A Summary of the Medicare Payment Advisory Commission (MedPAC) Virtual Meeting

HIGHLIGHTS FROM THE SEPTEMBER 1-2, 2022, VIRTUAL & IN-PERSON MEETING

PREPARED BY HART HEALTH STRATEGIES, INC.

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Context for Medicare payment policy

Presentation

Rachel Burton

Overview

COVID-19 has had a disproportionate impact on Medicare beneficiaries. Seventy-five percent of COVID-19 deaths were among people ages 65+. Medicare beneficiaries with disabilities (of any age) have had 50% higher risk of hospitalization than beneficiaries who qualify for Medicare due to age alone.

COVID-19 impacted health care utilization rates and health care providers' revenue. In the early months of the pandemic, people ages 65+ avoided care. Health care utilization began to rebound within a few months. Nearly half of Medicare beneficiaries ages 65+ reported having a telehealth visit in the past year. Congress appropriated hundreds of billions of dollars to providers to ensure they remained a viable source of care.

The Medicare program is now in a slightly better position financially than it was a year ago. Strong economic growth has led to higher-than-expected Medicare payroll tax revenues. Medicare beneficiaries who died of COVID-19 in 2020 tended to be high-cost beneficiaries with multiple medical conditions. National health care spending consumes a growing share of the country's gross domestic product (GDP). Medicare spending is expected to double in the next 10 years. Medicare Advantage (MA) spending per beneficiary has grown faster than fee-for-service (FFS) spending per beneficiary. Medicare faces a financing challenge: the number of workers per Medicare beneficiary is declining. To extend the solvency of Medicare's Hospital Insurance Trust Fund for 25 years, the Medicare payroll tax would need to be raised from 2.9% to 3.66%, or Part A spending would have to be reduced by 16.9%. General tax revenues have become the largest source of Medicare funding. Medicare FFS beneficiaries pay substantial premiums and cost sharing. Beneficiaries' reported health status has been improving over time. The most common chronic conditions are relatively inexpensive, and the most expensive conditions are relatively rare.

Clarifying Questions

Chair Chernew opened the discussion by emphasizing that when MedPAC makes recommendations, it applies the MedPAC criteria – paying efficiently to ensure access to high quality care. The Commission is not trying to solve the much broader set of challenges outlined in this chapter; MedPAC is not the Independent Payment Advisory Board (IPAB). He repeatedly stressed that this context chapter should be limited to issues that will not arise in other places.

Commissioners asked a variety of clarifying questions, including:

- ***Commissioner Ginsburg*** asked about how labor shortages more broadly have impacted Medicare, and about cost-sharing in MA plans. Staff could not speculate on the labor shortages issue. They noted that cost sharing should put a break on utilization – but pointed out that for 90% of beneficiaries this is a moot point because of supplemental coverage, etc. ***Commissioner Ginsburg*** suggested a greater focus on those beneficiaries with supplemental plans/original Medicare. ***Executive Director Mathews*** added that several years ago MedPAC had a series of chapters on redesigning the FFS benefit. They included discussion on the need for a supplemental charge on Medigap to offset the inductive effects of supplemental coverage.

- *Commissioner Safran* asked about extending the solvency of the trust fund – with the raising of the payroll tax, would it be possible to share what this would look like for employees? Staff responded that this would be difficult to identify, but they will see what they can do.

- *Commissioner Barr* asked how many FFS beneficiaries have supplemental insurance? She would like to see more on supplemental insurance trends. Staff will investigate this – how many beneficiaries have no supplemental coverage and how that has changed over time.

Commission Discussion

Suggestions for Chapter Revisions and Future Work. *Commissioner Poulsen* observed that in the list of prevalent vs. costly conditions, these are often also chronic vs. acute. He suggested staff look at how long these persist over time.

Commissioner Dusetzina suggested framing this chapter as - Medicare may have to pay more, but how can the program preserve access for beneficiaries without getting into a bidding war with private plans? Does the Commission need to draw more of a distinction between MA and FFS because the solutions and ways payment is thought about are different?

Commissioner Grabowski suggested that the chapter be more detailed about MedPAC's past recommendations and solutions.

Commissioner Casalino suggested explaining more about how consolidation impacts what Medicare pays, and mention that in decreasing competition consolidation can also decrease quality and perhaps access. *Commissioners Ryu* and *Barr* agreed with this point, with Commissioner Barr noting that depending on if the affected area is rural or urban, consolidation could save a community. *Commissioner Safran* underscored value-based payment as a lever for addressing these issues – pointing to the chapter last year on this evidence. She agreed that MedPAC should highlight the link between consolidation and value-based payment and the tradeoffs that are seen there: the benefits of consolidation to enable value-based payment along the downsides with respect to quality/access/cost.

Chair Chernew closed the session acknowledging the good discussion and engagement with the material. The challenge is not to solve all the fiscal problems of Medicare. MedPAC will look to add some of the issues discussed but will try to avoid in depth picking of topics. He will push to be disciplined in what is discussed in this context chapter.

Standardizing benefits in Medicare Advantage plans: Cost sharing for Part A and Part B services

Presentation

Eric Rollins

Overview

Staff noted that they will use the term "standardized benefits" to refer to both covered services and enrollee cost sharing. This presentation focuses on Part A and B services. Later this fall, they will give a presentation that focuses on non-Medicare supplemental benefits.

Selecting an MA plan can be a challenging process for beneficiaries. Plans differ on many dimensions. The average number of plans available doubled between 2017 and 2022 (from 18 to 36). Researchers have found that people have more trouble comparing plans when they have a lot of choices. Requiring plans to have standardized benefits could make it easier to compare plans. Standardized benefits have been used in other health insurance programs. All Medigap policies have been required to use standard benefit packages since the early 1990s. Some states specify the deductibles, cost sharing, and annual out-of-pocket (OOP) limits for their Affordable Care Act (ACA) plans.

MA plans can develop their own cost-sharing rules instead of using FFS rules. Plans can use copayments or coinsurance in most costs. Plans must charge a single, bundled cost-sharing amount for any facility services. Most plans use some of their MA rebates to charge lower cost sharing than FFS. MA cost sharing is subject to aggregate and service-specific limitations aimed at ensuring plan designs are not discriminatory. Most regular MA plans (82%) use daily copayments for inpatient acute care. Copayments are usually charged for the first five to seven days of the stay and amounts usually range from $200 to $400. MA cost sharing cannot exceed average FFS cost sharing for certain lengths of stay. MA cost sharing for inpatient acute care is typically lower than FFS cost sharing. MA and FFS cost sharing for skilled nursing facility care are relatively similar. Regular MA plans use copayments for many Part B services. Plans at the 90th percentile may charge two to three times more than plans at the 10th percentile. Special needs plans (SNPs) often have different cost sharing rules than regular MA plans.

Requiring MA plans to use standardized benefits would raise challenging policy issues. Plans would still cover all Part A and B services but hospice; standardization would focus on enrollee cost sharing. Plans could use a limited number of benefit packages. Standardization could be tied to actuarial value or involve the use of detailed plan designs. Staff presented an illustrative example of MA benefit packages with standardized cost sharing for Part A and B services. Potential payment implications: plan bidding behavior would change in ways that are difficult to predict. Standardization would give plans fewer ways to respond to changes in payment rates, and plans receive more rebates in some markets than others.

Clarifying Questions

Chair Chernew noted that this is not a question – should MA plans use standardized benefits - that MedPAC is voting on any time soon. He is just looking commissioners' general impressions. What problem are we trying to solve with this? To simplify choice. To support competition. There are other things that could be facilitated (competitive bidding) by standardized benefits.

Commissioners asked a variety of clarifying questions, including:

- ***Commissioner Dusetzina*** highlighted the doubling of plan options between 2017 and 2022. She asked staff to produce this numbers year by year. Staff will get that information. There was a jump in the number when the meaningful differences rule was eliminated.

- ***Commissioner Ginsburg*** quibbled with the idea that MA plans usually offer extra benefits – that is the reason they exist. Staff understood this point – but it is extra vis-a-vis FFS.

- ***Commissioner Kan*** asked if staff sees the dominant design being a low generosity product? He is trying to reconcile geographic cost variation information. Staff could not currently answer that, but we can look at it in future work. Commissioner Kan also asked them to contemplate assigning

actuarial values to plans. Staff asked him to consider the level of detail he would want to get down to. *Chair Chernew* noted that the ACA created metal tiers based on actuarial value, ignoring complaints about their actuarial calculator. There are de minimis rules around that. The Commission is not currently talking about standardize benefits within an actuarial value.

- *Commissioner Ginsburg* asked if staff expects cost sharing amounts to differ county by county depending on the actual cost of services? *Chair Chernew* responded that no – he does not envision them varying by county. MedPAC is not picking benefit packages. Staff did not do a specific dive into what this should look like, beyond standardized benefit categories and standardized values.

- *Commissioner Safran* noted existing differences across states in the way that standardization is done. Has there been any leveraging of that natural experiment – whether different ways of standardizing do or do not help consumers make rationale choices? Staff responded that CA has always had standardized plans. MA switched to a more standardized approach and the share of people who chose more generous plans went up. It was easier for beneficiaries to understand how plans differed, and insurers offered plans that were not on the market before. Chair Chernew believes standardization was central, to his understanding. It is high on the list of the experience for navigators and patients. The ability of plans to drive selection can diminish. He does not know of any states that went to standardization and then went back.

- *Commissioner Casalino* noted that it would be good to mention both the number of plans and the number of carriers in the chapter. He is concerned that commissioners are not all thinking about the same thing in terms of standardized plans. Each plan has the same benefits clinically but could vary on network of providers. That is what we have now. What is under discussion today is the standardization of cost sharing for these services. The issue is not supplemental benefits or networks.

Commission Discussion

Benefits to Patients, Provider Network Considerations. *Commissioner Sarran* explained his understanding of the Commission's goal here - promoting transparent, innovative, competitive marketplaces.

Commissioner Dusetzina noted the need to think about what the network looks like for patients' specialty care needs – if that network is not visible, it is hard to make the right plan decision. She would like to see more of that information brought in as the Commission thinks about standardizing. *Commissioner Barr* thought that the point of this work is to give them a starting point, and then patients can dig into more information.

Commissioner Kan noted the contextual differences between MA and the ACA - seniors on a fixed income cannot have unexpectedly high-cost sharing. He also noted standardization could reduce competition if not done correctly; there is huge geographic cost variation, and winners and losers will be created. It would be harder for smaller plans to differentiate themselves.

Commissioner Barr is excited about this and fully endorses the work for the sake of the beneficiary. It is impossible for them to evaluate options today. The broker system is broken. Plans could save broker fees by participating in a voluntary such program.

Commissioner Cherry believes today's work is directionally correct. There is currently a dizzying array of choices, and it does feel very transactional. Patients want to make sure they can access the plan they sign up for – plans should start with access to their primary care physician.

Commissioner Grabowski commended the illustrative examples. He supports matching cost sharing amounts rather than actuarial value. He does not want to create a two-tiered system for existing plans and enrollees. There should be an on ramp instead.

Commissioner Ryu agrees that there is a strong case to be made for simplification, but there is also a balance to strike – some of these elements are not standardizable (provider networks).

Commissioner Rambur is confident that people have stuck with plans because it is too confusion to switch to something different. She prefers a metal tiering approach vs. a very detailed menu of option. She would like more information to better understand if insurers could offer same package with different networks.

Commissioner Safran outlined her understanding of this work – it aims to achieve the ability to choose across plans with everything held constant other than price. Standardizing based on cost share and benefits rather than actuarial value comes closer to that goal. Coinsurance is such a black box. She suggested the possibility of convening consumer focus groups as MedPAC toys with different ideas to get input.

Innovation Tradeoffs. *Commissioner Poulsen* discussed the need to be mindful that action does not freeze out potential future innovation that would be beneficial. It is difficult to get innovation through consensus that must go through a bureaucratic process.

Commissioner Navathe acknowledged that there is evidence base for the Commission to be building off – MedPAC is fortunate. This should be scaffolding to launch this work. There are benefits to consumer choice, competition is better, positive selection effects. This is not a binary choice between standardization vs. innovation/flexibility. He suggested more analysis on regional variations.

Commissioner Casalino expressed concerns that these changes could lead to more consolidation on the insurer side.

Commissioner Kan agreed on the need to strike a balance to maintain innovation.

Medicare Advantage encounter data

Presentation

Luis Serna and Andy Johnson

Overview

Staff explained that Medicare Advantage (MA) plans are required to submit detailed information about each encounter an enrollee has with a health care provider, which – as of 2022 – is the sole data set used by CMS to calculate MA enrollee risk scores. Given risk scores drive Medicare payments to MA plans, and nearly half of eligible beneficiaries are enrolled in MA, the accuracy of these data are critical.

Staff provided background on the collection and use of these data, along with concerns the Commission raised related to significant data errors and omissions in these data and recommendations for improving the data in its June 2019 Report to the Congress. Staff noted that encounter data continues to be an incomplete reflection of the services used by MA enrollee, and highlighted the limited understanding of how MA plan payments correspond with service use, quality of care, and the provision of extra benefits that plans use with their rebates.

Unfortunately, plans are not incented to submit *complete* data, only data that contributes to risk scores. As a result, staff found that plans generally submit inpatient, outpatient and physician records, but not those for other settings given they are not used to risk adjust.

At present, data remain incomplete but is improving. Staff noted that, over the next cycle, they plan on examining whether the data can be used to analyze utilization patterns of inpatient psychiatric facilities, home health, and some Part B drugs. Staff asked Commissioners to discuss the current state of encounter data, other potential uses for encounter data and provide any other feedback as appropriate.

Commission Discussion

Commissioner Casalino said it was outrageous that we don't have better encounter data, but asked a few clarifying questions about the difference in claims and encounter data, what data would not likely be submitted as encounter data, and is its plans or providers that are the root cause of CMS not having complete encounter data. Staff explained that claims data is encounter data, but encounter data includes more than claims data as some encounter data are not payable. They also explained that encounter data that does not contribute to a risk score, such as data from home health, may not be submitted. ***Commissioner Kan*** suggested that plans submit all encounter data they receive, thus providers may not be submitting it to them for transmission. ***Commissioner Casalino*** suggested including information on prior recommendations, specifically around the role of the Medicare Administrative Contractors (MACs), in the chapter.

Commission Dusetzina was very enthusiastic about getting improved encounter data, and highly endorsed more data on Part B drug use, particularly when it comes to medication dosing (i.e., how much of a drug was administered).

Commissioner Grabowski echoed Commissioner Casalino's outrage and desire for complete and accurate encounter data. He was curious about matching to MDS data, similar to what was done for OASIS data, which staff is still looking into. He also noted that a lot of health economists are using encounter data and suggested there may be some lessons learned from this group of stakeholders.

Commissioner Damberg said she wholeheartedly supports effort to improve the completeness of the data, as well as granularity. She urged the Commission to "double down" on some of its prior recommendations, and also suggested considering a payment withhold (note: this was done in California).

Commissioner Barr noted the value of encounter data to providers, particularly in risk-based or value-based payment models. She hoped to have data beyond just MA, but for all commercial insurance. She said health information exchanges "are dead" and most data in EHRs is a mess. She supported the concept of having encounter data reported directly to the MACs since they are a familiar entity to the providers and also felt this would reduce administrative burden and costs, thus improving margins. Finally, she called for a standardized data set so that plans are collecting and sharing data that is

comparable and easy to merge. ***Chair Chernew*** noted the difficultly in the last point because of how MA plans pay or cover things differently, thus meaning they are not collecting the same data. He also reiterated that this is just an informational session, but no plan for recommendations. ***Executive Director Mathews*** noted that staff have talked to providers about their experience submitting encounter data, and some of the things they heard is that any given provider might be working with eight or nine different plans in their market, each of whom has a somewhat unique or idiosyncratic manner of submitting encounter data; different fields, different protocols, etc. The staff also heard that providers would have the experience of submitting an encounter record to a plan and it being bounced back as "un-submittable" with little explanation as to why it was bounced back, or how to correct it so ensure the data would be accrued to the encounter record. The MACs have processes for submitting no-pay claims, making this a potentially more streamlined and consistent method of submission of encounter data. ***Commissioner Damberg*** said this is precisely what providers in California experienced, and it created a lot of administrative burden. ***Commissioner Kan*** thought it would be better to have the providers submit to the health plan and the MACs, as the health plans use this data differently and for other back-end processes.

Commissioner Cherry was interested in seeing the Commission to more exploration and discovery on this issue, as – from a provider perspective – all of this data is in the medical record somewhere, but for some reason it is not making its way to where it is needed.

Commissioner Poulsen highlighted challenges that might be present when providers are in capitated arrangements and wouldn't ordinarily submit anything. Several commissioners suggested the number of capitated arrangements is relatively low.

Commissioner Casalino reminded the group that MedPAC has very explicitly told Congress that the Commission can't measure quality in the MA program. This is a huge issue because MA makes up almost half of Medicare. He said Medicare has been overpaying MA plans for 30 years, and not one of those years has the MA program saved Medicare money. He is tired of the "excuses," and wanted to know what the next steps would be in the roadmap to addressing this. ***Chair Chernew*** said they are not looking to make other recommendations this cycle, but some of this is foundational to other topics and will continue to be a focus.

Commissioner Sarran wants to see more studies on this issue because he suspects there is some other issue going on that is causing challenges with getting the needed encounter data. ***Commission Poulsen*** agreed there could be some issues related to inconsistences in data collection, which ***Chair Chernew*** agreed with and provided examples and exceptions.

In closing out the session, ***Chair Chernew*** noted the takeaway is that the MA program has been, and is growing to be, very important. He said the MA program itself was not designed to be as big as it seems to be growing, making these discussions on data more important.

Reforming Medicare's wage index systems

Presentation

Alison Binkowski and Jeff Stensland

Overview

Chair Chernew noted that the session would provide an overview of the issues with wage indices, and depending on how discussions go, the work may lead to recommendations this cycle. Staff noted that this work updates work from a June 2007 report and from information presented in October 2021.

Staff began by providing an overview of the current Medicare wage index systems, noting that Medicare's prospective payment systems (PPSs) use wage indices to adjust Medicare base payment rates for geographic differences in labor costs. This is generally done by multiplying the labor share of the PPS national base rate by the relevant wage index value for the area where the provider is located. For most provider types, CMS uses one wage index based on acute care hospitals' cost reports.

To calculate the initial wage index, CMS calculates the aggregate average hourly wage for acute care hospitals in each area and divides that by the national average. For 2022, the initial wage index is based on wages and hours from about 3,200 acute care hospital cost reports that began in 2018, which were aggregated to reflect relative costs for 459 labor areas, including 411 metropolitan statistical areas (MSAs) and 47 rural areas. Staff noted that most areas have wage index values slightly below 1, but a minority had much higher or lower values.

CMS starts by calculating the occupational-mix adjusted hospital wage index by using a separate survey of acute care hospitals to recalculate what each area's average hourly wage would have been if hospitals had employed the national average nursing mix. CMS then applies up to four types of exceptions, including:

- Reclassifications, which provide for a recalculated area wage index generally using all hospitals that are either located in or reclassified into each area
- Three wage-index floors, which apply to either the relative or absolute wage index for certain areas
- Out-migration, which provides for increases in counites with a high share of hospital employees who commute to higher wage areas
- Low-wage, which provides for increases for hospitals in the bottom quartile of wage indices

However, there are several concerns with the current wage index system, including:

- Failure of the system to isolate differences in labor costs (as the system also reflects hospitals' market power and their ability to keep wages low, which creates issues of circularity; hospitals' employment decisions regarding the relative mix of different occupations with different wages; and wage index exceptions for acute care hospitals that are not based on empirical differences in labor costs across different labor areas – e.g., there is no empirical basis for the wage index floors). CMS and Congress have tried to address these failures, but their efforts suffer from limitations.
- Exceptions allow manipulation and add burden, of which hospitals have increasingly taken advantage. For example:
    - Certain high-wage hospitals are reclassifying to rural areas, thereby raising the rural floor and increasing wage index values for urban hospitals in that state at the expense of all other states due to budget neutrality.
    - Certain low-wage hospitals are cancelling rural classification and then reapplying only once it is too late for CMS to include their data
    - Certain large urban hospitals are first reclassifying to rural areas and then reclassifying again, in the process gaining non-wage-index benefits such as residency spots.

In FY 2022, about 68 percent of acute care hospitals benefitted from at least one wage index exception, which can result in substantial increases in these payments. Acute care hospitals therefore have strong incentives to fight for their exceptions.

- Determination of labor areas based on either MSAs or the aggregation of the rest of the state's rural areas, without county-level smoothing, can result in a wage index for the large non-MSA area that does not account for variation across the state's non-MSA areas, as well as cliffs in wage index values across labor area borders.
- Use of initial IPPS wage index values for other PPSs, which may not accurately reflect the relative labor costs faced by other providers due to differences in wages or the mix of occupations employed by each provider type.

To address these concerns, staff have considered an alternative wage index, where the goal would be to accurately measure the labor costs of doing business that differ solely because of geography. Staff suggest that, to meet this goal, the wage index method would ideally use cross-industry, occupation-level wage data, weighted by sector-specific occupational weights; account for county-level variation in relative wages and smooth wage indices across adjacent counties; and have no exceptions. To the extent the policymakers do want to increase payments to certain providers, in particular those that are important for access and vulnerable to closure, payment increases should be targeted specifically to the providers to achieve defined and relevant policy goals and not made inefficiently through unrelated measures like the wage index.

Staff applied these principles to develop an illustrative alternative wage index for acute care hospitals, applying the methodology detailed on slide 17. Staff noted that the alternative isolates county-level differences in labor costs while limiting wage index cliffs, minimizes opportunities for manipulation and reduces administrative burden on Medicare, and more accurately reflects geographic differences in labor costs, all relative to the current system. Staff noted that under this alternative (if implemented in a budget neutral manner), IPPS payments would increase for acute care hospitals with no current wage index exceptions, a relatively low current wage index, in areas where acute care hospitals pay less than the usual premium above other employers' wages for similar employees, or in counties with higher wages relative to a parent area or adjacent to a county with a much higher wage index. Payments would change by more than 5 percent for a small minority of acute care hospitals once fully phased-in.

CMS also developed alternative wage indices for other providers using a similar methodology, but using occupations and weights specific to those sectors. This would result in wage indices that more accurately reflect relative labor costs for each provider type. Effects would be generally similar to those seen for the IPPS alternative wage index, but impacts on individual providers would be greater as other sectors have a higher labor share.

Commission Discussion

Overall Enthusiasm and Support for Particular Policy Elements. Commissioners generally voiced support for the work.

- *Commissioner Grabowski* noted that smoothing across areas is really important. However, he expressed concern about potential cliff effects of a 10 percent limit as reflected in the methodology used to develop the alternative.
- *Commissioner Grabowski* supported the idea of not having any exceptions. *Commissioner Poulsen* also noted that exceptions decrease transparency and increase sense of unfairness, and he

agreed with the elimination of exceptions. *Commissioner Damberg* noted that there are many problems with the current system, including the exceptions. *Commissioner Casalino* also supported eliminating exceptions.

- *Commissioner Grabowski* supported the idea of reweighting jobs based on who works in a hospital versus who works in a SNF. Applying the hospital wage index to other facility types, as is done under the current system, is problematic.
- *Commissioner Poulsen* agreed with the goal of separating the wage index from other policy goals. *Commissioner Casalino* suggested that focusing on addressing the policy issue could be a principle that applies across all the Commission's recommendations.
- *Commissioner Navathe* indicated that the wage index should be descriptive, not normative, and that the Commission should clarify that it is not suggesting that a particular way to staff facilities is right.
- *Chair Chernew* noted that there were two main approaches for thinking about improvements to the wage index – one to eliminate exceptions and one to focus on specific occupations.
- *Chair Chernew* noted that there is a problem in that what hospitals are paid influences what they do. An advantage of the occupation approach is that it breaks this cycle, but it creates other issues.

Clarification Questions.

- *Commissioner Kan* asked why the Commission's previous 2007 recommendations were not implemented. *Chair Chernew* suggested that it was less important to consider whether or not a recommendation will be implemented and more important to consider whether it was the right thing to do. Staff also noted that there is value in having a recommendation in the public sphere as a point of reference.
- *Commissioner Barr* asked how an urban hospital reclassifies as rural. Staff noted that hospitals may reclassify if they are in what is considered a rural county within an urban area. Increasingly commonly, urban hospitals can also reclassify under section 412.103 of the regulations, including by otherwise meeting requirements to be a rural referral center, which most large urban hospitals could meet. Rural referral centers get benefits such as 340B eligibility and the ability to reclassify to a different area, which can provide financial benefits.
- *Commissioner Navathe* asked how prevalent it is for rural hospitals/areas to have higher wage indices than urban areas. Staff noted that frontier areas have a floor of 1.0, so they can have higher wage indices. When some hospitals reclassify to rural, they can also raise the wage index. With respect to initial wage indices, it is not common, but it is also not rare. An example is Nantucket, where the higher rural wage index is appropriate.
- Commission Navathe asked about the distribution of wage indices by hospital. Staff noted that it looks similar to the distribution in of wage indices by labor market areas, with roughly the same number of hospitals above and below a value of 1.
- *Commissioner Navathe* asked whether there was an empirical basis for using a 10 percent geographic area adjustment in the illustrative model, and staff indicated that that size of adjustment was generally reasonable based on the data, but it was primarily based on the perspective of what would be a reasonable policy.
- *Commissioner Rambur* asked staff to reconcile two competing concepts: one that occupations and weights vary across sectors, and second that organizations can compete across sectors and services. Staff noted that all employers of RNs, for example, are competing for the same pool. Within a given area, however, different employer types (e.g., hospitals versus SNFs) may offer different levels of pay but also require different levels of work (e.g., twice as much pay for twice

as much work).

- *Commissioner Ryu* asked which jobs are included in the wage index. Staff noted that it is all occupations that are included on the cost reports. This includes clinical staff, maintenance, administrative, etc. Staffing is allocated across different units of the hospital. It does not include physician services or other advanced practice practitioners since they are not paid under the IPPS. It does include contracted positions.
- *Commissioner Damberg* asked about the use of geographic labor market areas defined by MSAs, with the rest included in residual statewide rural areas. Staff noted that because of sample size issues, it would be difficult to leave areas outside MSAs disaggregated.

Additional Analysis.

- *Commissioner Barr* asked whether staff had looked at the impact of the wage index changes on rural and safety net hospitals. Staff noted that they hope to come back with such analysis in the spring.
- *Commissioner Ryu* noted that many aspects of hospital staffing (e.g., IT, data, back office) are becoming increasing done via remote work. He asked whether the market is really local, or whether it is more national in those job classes. He suggested that this may be something to reconsider in the analysis. He noted that in his system, staff working on electronic medical records come from a national market, and some even come from different industries. Staff noted that most hospital staff work onsite, and if wages are equal, then it would not be a problem for updating wage indices and would likely decrease differentials across areas. In contrast, extracting these staff from the beginning could lead to bigger, but inappropriate, differentials across labor areas. *Commissioner Cherry* noted that remote work is challenging. It is not clear what proportion of the workforce will be remote and how that will affect costs. *Commissioner Poulsen* agreed with the need to consider remote workers, including for clinical care. *Commissioner Navathe* indicated that the Commission would need to track remote work over time. While he agreed that remote work would lower the differential, remote work may be more prevalent for rural areas than urban areas, so the effect may not be uniform. He did not think that it necessarily needed to be addressed for this recommendation.
- *Commissioner Damberg* suggested the need to be forward thinking about potential unintended effects.
- *Commissioner Casalino* noted that hospitals sometimes pay employed physicians more than what they receive under the Physician Fee Schedule and asked whether that makes a difference. Staff noted that no physician wages (except for administrative positions) are included in the wage index discussions.

Other Topics

- *Commissioner Cherry* noted a concern about downside risk to providers of up to -5 percent. Many physician practices are under considerable stress, trying to pivot to value-based care. This could be a stressor that could be introduced to the system a little too quickly, so caution may be needed. Staff noted that there is a separate geographic adjustment for physicians and that the Commission is not addressing the physician adjustments at this time.

Chair Chernew concluded by noting that there is a lot of enthusiasm for this issue. He noted that the Commission will likely separate out recommendations related to the exceptions and recommendations for the alternative scenario. He noted that this is a very important issue that can have implications across different payment areas, including Medicare Advantage and alternative payment models.

Addressing high prices of drugs covered under Medicare Part B

Presentation

Nancy Ray and Kim Neuman

Overview

Staff reviewed Part B coverage of a range of products. Price has been the largest driver of Part B drug spending growth. Most Part B drugs are paid at a rate of 106% of average sales price (ASP). Medicare Part B has limited tools to influence drug prices. Estimates suggest that U.S. drug prices are roughly double the prices in other countries. Higher prices in the U.S. reflect higher launch prices and more post-launch price growth. Some products approved under the FDA's accelerated approval (AA) pathway are launching at high prices with uncertain clinical benefit.

Staff outlined the following policy objectives for addressing high drug prices and price growth: improve payment for drugs with uncertain clinical benefit, spur price competition among drugs, improve financial incentives under the Part B drug payment system, and maintain incentives for innovation. They discussed the following options to improve Medicare's payment for Part B drugs.

For Part B drugs with uncertain clinical benefit: set a cap on payment until post-marketing trial confirms drug's clinical benefit. The cap could be based on the AA drug's estimated net clinical benefit and cost relative to standard of care, some increment of the payment rate for the standard of care, or 106% of the AA drug's ASP for three years and thereafter, based on payment rate for standard of care. Rebates could be established based on a percentage of the AA drug's ASP.

For Part B drugs with therapeutic alternatives: apply reference pricing. In 2017, the Commission recommended a type of reference pricing (consolidated billing code) for biosimilars and originator biologics. Reference pricing could be considered for Part B products with similar health effects. This would result in savings for beneficiaries and taxpayers. Each product would remain in its own billing code. A payment rate for a group of drugs with similar health effects could be set based on the lowest ASP of product in reference group, volume-weighted ASPs of all products in reference group, or the lower of the volume-weighted ASPs of all products in the reference group or the ASP of the specific product furnished.

Staff also discussed modifying the ASP add-on payment to be the lesser of 6%, 3% plus $21 or $175 per drug per day.

Clarifying Questions

Chair Chernew opened the discussion by noting the Commission is planning to move toward votes in this area – he would like to hear what commissioners are enthusiastic about or opposed to. He urged them to think of this issue in three parts: competition amongst similar products, incentives associated with the ASP+ model, and what to do about AA drugs (this area is the most complex). The policy options presented are not mutually exclusive.

Commissioners asked a variety of clarifying questions, including:

- *Commissioner Safran* asked if staff were concerned whether any of these models (the ASP proposal specifically) would result in facilities just increasing the number of days they are administering the drug? Staff discuss in the chapter. There are guidelines on dosage for certain treatment patterns. So that conversation would focus on treatment patters where there is flexibility. *Chair Chernew* spoke to the broader concern of cost shifting or supplier induced demand. If an organization could give a drug for more days, doing it at ASP+6 would be more lucrative than another number. Clinical considerations are the dominant form of what people decide what to do. But financial incentives do matter.

- *Commissioner Navathe* cautioned against not overengineering a solution her but creating a rationale solution that works more generally.

- *Commissioner Cherry* asked how staff came up with the three-year timeframe for a post market trial? Staff answered that this came from researchers who proposed this sort of approach. They could tweak it. *Chair Chernew* added that the AA pathway is very important. There are a lot of high value drugs that will go through this pathway, and we must be careful with the incentive to innovate in that space. MedPAC should give discretion to the Centers for Medicare and Medicaid Services (CMS) in giving them tools that they could ramp up if trials are not getting done in a timely manner.

Commission Discussion

Commissioner Dusetzina is very enthusiastic about this work. She appreciates revisions and attempts to tease apart coverage with evidence development/setting of prices in the absence of coverage with evidence development. MedPAC should proceed cautiously – most AA drugs are used to treat cancers or are drugs where we do not have other alternatives. The Commission needs to be explicit in recognizing this innovation/access tradeoff. Sponsors are already required to do follow up studies, and we do not want to be redundant. *Chair Chernew* summarized his perspective of the AA space: MedPAC should give CMS guidance on using its discretion as it relates to price capping, not price setting. That discretion might ramp up in the period after additional trials have been done. *Commissioner Dusetzina* agreed – the Commission should provide guidance on the circumstances where a product is more likely to be selected for price evaluation. She fully endorsed the proposed reference pricing model for biologics/biosimilars, and fully supports the modified combined setup for reimbursing for high price drugs and getting away from the 6% add on.

Commissioner Barr spoke about how the U.S. is subsidizing drugs for the rest of the world. She proposed rebating 150% of the OECD average, and leveraging the work done by other countries on clinical effectiveness.

Commissioner Poulsen agreed with these points. MedPAC needs to be thoughtful about how this work is done. There is good evidence that the 6% add on is perverse and going to a per dose would probably be perverse too.

Commissioner Sarran is very comfortable with all the options on the table. On AA drugs – maybe the best approach to encourage CMS to apply coverage with evidence development more often than they previously have, and to do it with a real defined timeline. Aduhelm is both a good and bad example of what can go wrong – many think the Food and Drug Administration (FDA) blew it on the clinical grounds and CMS was left to pick up the pieces. He also commended the ASP solution for its elegance.

Commissioner Safran is excited about the use of levers to force the post coverage evidence development that really is not happening. The lack of enforcement of requirements that do exist is appalling. She also supports the idea of introducing reference pricing here and likes Commissioner Barr's idea of including foreign pricing. It does feel like MedPAC needs to consider how to mitigate driving up the number of days medications are used to increase revenue.

Commissioner Damberg supported all options presented. She thinks they will strengthen what CMS can do to get handle on drug spending. She also appreciated comments from Commissioner Barr about what is the reference price (and the ability to look to other countries). In thinking of unintended consequences – how might reference pricing result in the elevation of the reference against which the price is being set?

Commissioner Navathe is very supportive of the general direction of this work. There is a balance to be struck here – the Commission wants to incentivize innovation and the appropriate use of the AA pathway. He likes the idea of thinking of other OECD countries as informational tool but reminded commissioners that the U.S. has slightly different values in terms of innovation and is likely willing to pay a premium for that.

Chair Chernew acknowledged the literature connecting financial incentives and innovation in the chapter. The evidence is clear that there is a connection between the two. That is what makes this so hard. The Commission's goal is not to drive the price of something in AA down to standard of care. The goal is to reduce the unreasonable pricing in this space, given the lack of evidence. CMS should have the ability to act in those cases. The bar for CMS action should be lower.

Commissioner Rambur supports this work. She agrees with prior comments on the need for guardrails against upsurges in volume. She asked staff to provide a more specifics of who pays for coverage with evidence development.

Commissioner Casalino does not buy the argument about innovation. *Chair Chernew* responded that there is evidence and academic research on this, but it can be controversial. *Commissioner Dusetzina* agreed that if the Commission is too aggressive, then money would probably leave industry for other things. This is all complicated by how trials are funded, and investments are made in industry. Drug development is difficult and expensive. *Chair Chernew* believes the evidence is strong that there is a connection between financial incentives and innovation. But that does not give manufacturers a blank check.

Chair Chernew wrapped up the discussion. MedPAC will move toward votes with more explicit versions of this report. On the AA issue – there is enthusiasm for encouraging trials to get done in a timely manner, with some enthusiasm to find policy options to give CMS discretion to address the problems they find in the system. Absence of evidence does not mean a drug does not work. For the most part FDA does an outstanding job. MedPAC wants to be respectful of that process.

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The next MedPAC meeting will be held on September 29-30, 2022