data, push button, get rates. And, you know, I think when we started thinking about it, I think there are some limitations, not with the particular data set that we analyzed but just in general, about, you know, how -- so right now, kind of the program can mandate compliance, and so for these private payer databases, you know, certainly payers don't have to submit the data. So you can't guarantee that you're going to get a representative sample or representative census for the particular types of payers that you want. So, you know, the Congress mandated certain types of payers had to report their data, or labs had to report data and certain types of payers, including MA and Medicaid MCOs and other private payers.

So I think the ability to kind of customize it to

your needs and wants is probably more limited than you would like, and that certainly is the case with kind of a boutique kind of data collection process.

DR. CHERNEW: So I do appreciate that, and as we go forward, I will just say, first of all, all those are completely valid concerns. I think the question is the quantification of those concerns with the quantifications of concerns from another somewhat imperfect method. And so I would not argue anything you said. In fact, the opposite would be true. I would support -- if asked the same question that you were just asked by me, I would give the exact same answer that you gave. I think that was spot-on. And I think like many things, there is a balance, and I think as we continue to go through this, we'll think about that balance. But I think the work we've done with RTI is really important because you can't compare this balance unless you've really done an example to see how the other options and what they would be. And I think you've outlined a really important and useful way to get at a lot of this that we can then compare. And I think we can -- this will not be the end of this discussion either. It is another important conflict, one that we deal with. So this

will be for -- as we delve into this further, we will see where it goes. But I really do appreciate that work.

DR. PAUL GINSBURG: Mike, before we sign off, can I --

DR. CHERNEW: Yes.

DR. PAUL GINSBURG: One quick thought on this. It seems as though the report definitely answered the questions that, you know, Congress asked us. But it seems to just be getting into the issue of how should Medicare be paying for clinical laboratory services today and going forward. And it almost seems like, you know, we've done what they asked, but we haven't really done the job of, you know, coming up with -- rather than patching the current policy of getting better ways of collecting the data, you know, should we take it on ourselves to actually go and come up with the best approach given what we know today in this area, rather than just answer the questions.

DR. CHERNEW: Yeah, so assuming that that was sort of not a rhetorical question but one addressed to me, and I sometimes suffer the fate of believing that rhetorical questions were actually asked of me, I will find an answer, and I think the short answer is, yes, we should

be broad in our thinking about how we pay for things. That is true across all the things we pay for, so I think that's what you're leaning towards, and I agree with you. And the question then is how that fits into the rest of the many, many other things that are on our plate and how we deal with them.

So, again, there's a lot to be done in a lot of areas, and this is one, and how we prioritize that and, frankly, how far outside of the box we want to go is just something that has to be an ongoing conversation. I know there's interest -- you mentioned in your comment, for example, aspects of bidding, which I understand, and there's questions about how far to go down that path and what data to get and how we would do that work. And, again, we will have to continue to discuss where that fits into the overall agenda. But the short answer to your question -- I guess the ship has sailed on short. The most direct answer to your question is we should not limit ourselves to exactly what we were asked necessarily, and make sure that across all aspects of Medicare payment we're thinking about how to give the appropriate reimbursement to efficient providers.

DR. PAUL GINSBURG: Yes, thanks, Mike. You know, when I think back, when you mentioned rhetorical, perhaps the question was half-rhetorical, but you have given a great answer.

DR. CHERNEW: I'm pausing intentionally, by the way. Dana, I don't think there's anyone else in the queue, but I've lost track of the queue.

MS. KELLEY: No, there's not.

DR. CHERNEW: This is sort of the "going once, going twice, going three times" pause.

[Pause.]

DR. CHERNEW: Okay. So to those of you listening, please remember the standard statement that we really, really look forward to your comments. Please reach out to us and make them. We will listen. The earlier in every cycle you get to us, sort of the better.

I want to give a particular shout-out to Karen and Sue who are enjoying their last meeting. I actually think this was a really interesting set of topics for that meeting. Your contributions have been invaluable, and you will be missed both professionally and personally. So, again, a real shout-out.

I want to give a shout-out to David Glass, who I hope is listening, for all I've learned from him, even going back to 2008 when I started my first time here, but throughout. It is, in fact, the staff that makes MedPAC's work so strong, and I really appreciate the dedication and the contributions that David made.

And to Molly and Sam and Carolyn and -- I need to make sure I get this exactly right. I am so sorry. Molly, Sam, and Carolyn will be departing. Again, I haven't got to meet you in person because of this very odd year, but your contributions have been important. I think it's fitting, Carolyn, that you got to close out your time presenting, and we look forward to seeing you in upcoming years. So that will be great.

We will continue focusing on all of the issues we have discussed. Does anyone want to add any broader last words as we close this cycle and prepare for what will be a much more traditional cycle with any luck going forward?

[No response.]

DR. CHERNEW: Jim, I'm looking at you.

DR. MATHEWS: I think we're good. We will rejoin our next public meeting cycle beginning September 2nd and

3rd and again, hopefully under more traditional circumstances.

DR. CHERNEW: Yes, and so thank you to all the Commissioners for your time this cycle and making my first somewhat odd year as productive as I think it was. I really think we've gotten into a good place in many areas, and that's all due to your engagement and professionalism.

So, again, thank you. Good night, everybody. Have a wonderful summer until we reconvene again.

[Whereupon, at 11:39 a.m., the Commission was adjourned.]