MEDICARE PAYMENT ADVISORY COMMISSION

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DR. CHERNEW: Welcome, everybody, to the January MedPAC meeting. We have a very packed and important agenda. We are going to start with a series of sessions about the update recommendations, building on our meetings from December. The first topic we're going to discuss is going to be the hospital inpatient and outpatient update and a little bit of the mandated report on post-acute care transfer policy.

So, without further ado, I'm going to turn it over to Alison to kick us off. Alison?

MS. BINKOWSKI: Hi. Good morning. 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. This presentation will provide a very brief summary of our December 2020 presentation that assessed the adequacy of Medicare's payments for hospital services, followed by two forecast updates since our December meeting. The presentation will then conclude with a draft recommendation for updating hospital payments in 2022 as well as the results of a mandated report on expanding post-
acute care transfer policy to hospice. Additional details, including additional information on the characteristics of relatively efficient hospitals requested by Commissioners are in the mailing materials.

Numerous MedPAC staff made significant contributions to this work. In addition to those staff listed on the slide, we would also like to thank Brian O'Donnell and Sam Bickel-Barlow.

As a reminder, MedPAC assesses the adequacy of fee-for-service Medicare payments by looking at four categories of payment adequacy indicators: beneficiaries' access to care, quality of care, provider's access to capital, and Medicare payments and providers' costs. The specific set of indicators used for hospitals are enumerated on this slide.

Based on these indicators, we will present the draft update recommendation for IPPS and OPPS base rates in fiscal year 2022.

As we noted in December, a key difference from prior years, both for hospitals and all other sectors, is the coronavirus public health emergency which has had tragic effects on beneficiaries' health and the health care
workforce and material effects on hospitals and other providers.

As in past years, to recommend payment updates for the upcoming year, we start with indicators of payment adequacy based on the most recent available and complete data, which this year is generally 2019. We then consider preliminary newer data from 2020 and evaluate current law and expected environmental changes in 2020, 2021, and 2022 to develop the draft update recommendation for 2022.

To the extent the coronavirus effects are temporary or vary significantly across providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2022 and future years.

As we described in December, indicators of hospital payment adequacy were generally positive. Specifically, beneficiaries maintained good access to hospital care, as indicated by hospitals' aggregate occupancy rate remaining stable in 2019 at 64 percent, hospitals' marginal profit on Medicare inpatient and outpatient services remaining over 8 percent, and fewer closures in 2020 than in 2019. The quality of hospital
care improved modestly, including modest decreases in risk-adjusted mortality and readmission rates. Hospitals' access to capital improved in 2019, including the aggregate all-payer total margin reaching a record high of 7.6 percent, and hospitals' aggregate Medicare margin remained negative in 2019 but improved, including the margin of relatively efficient hospitals increasing to near zero. And we project that hospitals' margin will continue to improve in 2021.

Since our December meeting, there have been two key changes. First, CMS reduced its forecast of the 2022 update to hospital rates under current law; and second, Congress extended the suspension of the Medicare sequestration, which affected our projection of hospitals' Medicare margin in 2021.

Since December, CMS updated its forecast of changes in the annual update to hospital payment rates for 2022 from 2.7 percent down to 2.4 percent. Specifically, CMS decreased its estimate of the market basket 0.1 percentage points and increased its estimate of productivity growth by 0.2 percentage points.

As a reminder, this is still just a forecast.
The actual update in 2022 will depend on the most recent forecasts at the time the IPPS final rule is published in summer of 2021.

As in December, we project that IPPS hospitals' overall Medicare margin will increase from its 2019 level of minus 8.7 percent. However, with the suspension of the 2 percent sequestration on Medicare payments extended through March 2021, we have updated our estimate of IPPS hospitals' overall Medicare margin in 2021 to minus 6 percent.

On the environmental front, since early 2020, the coronavirus has been a human tragedy. It has also affected hospital services, as described in more detail in your mailing materials.

In particular, inpatient and outpatient volume declined in April 2020, followed by partial summer rebounds that varied by type of service. Some more details are in your mailing materials.

The collection of quality data was suspended, making it hard to assess the quality of hospital care. Hospitals' access to capital remained strong due to federal support of over $70 billion in supplemental
funds to help hospitals rise to the pandemic challenge. As of now, we find no evidence of widespread financial struggles at hospitals in 2020; however, the circumstances of individual hospitals may vary substantially. Some hospitals may have struggled with access to capital, while several large hospital systems have returned some relief funds they received as they exceeded their pandemic related losses.

We estimate that both Medicare payments and costs per stay increased in 2020, as Congress increased Medicare payments to help offset hospitals' increased costs during the public health emergency, including the suspension of the 2 percent sequestration and a 20 percent increase for COVID-19 inpatient stays.

While the third wave of the coronavirus is having tragic effects on beneficiaries and health care workers, the increased cases have not necessarily hurt hospitals' financial performance.

In conclusion, while the effect of the coronavirus on hospitals varied substantially across hospitals and time periods, at this time, we do not anticipate any long-term changes to the hospital landscape.
that will persist past the end of the public health emergency and therefore warrant inclusion in the annual update to hospital payment rates.

With those updates and environmental changes in mind, we turn to considerations for the draft recommendation. These include maintaining payments high enough to ensure beneficiaries' access to care and close to hospitals' cost of efficiently providing high-quality care, maintaining fiscal pressure on hospitals to constrain costs, and minimizing differences in payment rates across sites of care consistent with our site-neutral work.

Clearly, there are tensions between these objectives that require a careful balance in the draft recommendation.

Furthermore, as we mentioned previously, to the extent the COVID-19 public health emergency continues, any needed additional financial support should be targeted to affected hospitals that are necessary for access and done outside the annual update process.

With that, the draft recommendation reads "For fiscal year 2022, the Congress should update the 2021 Medicare base payment rates for acute care hospitals by 2
Recall that there was a lower increase in 2019, 1.35 percent, and hospitals maintained their patient care margins. Therefore, we believe that hospitals will be able to maintain or increase their margins in 2022 with the draft update.

The 2 percent update in the draft recommendation along with the 0.5 percent statutory increase to inpatient payments would result in a net update to inpatient payments of 2.5 percent, while the update to outpatient payments would be 2 percent.

Together with our standing HVIP recommendation, the removal of the current quality program penalties would increase inpatient payments by an additional 0.8 percent, for a net update of 3.3 percent for inpatient payments, above estimated current law. The outpatient update would be 2.0 percent, below estimated current law. The combined result is estimated to increase spending relative to current by between $750 million and $2 billion in fiscal year 2022 and between $5 billion and $10 billion over five years.

We do not expect these changes to affect
beneficiaries' access to care or providers' willingness to treat Medicare beneficiaries relative to current law. Lastly, we also want to remind you on results of a mandated report. The Bipartisan Budget Act of 2018 mandates that MedPAC evaluate the expansion of the post-acute care transfer policy to hospice and its effect on beneficiaries' access to hospice service and on hospital payments.

Under the post-acute care transfer policy, IPPS hospitals receive per-diem payments for certain conditions instead of the full amount when a Medicare beneficiary has a short inpatient stay and is transferred to a post-acute care setting. Starting in 2019, hospice was added to the existing list of post-acute care settings to which the transfer policy applies. Our analysis indicates that the policy change produced savings, about $300 million in fiscal year 2019, without any discernable changes in Medicare beneficiaries' timely access to hospice care. And with that, I turn it back to Mike.

DR. CHERNEW: Great. Thank you so much. We're about to move to a vote. First, let me ask
if there are any -- I will make a comment in a minute, but let me ask if there are any other comments that folks might want to make before we move to a vote or before hearing my comments.

DR. RILEY: Yes. Mike, this is Wayne. I have a question.

DR. CHERNEW: Wayne, please.

DR. RILEY: Yes. Good morning, Commissioners. Alison, thank you for your presentation. Just a question on the sequestration moratorium. From my read of it, it appears that there's a difference between the moratorium applied to inpatient versus outpatient because of the use of the federal fiscal year in one of those and the calendar year in the other. So just from my read of it, it looks like there will be a difference in terms of the sort of protection that the moratorium on the sequestration will have on those two sort of buckets of hospital activity. Can you expound on that, please?

MS. BINKOWSKI: So you're correct that the suspension was extended through the end of March 2021 in inpatients on a fiscal year basis while outpatients are on a calendar year basis. For the purposes of our projected
margin, which we do at an aggregate hospital level across all services, we do that on a fiscal year basis.

DR. RILEY: Very well. Second question would be you mentioned that that does not look -- that you see no evidence, that the staff sees no evidence of sort of a negative impact to hospital margins vis-à-vis the public health emergency. Can you walk us through how you derived at that Gestalt around that?

MS. BINKOWSKI: I can, but I'll let Jeff jump in to say something more articulate.

DR. STENSLAND: I would say this is when we did this in the fall, where we looked at how much did the reduction in certain services like scheduled surgeries and that kind of thing, which certainly had a big hit on hospitals in the spring, and then we looked at, well, how big was that hit relative to the aid that the hospitals received through the pandemic relief funds. And I think in the fall, we talked about that and it looked like there may be some differences amongst hospitals, but on average, we didn't see anything that was clear that was going to be a net -- a big negative. And then we saw some big systems, HCA and Mayo, reported that they recovered faster than they
thought and gave a lot of the money back, and so it's not clear right now how much of that money that was given back will be recycled to other providers. And that's pretty much as much of the data that we have through the third quarter of 2020.

Now, the fourth quarter has ended, but we haven't actually seen those results yet of what happened in the fourth quarter. And it may be better; it may be worse.

When we looked back at the results from early on in the year, it wasn't that clear that hospitals that were in areas of the country where there was lots of COVID did worse financially than hospitals in the country where there was less COVID. I think it was certainly a tragedy not just for the patients but for all those employees of those hospitals that we're dealing with.

In some cases, we saw that if you were in a high-COVID area, your revenue declines were lower than if you were in a low-COVID area because you did get some revenue from your COVID patients, which is not something that anybody wants to happen, but it is what happened.

So that's kind of all the puts and takes that come in there to say that it's not a clear -- it's not
clear how much of a financial hit there will be from hospitals, and it's not clear if the hit will be worse, bigger than the amount of funds that they get through the pandemic relief funds.

Again, this is a tragedy for the patients, a tragedy for the employees, but it's not clear it's a tragedy for the hospital finances at this point.

DR. CHERNEW: Okay. Wayne, I think you're muted.

DR. RILEY: Yeah. Jeff, thanks for that.

Not to belabor this, but I do have concern about safety net and community hospitals. They're less likely to have the financial sort of glide path, given their smaller footprint than the bigger systems. So just a cautionary note that I would like to mention, I think one of the biggest concerns I have leading an institution with a safety-net teaching hospital is the labor cost, i.e., nursing. We're going to have sort of a challenge over the next two years because some nurses have thrown in the towel. They're cutting hours.

One of the bedrocks of care and quality in a hospital is the nurses, not so much us doctors, but nurses.

I see my nursing colleagues smiling because I learned that
a long time ago, especially your interns. Nurses really
make the best caregivers, and they do more work than we
ever have acknowledged in hospitals.

So I'm worried about labor costs going forward.
I'm worried about a post-COVID hangover or overhang on
certain sectors of the hospital industry that care for
Medicare beneficiaries. So I would just say that as a
commission, we need to have our antenna up about that going
forward. So thank you for that.

DR. CHERNEW: Wayne, first, I agree, and we are
definitely challenged in the environment we're in. We've
tried to make a recommendation accordingly for what we
think will be doing on in 2022, but your points a very well
taken. And we will be continuing to monitor all of this
going forward.

Remember this is a shorter session in the path
because a lot of the material was present in December, and
so we only have about 10 more minutes left. And that
includes the vote. I have two people on the list, and if
you could be short and if we could go through that, that
would be great. The first is going to be Bruce, and then
we're going to have Jon Perlin, so Bruce.
MR. PYENSON: Yeah. Thank you very much. Alison, I wonder if you could go to the summary slide. I've got a context question, or perhaps presentation question. Of course -- let's see. I'm sorry. The summary of the recommendation, which shows the inpatient and the outpatient detail, along with the HVIP. Of course, I'm hopeful and even optimistic that the standing HVIP recommendation will occur.

So my question is, why isn't the recommendation, that it's 2 percent update, but if HVIP is implemented then it's a 1.2 percent update? And maybe that's a question for Mike.

DR. CHERNEW: Yeah, I can answer that question. So the first point is the assessment of the criteria, including things like the margin for the efficient hospital in 2022, are all based on the 2 percent update. So, for example, the estimate would be, recognizing all of the noise and how hard it is to do this estimate, that with the 2 percent update alone the efficient hospital would have a positive margin in 2022. There's a lot of noise around those types of things, and Wayne points out some of the challenges legitimately.
The HVIP recommendation, which is a separate recommendation, was made in the past. It is still a standing recommendation. It is a general rule. We don't tie all of our recommendations together. It's too difficult, as a matter of course, to say if you take Recommendations A and B, then our Recommendation C would be this, or vice versa. So I think you should think about these as separate recommendations, where the criteria applied to this recommendation is the criteria we use for all of the updates, and the HVIP recommendation, which is discussed in much more detail in the chapter where we made the HVIP recommendation -- that was a previous cycle -- is there, and we will continue to do that. Obviously, if the HVIP recommendation were implemented, that would affect the results for future updates.

But you would view the recommendations as, in some sense, standalone, but that being said, if both were adopted then you would see the information that's on the slide. I'm not sure if that was a good enough answer. It was a longer answer given I wanted everybody to be brief, and even worse I'm going to ask Jim if he wants to say anything else.
DR. MATHEWS: So again, the current iteration of the recommendation reflects our best assessment as to where the Commission as a whole was at the December meeting, where there was some appetite for both the 2 percent update for inpatient and outpatient but a preponderance of Commissioners who also expressed rerunning the prior HVIP recommendation alongside. Had we not done that, the impacts of the update recommendation alone, shown on the slide, would have resulted in a reduction in payments to hospitals relative to current law, and I do not think that was the thinking of the majority of the Commissioners at the December meeting.

MR. PYENSON: Well, I'm -- well, thank you for the explanations. I'm concerned that the optics of this present an upside that's perhaps not our intent. But thank you.

DR. CHERNEW: Jon Perlin.

DR. PERLIN: Well, thank you, and let me thank the staff for a very thoughtful and generally well-researched chapter. And let me just say at the outset that I'm going to support the recommendation of the Chair.

But respectfully I'm going to defer on the
assessment that the effects of coronavirus are temporary.

Heaven help us. We believe coronavirus, COVID, is temporary, but I think the health system is forever changed. We'll deal with that in areas such as telehealth on the positive side, but some of the durable effects are going to leave a somewhat wounded provider candidate.

Let me just put the context -- and I want to also emphatically agree that our policy has to support the durable context, not the things that we believe are transient. But I want to enumerate the things that do converge in 2021 and 2022, the year, of course, we're making the recommendation for, that the hospital environment will be facing.

So the moratorium on the sequester ends at the end of March for both outpatient and inpatient, and that is essentially a 2 percent hit, in real terms, to the revenues. Second, on the CARES Act -- and thanks, Jeff, you mentioned that our organization happened to return all of the funds, so I think I can say this with a broader perspective -- which is that for those entities that actually haven't repaid the accelerated payments on their Medicare, which helped to tide them through the difficult
period of very decreased volume, there is a 25 percent
garnishment going to a 50 percent garnishment, terminating
at 29 months, that actually comes due with interest. So
these things converge, so you could actually have
tantamount to a 52 percent negative update against what
we're recommending.

There are also, I think, some transient effects
when we look at 2020 and the effect of COVID. You
mentioned the HRSA supplement for taking care of complex
COVID patients. That, of course, corresponds to the
duration of public health emergency. Second, and, you
know, it's been well reported, and you've indicated this as
well, is that Medicare beneficiaries stayed away from
health care because of concerns about entering the hospital
environment, which had the ultimate effect, not only at the
outset, of decreasing all volume, but ultimately
concentrating the volume of higher acuity on absolutely
unavoidable activities, and those tended to have higher
margins which were transiently not offset by the lower
margin activity. I just note that these factors converge.

Finally, I want to address labor. Dr. Riley
mentioned the impact on nursing. You know, there's been a
lot of attrition. It's an absolute seller's market in the environment, and I see some of my nurse colleagues nodding their heads, that the compensation is unprecedented at the moment.

By the way, in conjunction with the changes in the physician fee schedule, certain of the hospital-based physicians who themselves have lower volume on the pro fees, actually are requiring greater supplementation from the hospitals that also adds to the cost of operation.

To the point that was raised about HVIP, you know, my recollection is that still requires statutory change to get past the current penalty programs, and I'd also note that HVIP is an earned incentive and will be distributed differently, perhaps even further challenging some of the rural or safety net or other vulnerable hospitals.

Finally, in terms of the broader context on quality, one of the things that we've seen proven to us is a lack of surge capacity. I think our country needs to take a look at whether we invest in just adequate or capacity for expansion. You know, this doesn't support that sort of surge capacity that we would all want.
And finally, in the chapter, it notes that 80 percent of costs are variable. What are variable costs? The variable cost is labor, and there are only three ways – fewer individuals, lower paid individuals, or supplement by capital-intensive technologies. And I just draw this out not because I don't support the recommendation. I do, because I agree with the philosophy of the durable policy matching the durable need, and I think that's right. But I do, for these reasons, diverge on the assessment that the effects of coronavirus are not longer lasting. These are bridges we'll have to cross in the future, but I just felt compelled to share a sort of ground-level view from an organization that's not taking care of over 100,000 COVID-positive inpatients, as some breadth of perspective.

Thanks so much.

DR. CHERNEW: Yeah. Jon, thank you so much. I want now to call this to a vote in our virtual environment. And I think the way this is going to work is Dana Kelley, you are going to call folks' names and folks are going to vote. So Dana.

MS. KELLEY: Okay. If everyone could just answer with yes, meaning you support the draft recommendation; no,
you do not; or indicate if you are abstaining from the vote.

Paul?

DR. PAUL GINSBURG: Yes.

Larry?

DR. CASALINO: Yes.

Brian?

DR. DeBUSK: Yes.

Karen?

DR. DeSALVO: Yes.

Marge?

MS. MARJORIE GINSBURG: Yes.

David?

DR. GRABOWSKI: Yes.

Jonathan Jaffery?

DR. JAFFERY: Yes.

Amol?

DR. NAVATHE: Yes.

Jon Perlin?

DR. PERLIN: Yes.

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.

MS. KELLEY: And Mike.

DR. CHERNEW: Yes. So thank you, everybody, and the comments were well taken and will continue to be something that we monitor as we go forward. These are really unprecedented times and they continue to be so. And if I didn't express thanks to all of you for the work that you're actually doing in providing care, let me do so now. MedPAC is really important. Some of your other work might be more so, but we really do appreciate it.

DR. CHERNEW: So we're going to transition now to
discussing the updating rules for the physician other
health professional services chapter, and I think I'm
turning it over to Rachel. Rachel?

MS. BURTON: Good morning. In this session,

Ariel Winter and I will give a high-level recap of our
assessment of the physician fee schedule's payment adequacy
and the draft recommendation for 2022. We will also
identify new material added to our paper, which was sent to
Commissioners prior to this meeting, and contains more
information than we will cover here today. Our colleagues,
Geoff Gerhardt and Ledia Tabor, will be on hand to help
answer questions. As noted earlier, the audience can
download a PDF of these slides from the Control Panel on
the right side of their screen, under the Handouts section.

As a quick recap, the fee schedule is used to pay
physicians and other health professionals for about 8,000
different services. These fee schedule payments are on top
of payments clinicians may qualify for if they practice in
certain settings, such as a hospital or a nursing facility.
In 2019, Medicare paid $73.5 billion to 1.3 million
clinicians for fee schedule services.

Under current law, there is no update to base
payment rates for 2022, but clinicians can potentially
receive a positive or negative performance-based adjustment
to their payment rates if they are in the Merit-based
incentive payment system (or MIPS), or they can receive a 5
percent bonus if they are in an advanced alternative
payment model.

In response to Commissioners' comments at the
December meeting, we have added new information to our
draft chapter on physician payment adequacy.

Pat, you asked if we could break out some of our
access-to-care results by age groups. When we went back to
the office and checked with our survey vendor, it turned
out we could do this, so we now compare access for
beneficiaries of different ages, and find that there are
very few differences between them. We actually find that
the oldest beneficiaries tend to have slightly better
access than younger elderly beneficiaries. Specifically,
we find that in 2020, fewer beneficiaries in their 80s or
older reported being dissatisfied with their care, or
having difficulty finding a new primary care provider, or
foregoing care.

We have also reviewed more recent months of data
on service volume and revenues in 2020, and find that these have largely rebounded since the initial months of the pandemic. Among Medicare beneficiaries, we find that primary care visits and certain other services largely recovered in the summer and remained steady through November. For privately insured patients, we find that revenues are now higher than they were at the same time last year, and have been since July.

Our chapter now also identifies the percent of Medicare beneficiaries who had a clinician encounter in 2019. It is 98 percent.

Since there was some interest in December in addressing the imbalance between payments for primary care clinicians and specialists, this slide provides a recap of the Commission's prior work in this area and some future plans.

In 2011, the Commission recommended that CMS collect data to establish more accurate RVU values for services. In 2015, we recommended that Medicare pay new supplemental payments per beneficiary per month to primary care providers. And in 2019, we recommended that CMS collect better information on the specialties that APRNs
and PAs practice in, so that we can determine what percent of these clinicians are primary care providers. We are currently unable to measure this using claims data.

In 2019, staff also presented information on scholarships and loan forgiveness programs for primary care providers, and then last November we presented findings from interviews with stakeholders on other ways to attract more physicians to primary care. At that last meeting, Commissioners expressed interest in focusing on the geriatrician workforce, which is what Ariel and I are now researching and expect to come back to you on next cycle.

For context, we also note that in early December, CMS finalized increases to the RVUs for E&M, office, and outpatient visits. This will disproportionately benefit primary care clinicians, and is consistent with the policy in our June 2018 report.

CMS also proposed a new add-on code for E&M visits, which we opposed. Since re-evaluations of codes must be budget neutral, CMS planned to reduce the fee schedule's conversion factor by 10 percent in 2021. In late December, Congress delayed the new add-on code by three years and provided about $3 billion to partially
offset the reduction to the conversion factor. These additional funds are only provided for 2021 and not in subsequent years.

The net results of all of these changes is that pay rates for E&M office visits will still increase, and most other codes will experience only small reductions.

I'll now turn things over to Ariel.

MR. WINTER: Some Commissioners raised concerns at the December meeting about payment differences between settings, so this slide summarizes our prior work on site-neutral payments. The issue is that Medicare often pays hospital outpatient departments more than freestanding physician offices for the same service, such as an E&M office visit. This is because an HOPD service leads to two payments: one for the HOPD and one for the clinician's professional service, which is paid under the physician fee schedule. So the total payment is higher than if the service was provided in a physician's office.

Hospitals have responded to this incentive by buying physician practices and converting them to HOPDs, which increases Medicare program spending and beneficiary cost sharing. For example, we estimate that in 2019,
Medicare spent $1.4 billion more than it would have if payment rates had been the same in both settings, and beneficiaries' cost-sharing was $360 million higher.

To address this problem, the Commission recommended aligning the total payments for E&M office visits and selected other services by reducing HOPD rates.

In 2015, Congress reduced payment rates for all services in new, off-campus HOPDs beginning in 2017. Subsequently, CMS reduced rates for E&M visits in all off-campus HOPDs beginning in 2019, but this policy is the subject of ongoing litigation.

Please let us know if there's additional work that you'd like us to pursue in this area.

Returning to our payment adequacy analysis, payments appear to be adequate. Most beneficiaries report good access to care even during the pandemic. The number of clinicians billing Medicare is increasing, and the number of clinician encounters per beneficiary is also growing.

Turning to quality, it is difficult to assess the quality of individual clinicians, but our findings using population-based quality measures show opportunities for
improvement. There is wide geographic variation in the rates of ambulatory care sensitive hospitalizations and ED visits, and there is substantial use of low-value care.

In terms of payments and costs for clinicians, Medicare payments per beneficiary are growing. The MEI continues to increase. The ratio of commercial payment rates to Medicare rates for clinician services grew slightly, and physician compensation from all payers has been rising, although there are still substantial disparities between primary care physicians and certain specialties.

This leads us to the draft recommendation, which reads: For calendar year 2022, the Congress should update the 2021 Medicare payment rates for physician and other health professional service by the amounts determined under current law.

Current law calls for no update in 2022, but about a million clinicians receive positive adjustments of up to almost 2 percent under MIPS or get 5 percent bonuses for being in an advanced alternative payment model.

In terms of implications, there would be no change in spending compared with current law, and this
should not affect beneficiaries' access to care or providers' willingness and ability to furnish care.

This concludes our presentation, and I'll now turn things back over to Mike.

DR. CHERNEW: Thank you. Again, we are in another shortened session because of similarities where we were before. I will have one quick comment possibly when we get through, but first I want to go to Betty and then to Larry.

DR. RAMBUR: Okay. Thank you very much. My comment probably looks more towards looking forward, but I think it's important to have it on the record.

The data in the material suggests that Medicare beneficiaries are accessing primary care and that care is increasingly delivered by nurse practitioners and PAs. And I know we have recommendations about trying to encourage more physicians to enter primary care. I'm personally not overly optimistic about that. It's clear that medical students and residents are not looking towards primary care, and nurse practitioners and PAs are.

I'd just like to briefly share data: 89.7 percent of nurse practitioners are educated in primary
care, but only 69.7 percent deliver primary care. That's still a big number. But the difference there, I assume, is also related to payment policy that favors specialty care.

We discussed physician compensation adequacy as being a positive piece and noted the difference between specialty physicians and primary care physicians, but didn't note the large gap between primary care physicians at 254,000 a year, nurse practitioners at 110,000, and PAs at 111,000. So, looking forward, I think that it will be important to include greater focus on those that are increasingly delivering primary care, and the issue of claims data that was mentioned is so important, and I know you've gone on record, but just to say it again, it will be critical that incident to billing is gone so that we can really track these data more clearly by delivery of services.

And, finally, I just wanted to share that, according to 2020 data from the American Association of Nurse Practitioners, even the nurse practitioners who are not working in primary care, who are working specialty area, it's often psych mental health or hospice and palliative care.
So I support our recommendation, but I do think in the future we need to focus more broadly on the primary care workforce.

Thank you.

DR. CHERNEW: Great, Betty. Thank you. Larry.

DR. CASALINO: Yeah, I'll support the recommendation as well, and great work by the staff. I did just want to emphasize -- I think I said this at the last meeting -- the optics of current law which results in no increase for the majority of clinicians doesn't sit well, I think, with, let's just say, the physician labor force, and I suspect not with advanced practitioners either. So I hope we'll think about the current law in the future.

Current law is intimately tied to MIPS. I don't know if there's anybody who thinks that MIPS is a success, really. I know we've had recommendations about MIPS in the past, and I would like the Commission, if possible, to try thinking some more about MIPS and then the link to physician fee schedule updates on a future agenda.

Then the only other thing I'll say is, again, if need be, going forward, when these lawsuits are settled, I hope the Commission will land again on neutrality in terms
of site-specific payments for physician services. But I will support the recommendation this year at least.

DR. CHERNEW: Larry, thank you, and it is a continuing concern, the trajectory of physician updates overall. I have a request to talk from Amol. Amol.

DR. NAVATHE: Thank you. So I just actually wanted to pick up on Larry's points. I had an inkling of where he was going to go. So I agree with his point, which is in ongoing work it would be nice if we can consider MIPS, and specifically if you think about how in some of the other sectors, like in the hospitals case, even in our recommendations, we describe what would happen if we followed HVIP and what would happen if the penalties were withdrawn.

In future work, it would be nice if we considered, you know, what would happen hypothetically if we could remove MIPS, since I think we're kind of placed in an awkward situation here where the Commission has recommended MIPS be stopped, and at the same time we're, of course, having to understandably base our recommendations right now based on MIPS continuing and what that means for adjustments to physicians. And so as we go forward, it
would be nice to articulate, you know, if MIPS were indeed stopped, based on the Commission's recommendation, how would we determine and then update the physician fee schedule accordingly, the payment updates to the physician side? I think it would be -- it would sort of behoove us, the same way that we kind of do it for some other sectors as we go forward, but I will support the recommendation this time.

DR. CHERNEW: Amol, thank you. So in a moment, we're going to go to the vote. Let me say a few other things just broadly, which is true for all of the other sectors, by the way. The intent, of course, is to apply our criteria across the board to the sometimes frustrating activity of giving a uniform update recommendation, which is what we are doing. And we do, as the HVIP and as MIPS, have a series of other related recommendations. Some of the things, for example, the E&M rule, move in directions that we have been supportive of in other related work, supporting primary care, for example, and we will continue to do that.

So I very much hear the spirit that all three of you raised about where we are going, and we are going to
continue on that path to understand what's going on in the market for professional services. So that is good. And I think the key point here is right now, by the criteria that we use, we seem to be okay with the recommendation where it is. So I guess we'll find out as we are about to vote, but at least that was the thinking in it. And by no means is it meant to preclude the fact that we need to do a lot of continued work on access, heterogeneity and access, what's going on with MIPS, what's going on with the workforce outside of the physicians, and all the things that have been raised. I could not agree with those comments more. So I'm now turning it back to Dana Kelley, whose face has disappeared, but I assume she's still here.

MS. KELLEY: Okay. I will take the roll again. Yes if you support the recommendation, no if you do not.

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: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Sue?
MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: All right then.

DR. CHERNEW: All right then.

So we are now going to move to a series of expedited voting sessions where we are going to lump a number of groups together, a number of sectors together, because largely the material is the same as we had in December, and there was a reasonable consensus about where we were or where we should go. And so we're going to present these somewhat quickly, work through the votes on them in an expedited manner with this session, and then we'll follow up by another one, and then we're going to move to some of the other broader topics that we will be working through policy options and thinking about further down the line.

So I'm not sure who I'm turning this over to right now, but whoever has -- I think I heard "Dan."

MS. KELLEY: Yes, Dan Zabinski is up first. Dan,
are you on?

DR. ZABINSKI: Yep.

DR. CHERNEW: Okay, Dan, take it away.

DR. ZABINSKI: Thank you. Good morning. Let's see. At the start I just want to say that the audience can download a PDF version of the slides for each of the three presentations in this session in the handout section of the control panel. That's on the right-hand side of your screen.

For ambulatory surgical centers, at the December 2020 meeting, we presented update information for ambulatory surgical centers, or ASCs, and provided draft recommendations.

In your updated draft chapter, we have added text in response to some Commissioner comments from the December meeting. In particular for Bruce, we edited a sentence about adjustments to the ASC payment rates to maintain budget neutrality in the ASC payment system.

And then for a number of Commissioners, we added a footnote that explains some of the reasons for the large differences in the number of ASCs that exist among states. Reasons include differences in certificate-of-need laws
among states and the global budget system for Maryland hospitals.

So in today's presentation, we'll provide an abbreviated version of the payment adequacy analysis for ASCs that we presented in December.

First, important facts about ASCs in 2019 include that Medicare fee-for-service payments to ASCs was $5.2 billion. The number of fee-for-service beneficiaries served in ASCs was about 3.5 million. And the number of Medicare certified ASCs was about 5,800. Also, since we last met, CMS has updated the ASC payment rates by 2.4 percent for 2021.

Now, our analysis of ASC data shows that indicators of payment adequacy are positive. For 2019 we found that the volume per fee-for-service beneficiary increased by 2.7 percent; the number of fee-for-service beneficiaries served in ASCs increased by 0.9 percent; and the number of ASCs increased by 2.5 percent. In addition, Medicare payments per fee-for-service beneficiary increased by 8.3 percent.

Also, the growth in the number of ASCs suggests that access to capital has been adequate. For example,
there has been a fair amount of acquisitions and partnerships with ASCs by corporate entities, which also requires access to capital.

Measures of quality in ASCs improved from 2013 through 2017 and were largely unchanged from 2017 to 2018. However, we do have some issues with the quality measures in the ASC system. We believe that CMS should add more claims-based outcomes measures, and we are concerned about CMS' decision to delay use of the CAHPS-based patient experience measures.

Finally, a limitation of our analysis is that we can't assess margins or other cost-based measures because ASCs do not submit cost data to CMS, even though the Commission has frequently recommended that these data be submitted.

So for the ASC update for 2022, we have two draft recommendations.

First, for calendar year 2022, the Congress should eliminate the update to the 2021 conversion factor for ambulatory surgical centers. Given our findings of payment adequacy and our stated goals, eliminating the update is warranted. This is consistent with our general
position of recommending updates only when needed.

The implication of this recommendation for the Medicare program is that, relative to current law, it would decrease spending by $50 million to $250 million over one year and by less than $1 billion over five years.

Also, this recommendation is not expected to have any effect on beneficiaries' access to ASC services or providers' willingness or ability to furnish those services.

Now, the Commission has long argued that ASCs should submit cost data to help determine accurate payment rates for ASCs and guide future updates. So, once again, we have this draft recommendation: The Secretary should require ambulatory surgical centers to report cost data.

The importance of this recommendation is that the Commission has recommended this policy for over a decade. At the same time, CMS has been largely neutral on committing to collecting cost data from ASCs.

The Secretary could limit the burden on ASCs by using a streamlined system of cost submission.

Implementing this recommendation would not change Medicare program spending. We anticipate no effect on
beneficiaries. However, ASCs would incur some added administrative costs.

Now I turn it back to the Chair for discussion.

DR. CHERNEW: Okay. Thank you. I think we have time for one comment, and I think the person who wants to make that comment is Brian. And I think the way this is going to work, Dana, just before Brian speaks, is we're going to do each of these sequentially, so we're going to go to the vote on ASCs before we go to the next sector. Is that right, Dana?

MS. KELLEY: Yes, that's correct.

DR. CHERNEW: Okay. So, again, we're going very quickly, so we'll have in the expedited voting session as expedited comment, so, Brian.

DR. DeBUSK: Yes, thank you. I just wanted to make one brief comment. I'm going to support the recommendation as written, but I do hope in future work we will revisit this idea that ASCs are growing at an adequate rate.

You know, when I see 0.9 percent growth in beneficiaries served and 2.5 percent growth in the number of ASCs against a backdrop of a service that has 46 percent
savings to taxpayers and to beneficiaries, to me that is alarmingly low growth. If this were a program that was just marginally less expensive or marginally beneficial financially, I would understand it. But, you know, we're in a Medicare world where 2 percent or 3 percent or 4 percent savings is huge, and this is a sector that's offering 10 to 20 times those savings. So I do hope in future work that we'll go back and revisit this with ASCs.

Thank you.

DR. CHERNEW: Brian, thank you, and I think we should move on to the ASC vote, and I think that's the next step. Then I think we'll move to dialysis. So, Dana, do you want to go with the vote?

MS. KELLEY: Yes. For the first draft recommendation regarding the update to the conversion factor, 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: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Sue?
MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: And for the second recommendation regarding the collection of cost report data for ambulatory surgical centers, Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes, capital letters, vehemently.

MS. KELLEY: Brian?

DR. DeBUSK: Yes, and I second Larry's capital letters.

MS. KELLEY: Karen?

DR. DeSALVO: Yes. Friendly amendment to capital letters with an exclamation point.

MS. KELLEY: Marge?

MS. MARJORIE GINSBURG: Yes.

MS. KELLEY: David?

DR. GRABOWSKI: Yes.

MS. KELLEY: Jonathan Jaffery?
1. DR. JAFFERY: Yes.
2. MS. KELLEY: Amol?
3. DR. NAVATHE: Yes.
4. MS. KELLEY: Jon Perlin?
5. DR. PERLIN: Yes.
6. MS. KELLEY: Bruce?
7. MR. PYENSON: Yes.
8. MS. KELLEY: Betty?
9. DR. RAMBUR: Yes.
10. MS. KELLEY: Wayne? Have we lost Wayne?
11. DR. RILEY: Yes.
12. MS. KELLEY: Oh, there he is. Jaewon?
13. DR. RYU: Yes.
14. MS. KELLEY: Dana?
15. DR. SAFRAN: Yes.
16. MS. KELLEY: Sue?
17. MS. THOMPSON: Yes.
18. MS. KELLEY: Pat?
19. MS. WANG: Yes.
20. MS. KELLEY: And Mike?
21. DR. CHERNEW: Yes.
22. MS. KELLEY: All right then.
DR. CHERNEW: Okay. So I think now we're going
to go to Nancy and Andy to talk about dialysis. Nancy and
Andy.

MS. RAY: Good morning. Today's presentation on
assessing the payment adequacy of outpatient dialysis
services consists of three sections. First, I will answer
a question raised during the December meeting. Then I will
summarize the indicators of payment adequacy that we
reviewed in December. Lastly, I will present a draft
update recommendation for your consideration. The update
analysis and recommendation will be included as a chapter
in our March 2021 report. Also, this is an abbreviated
version of the information presented at the December
meeting.

As background, in 2019, there were roughly
395,000 fee-for-service dialysis beneficiaries treated at
7,700 dialysis facilities. Total Medicare fee-for-service
spending was about $12.9 billion for dialysis services.

The revised chapter includes additional material
about a number of issues raised at the December meeting.

What I'd like to highlight for the presentation addresses
many commissioners' requests for information about the
supplemental sources of health coverage for fee-for-service dialysis beneficiaries.

As shown on the table, in 2019, fee-for-service dialysis beneficiaries were more likely to be eligible for Medicaid and less likely to have other supplemental sources of health coverage than fee-for-service non-dialysis beneficiaries. Twenty-four percent of both groups had no source of supplemental coverage.

Next, I will summarize the payment adequacy analysis. The indicators assessing adequacy are generally positive, and you have seen all of this information in December.

Regarding access to care, there is a net increase of about 200 facilities between 2018 and 2019.

Regarding capacity, the growth in dialysis treatment stations exceeded the growth in the number of fee-for-service dialysis beneficiaries between 2018 and 2019. And looking at volume changes, the growth in the number of fee-for-service dialysis beneficiaries and Medicare-covered treatments remains steady.

The 25 percent marginal profit suggests that providers have a financial incentive to continue to serve
Medicare beneficiaries. Moving to quality, the percent of dialysis beneficiaries using home dialysis increased over the past five years, and that's a good thing. Hospital admissions and mortality and percent of hospitalized beneficiaries with a readmission have held steady.

Regarding access to capital, indicators suggest it is robust. An increasing number of facilities are for-profit and freestanding. Private capital appears to be available to the large and smaller-sized multi-facility organizations.

Moving to our analysis of payments and costs, in 2018, the Medicare margin is 8.4 percent, and the 2021 projected Medicare margin is 4 percent.

So based on our findings that suggest that outpatient dialysis payments are adequate, the draft recommendation reads "For calendar year 2022, the Congress should eliminate the update to the 2021 Medicare end-stage renal disease prospective payment system base rate."

This draft recommendation is a change from the December draft recommendation based on Commissioners' comments about the equity of update recommendations across
In terms of spending implications, this draft recommendation is expected to decrease relative to current law, a spending decrease relative to current law of 50- to $250 million over one year and $1 billion to $5 billion over five years.

Regarding effects on beneficiaries and providers, we anticipate that beneficiaries will continue to have good access to care, and we anticipate that this recommendation will have no effect on providers' willingness and ability to care for Medicare beneficiaries.

I now turn it back to the Chair.

DR. CHERNEW: Thank you so much, Nancy.

So, again, we have time for one expedited comment in our expedited session, and that comment is going to go to Pat.

MS. WANG: Thanks so much. I appreciate this. I certainly support this recommendation.

As we have discussed in the past, dialysis is sort of like an extreme example of consolidation in the service market. Two organizations provide 75 percent of dialysis services. They also happen to be vertically
integrated, supplying many of the materials and so forth that are required to deliver their services to Medicare beneficiaries.

We've talked about it before. I think that it would be helpful going forward for the staff to tease out whether there is a better way, a broader view of financial performance behind the Medicare cost report simply because it seems like a vertically integrated, very large organization with means of production included that the Medicare cost report may not be giving us the full picture of what's really going on. So some kind of enterprise-wide view of the relevant portions of vertical integration that feed into a service that is provided on the Medicare cost report, I think, would be helpful for context going forward.

Thank you.

DR. CHERNEW: Yeah. Pat, thank you. I must say, just broadly, how we deal with the increasing complexity and vertical integration in the health care sector in a world in which we're making updates by these sectors of IP schedules is a sort of keep-you-up-at-night kind of comment. I wish I had something deeper to say, other than,
as you know, it's a topic we continue to look at, and we will continue to do so. And that is certainly relevant here.

But that said, given the task at hand, I think we're going to go to the vote.

MS. KELLEY: Okay.

DR. CHERNEW: Dana?

MS. KELLEY: All right. For the end-stage renal disease PPS base rate update recommendation, Paul?

DR. PAUL GINSBURG: I vote yes and want to point out that Pat's comment is very valuable for our future considerations.

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: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: And, Mike?

DR. CHERNEW: Yes.
Okay. Thank you all, and for the last sector in this particular expedited voting session. We have hospice, and that means we have Kim.

Kim, you're up.

MS. NEUMAN: Good morning.

Now we're going to review the indicators of hospice payment adequacy and discuss the draft hospice update recommendation for 2022 and a policy to modify the hospice aggregate cap.

We discussed these issues at the December meeting, and there's more detail in your mailing materials. We revised the materials based on your December discussion. For example, we added an analysis of new hospices in California and Texas and included more discussion of the implications of the hospice cap policy.

So, first, a few key facts about hospice. In 2019, over 1.6 million Medicare beneficiaries used hospice services, including more than half of beneficiaries who died that year. Over 4,800 Medicare hospice providers furnished services to those beneficiaries, and Medicare paid those hospice providers about $20.9 billion.

So now we'll look at our indicators of payment
adequacy which are strong. In terms of access to care, the supply of hospice providers continues to grow, increasing about 4 percent in 2019. Hospice use also increased. Both the share of Medicare decedents using hospice and average length of stay increased in 2019.

Marginal profit in 2018 was 16 percent, which suggests providers have an incentive to accept new Medicare patients.

Quality data are limited. Process measures are mostly topped out. Visits at the end-of-life increased slightly while Hospice CAHPS survey performance was stable.

A study by the OIG identified a group of about 300 hospices based on survey and complaint data that were poor performers.

Indicators of access to capital appears good. The number of providers continues to grow, suggesting that capital is accessible. Financial analyst reports suggest the sector is viewed favorably by investors.

So this brings us to margins. For 2018, we estimate an aggregate Medicare margin of 12.4 percent, and for 2021, we project an aggregate margin of 13 percent.

Our 2021 margin projection increased slightly from the

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December presentation, from 12 to 13 percent, because of the recent legislation suspending the sequester for three additional months, through March 2021.

So now let's switch gears and talk about the hospice aggregate cap. The cap limits total payments a hospice provider can receive in year. The cap is an aggregate limit, not a patient-level limit. If a provider's total payments exceed the number of patients served by that provider, multiplied by the cap amount, the provider must repay the excess to Medicare.

Currently, the cap is about $30,684, and the cap is not wage-adjusted.

In 2019, about 16 percent of hospices exceeded the cap. These providers would have had very high margins if not for the cap.

In lieu of an across-the-board payment reduction last year in March 2020, the Commission recommended the cap be wage-adjusted and reduced 20 percent. This cap policy recommendation would make cap more equitable across providers and focus payment reductions on providers with high margins and long stay. Congress has not acted on that recommendation.
So given the margin in the industry and our other positive payment adequacy indicators, the Commission has developed a two-part draft recommendation similar to last year. The draft recommendation would keep the payment rates unchanged in 2022 at the 2021 levels for all providers, and it would also reiterate the Commission's hospice cap policy recommendation, which would focus payment reductions on providers with disproportionately long stays and high margins.

The draft recommendation reads "The Congress should for fiscal year 2022 eliminate the update to the 2021 Medicare base payment rates for hospice and wage adjust and reduce the hospice aggregate cap by 20 percent."

In terms of implications, the draft recommendation would reduce spending relative to current law by between $750 million to $2 billion over one year and between $5 billion and $10 billion over five years.

In terms of implications, we expect that beneficiaries would continue to have good access to care, given the current indicators of payment adequacy and margins in the industry. We also expect continued provider willingness and ability to care for Medicare beneficiaries.
So that concludes the presentation, and I turn it back to Mike.

DR. CHERNEW: Great. Kim, thank you so much.

This is another sector we've done a lot of work in. Much of that work has been outside of the specific update factors, and it's obviously a particularly important area.

So I don't see anyone wanting to make a comment.

So I'm going to pause for one second. Then I'm going to go to the vote.

[Pause.]

DR. CHERNEW: Okay. Dana?

MS. KELLEY: All right. For the draft recommendation on the hospice update and the aggregate cap.

Paul?

DR. PAUL GINSBURG: Yes.

Larry?

DR. CASALINO: Yes.

Brian?

MS. KELLEY: Marge?
1 MS. MARJORIE GINSBURG: Yes.
2 MS. KELLEY: David?
3 DR. GRABOWSKI: Yes.
4 MS. KELLEY: Jonathan Jaffery?
5 DR. JAFFERY: Yes.
6 MS. KELLEY: Amol?
7 DR. NAVATHE: Yes.
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15 DR. RILEY: Yes.
16 MS. KELLEY: Jaewon?
17 DR. RYU: Yes.
18 MS. KELLEY: Dana?
19 DR. SAFRAN: Yes.
20 MS. KELLEY: Sue?
21 MS. THOMPSON: Yes.
22 MS. KELLEY: Pat?
MS. WANG: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

Okay. I think we are now going to continue moving into sort of the next session of expedited voting, but it's going to feel very much like the last session. And we're going to start not with the SNF, the skilled nursing facility session, and I believe that's going to be Carol.

DR. CARTER: That's right.

Before the PAC group starts its presentations, I want to note that PDF versions of the slides can be found in the handout sections of the control panel on the right-hand side of the screen. In this session, each of us will present high-level summaries of our sector that was discussed at length at the December meeting. Details of the analyses and findings can be found in the papers.

We'll start with the update to Medicare's payments to skilled nursing facilities. This chapter now includes information that was requested at the December meeting.

Marge, you asked about closures by ownership.
Betty, you noted the need for accelerated quality improvement, and, Pat, you asked about differences in Medicaid shares between SNFs with high and low Medicare margins.

Let's start with an overview of the SNF industry in 2019. There were about 15,000 providers, most of which also provide long-term care services.

About 1.5 million beneficiaries, or about 4 percent of fee-for-service beneficiaries, used SNF services.

Program spending totaled almost $28 billion.

Medicare makes up a small share of most nursing facilities' volume and revenue, about 9 percent of days and about 16 percent of revenues.

As we reviewed in detail in December, our indicators are generally positive. Beneficiaries appear to have access to services. SNFs made small improvements in the two quality measures. SNFs have adequate access to capital, and this is expected to continue. The low total margin reflects the low payments from other payers. The 2019 Medicare margin was 11.3 percent, and the margin for the efficient provider was even higher. Both of these
indicate that Medicare's payments are too high relative to the cost of care. The Medicare margin for 2021 is projected to be 10 percent.

This brings us to the Chair's draft recommendation. It reads "For fiscal year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for skilled nursing facilities."

The level of Medicare's payments indicate that a reduction is needed to more closely align aggregate payments to aggregate costs. However, the effects of the coronavirus and impacts of the new case-mix system are uncertain. Therefore, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with costs while exerting some pressure on providers to keep their cost growth low.

In terms of implications, relative to current law, this recommendation would lower program spending by between $750 million and $2 billion for fiscal year 2022 and by between $1 billion and $5 billion over five years.

Spending would decrease relative to current law because the current law update for the year is projected to
be 2 percent.

Given the high level of Medicare's payments, we do not expect adverse impacts on beneficiaries. Providers should continue to be willing and able to treat beneficiaries.

And with that, I'll turn things back to Mike for your vote.

DR. CHERNEW: Thank you, Carol.

Again, we've spoken a lot about COVID and concern about it overall, and that's certainly true of all the sectors. I must say this sector has been particularly hard hit.

Again, we do have time for a question, and this time, it is going to go to Marge. So, Marge?

MS. MARJORIE GINSBURG: Yes. And perhaps I should remember this, but as I recall from earlier information about SNFs, that nonprofit SNF's margin is really very tiny compared to for-profit. So I will be voting yes to this, but I wonder if there is any information specifically on the implications for nonprofit SNFs.

DR. CHERNEW: Carol?
DR. CARTER: You are right that they're in general, but I would say over the last 10 years, there's been about a 10-point spread between the profit margins between nonprofits and for-profits. That reflects several factors, including they have higher costs per day, and they've had typically much higher cost growth. So they have not managed their costs as well as the for-profit sector.

They've also, in the past, tended to have lower shares of the highest intensive therapy patients that were the most profitable.

So I think we understand the differences, somewhat anyway, between the sectors, but it has not led us to, say, recommend differential updates between the two groups of providers.

MS. MARJORIE GINSBURG: One follow-up question. This may seem a little bizarre. Have we ever made recommendations that differentiate for-profit from nonprofit?

DR. MATHEWS: We have not.

DR. CARTER: No.

DR. CHERNEW: No.
And I think it would be particularly hard, by the way, to do so, but I think the point you make, which is a broader point, Marge, is that in all of these sectors, there's heterogeneity across providers. And again, I think it illustrates just the challenges with running the system the way the system is run because this is certainly not the only sector where I worry about some providers more so than others.

But our recommendation and the way the fee schedules work is common across all the providers and doesn't take ownership into account, ownership type into account.

David, I think you also have a quick comment.

DR. GRABOWSKI: Yes. I'll be very brief, Mike.

So I'm also very supportive of the recommendation. As you noted, Mike, we know that COVID has had this devastating impact on individuals receiving care in SNFs and also the individuals working there.

Jon Perlin said it really well with respect to hospitals. The pandemic will thankfully end, but the effects will be felt for quite some time. Some sectors, I think, will have a shorter recovery than others. They will
return to pre-pandemic utilization levels.

I'm less certain what's going to happen with skilled nursing facility care. We've seen during the pandemic, this real shift towards home health care. I wonder about the permanence of that going forward, and so, Mike, I just wanted to flag this issue. This doesn't change anything we're doing today, but I think it's worth putting on the record that this is something we'll want to monitor much like telemedicine and some of the others areas where I do think we're seeing a change here. And that's going to have implications down the road in future years.

Thanks.

DR. CHERNEW: Great. I will respond to that but first I think Jim wants to say something.

DR. MATHEWS: Yeah. Mike, sorry, just one more comment in response to Marge, and Carol, I could use a gut check here. Part of the difference in financial performance between for-profit and nonprofit SNFs over time is what Carol said about differences in case mix, that for-profits seem to be more selecting highly profitable rehab patients and nonprofit SNFs have a disproportionate share of medically complex patients that are less profitable. In
prior recommendations, going back to 2008, we recommended changes to the payment system that would minimize differences in profitability by case type, and CMS implemented changes not inconsistent with what we recommended this year.

So I think we would expect the differences in profitability that are attributable to differences in mix of patients to start to mitigate over time.

DR. CARTER: I agree.

DR. CHERNEW: Thank you. Thank you, Jim, and back to your comment, Dave, and I think this is true throughout, as it's my first year of being Chair, having to do it in the midst of COVID, which means we can't see each other in person and all of the understanding about what happens going forward is complicated by the impact that COVID will have on every sector, by the way, although admittedly SNF is probably top of the list in terms of some of the challenges they've faced. At least clinically that's certainly true.

Nevertheless, I don't want to diminish the challenges that everybody has had in COVID, and I will just say, for the listening, we will spend a lot of time, and do
spend a lot of time thinking about this, and I might add a
shout-out to the staff who, under very difficult
circumstances, worked into every chapter a really
thoughtful discussion about a really difficult topic about
how COVID will affect things now and in the future. And,
of course, the durable point matters because there's
obviously been a bunch of other support for these
providers, for the direct stuff, the durable stuff, what
matters. The durable part is also the hardest part to
anticipate, for a range of reasons. So we will continue to
do that, and I really do thank the staff for all of their
hard work in doing something that really they have not had
to do before, because COVID is something none of us have
had to do before, thankfully.

So with that said, I'm going to pause for a
second and then go to the vote.

All right. Dana?

MS. KELLEY: Okay. For the skilled nursing
facility update draft recommendation. Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.
1 MS. KELLEY: Brian?
2 DR. DeBUSK: Yes.
3 MS. KELLEY: Karen?
4 DR. DeSALVO: Yes.
5 MS. KELLEY: Marge?
6 MS. MARJorie GINSBURG: Yes.
7 MS. KELLEY: David?
8 DR. GRABOWSKI: Yes.
9 MS. KELLEY: Jonathan Jaffery?
10 DR. JAFFERY: Yes.
11 MS. KELLEY: Amol?
12 DR. NAVATHE: Yes.
13 MS. KELLEY: Jon Perlin?
14 DR. PERLIN: Yes.
15 MS. KELLEY: Bruce?
16 MR. PYENSON: Yes.
17 MS. KELLEY: Betty?
18 DR. RAMBUR: Yes.
19 MS. KELLEY: Wayne?
20 DR. RILEY: Yes.
21 MS. KELLEY: Jaewon?
22 DR. RYU: Yes.
Okay. I believe now we are going to turn to Evan and home health. I didn't have to look at my notes. It turns out it's on the screen. So Evan, you're up.

MR. CHRISTMAN: Thank you, Mike. Now we will review the indicators for home health using the same framework you saw for the other sectors.

As an overview, Medicare spent $17.8 billion on home health services in 2019, and there were over 11,300 agencies participating. The program provided about 6.1 million episodes to 3.3 million beneficiaries.

Turning to our framework, here is a summary of the indicators. Virtually all beneficiaries, 99 percent, live in an area served by home health. Episode volume declined slightly, but this was unrelated to payment, and
home health agencies have positive marginal profits of 18 percent in 2019. For quality measures, the rate of hospitalization decreased slightly in 2019, which is an improvement, while the rate of successful discharge to the community increased slightly, which is also an improvement.

The all-payer margins were almost 6 percent in 2019, and access to capital for large for-profit home health agencies is adequate, according to financial analysts. Home health agencies had margins of 15.8 percent in 2019, and we estimate margins of 14 percent in 2021.

The financial performance of the sector under Medicare is strong, and these are among the highest margins of any fee-for-service provider you will see this cycle.

This brings us to our draft recommendation, which reads, for calendar year 2022, the Congress should reduce the 2021 Medicare base payment rate for home health agencies by 5 percent. The implications are that this would decrease spending relative to current law by $750 million to $2 billion in 2022, and over $10 billion over five years.

For beneficiary and providers, we expect access to care will remain adequate. It should not affect the
willingness of providers to serve beneficiaries but it may
increase cost pressure for some providers.

This concludes my presentation.

DR. CHERNEW: I'm going to see for a second. We
do have time for a comment if someone pops up.

Okay, Dana, I think we're going to go for a vote.

MS. KELLEY: Okay. On the home health update
recommendation. 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: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: And Mike.

DR. CHERNEW: Yes. Okay. Notice how rapidly these expedited things go by. So we're going to move on now to Jamila, and that's going to take us to inpatient rehab.
DR. TORAIN: Thanks, Mike. Good afternoon. We continue with the date to Medicare's payments to inpatient rehabilitation facilities. This chapter includes information about IRF and the utilization that was requested at the December meeting. Now we will review the indicators for IRF using the same framework you saw in the other sectors.

Here is a reminder of the IRF industry in 2019. There were about 1,152 IRFs; 25 percent of IRFs were freestanding but these IRFs tend to be bigger, so they accounted for over half of Medicare discharges. The average length of stay was 12.6 days in 2019. Medicare accounted for about 58 percent of IRFs' discharges. There were 409,000 stays to 363,000 beneficiaries, and program spending totaled $8.7 billion.

In summary of the materials we discussed in December and were included in your mailing materials, we found that the IRF's payment adequacy indicators were positive.

With regards to beneficiaries' access to care, IRFs continue to have capacity that appears to be adequate to meet demand. With regards to quality of care, our risk-
adjusted outcome measures have remained relatively stable since 2015. With regards to IRFs' access to capital, IRFs maintain good access to capital markets. The all-payer margin for freestanding IRFs is a robust 10.4 percent. With regards to Medicare payments and IRFs costs indicators they were positive. In 2019, the aggregate Medicare margin was 14.3 percent. We project a margin of 16 percent in 2021.

So, to summarize, we observe capacity that appears to be adequate to meet demand and that providers should have an incentive to take more Medicare beneficiaries that qualify for IRF-level care given the strong marginal profits for both freestanding and hospital-based facilities.

And so that brings us to the update for 2022. Based on the strength of the payment adequacy indicators and because the indicators were positive in 2019, it reads: For the fiscal year 2022, the Congress should reduce the 2021 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

To review the implications:

On spending, relative to current law, spending
would decrease by between $750 million and $2 billion in 2022, and by between $5 billion and $10 billion over five years. Current law would give an update of 2.2 percent.

On beneficiaries and providers, we anticipate no adverse effect on Medicare beneficiaries' access to care. The recommendation may increase financial pressure on some providers.

This recommendation would be accompanied by a reiteration of our March 2016 recommendations to the Secretary to conduct focused medical record review and to expand the outlier pool to increase outlier payments for the costliest cases.

And with that, I will turn it back to Mike. Thank you.

DR. CHERNEW: Jamila, thank you. That was very good. We do have a comment from Pat, so Pat, you're up.

MS. WANG: Thanks, Mike. This is more of a question. Jamila, can you remind us whether between the freestanding and the hospital-based sectors whether there is a difference in the mix of services provided?

DR. TORAIN: The mix of services provided between hospital-based and freestanding?
MS. WANG: Yeah. Is it a different focus from freestanding and hospital-based? Same proportion?

DR. TORAIN: Exactly.

MS. KELLEY: Well, Jamila, I think there is a difference in the types of cases that they tend to admit.

MS. WANG: That's what I mean, yeah.

DR. TORAIN: Oh, you mean the cases. So yeah, we're doing more work in that area. We're trying to look in to see -- we do see differences between for-profit and nonprofit in hospital-based and freestanding. But we are doing more work into seeing why exactly there are differences in the cases that are selected between the two.

MS. WANG: Okay. And that leads to sort of the second question, which I'm sorry, I just don't remember. In the reform of post-acute care payment, was it possible at that time -- and maybe this is question for Carol, to see whether there were impacts on freestanding versus hospital-based margins? Because your modeling did show some shifts in margin according to hospice as well as sort of organizational status, I guess. And I just can't recall whether that was also true for the IRF.

MS. KELLEY: Is Carol still on?
DR. CARTER: Yeah, I'm on. So when we modeled
the PAC PPS, in general, money did -- the payments would
increase for hospital-based and for nonprofit facilities,
given their mix of patients and the medical complexity,
moving money towards those patients and away from
rehabilitation-only patients.

MS. WANG: Thank you. The comment then is
underscoring the importance of broader payment reform
beyond the straight updates, specifically in the PAC PPS.
And to Jim's point earlier, paying for the same service,
comparably, wherever it might occur. Thank you.

DR. CHERNEW: Yes, and so I agree, and, of
course, in certain areas -- Brian would mention this in the
case of ASCs, there's complicated case mix adjustment
issues that go on. So I guess for those listening, you
hear a lot of, I think, consensus amongst the Commissioners
on this point, and in each of the different particular
clinical areas the nuances in the data and the analytics
vary. But directionally, I think, we're largely in
agreement about what we would like to be able to do.

So that said, I think we are now going to go for
a vote on this. Dana?

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: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: And Mike.

DR. CHERNEW: Yes.

And we are now switching to Katherine, and we're going to do LTCHs. Katherine?

MS. LINEHAN: Thanks. Now we'll turn to assessing payment adequacy and updating payments for long-term care hospital services.

As we discussed in December, LTCH care is relatively expensive and infrequently used. The average fee-for-service Medicare payment for LTCH case was about $41,000 across all cases, and approximately $47,000 across
cases meeting the LTCH PPC criteria. Fee-for-service Medicare beneficiaries had about 91,000 stays, and total Medicare spending was approximately $3.7 billion in 2019 for care furnished in 361 LTCHs.

In summary of the indicators we discussed in December and that were detailed in your mailing materials, access to care indicators were consistent with changes to the payment system. Occupancy rates across the industry were steady in 2019. Although volume of LTCH services continued to decline in 2019, this is in large part due to reduction in non-qualifying cases.

In terms of quality of care, unadjusted mortality rates were stable, as were risk-adjusted rates of hospitalization. Risk-adjusted rates of discharge to the community declined slightly between 2018 and 2019.

The effect of fully implementing the dual-payment rate system, will continue to limit industry growth and access to capital in the near term. The aggregate margin for LTCHs with a high share of cases meeting the LTCH PPS criteria was 2.9 percent in 2019. Our projected margin for these LTCHs in 2021 is 2 percent, which reflects the three-month extension of the suspension of the sequester in the
coronavirus/omnibus spending bill passed in late December 2020.

There is no statutory update for Medicare payments to LTCHs. However, CMS historically has used the LTCH market basket as a starting point for establishing the LTCH update. Therefore, we make our recommendation to the Secretary.

The draft recommendation reads, for fiscal year 2022, the Secretary should increase the fiscal year 2021 Medicare base payment rate for long-term care hospitals by 2 percent.

This 2 percent update is expected to reduce federal program spending relative to the expected update by less than $50 million in 2022, and by less than $1 billion over five years. We anticipate that LTCHs can continue to provide Medicare beneficiaries who meet the LTCH PPS criteria with access to safe and effective care.

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

DR. CHERNEW: Great. Thank you. That was, I think, very clear in a sector that is complex and changing, and, of course, how all of this payment works across the different post-acute sectors is complex.
I'm just waiting for a second to see if someone was going to say something.

All right. Dana, we're going to go to a vote.

MS. KELLEY: Okay. For the update recommendation for long-term care hospitals. Paul?

DR. PAUL GINSBURG: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Brian?

DR. DeBUSK: Yes.

MS. KELLEY: Karen? I think we've lost Karen.

All right. I'll continue on and we'll come back to her. Hopefully she will quickly join us again.

Marge?

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: Dana?

DR. SAFRAN: Yes.

MS. KELLEY: Sue?

MS. THOMPSON: Yes.

MS. KELLEY: Pat?

MS. WANG: Yes.

MS. KELLEY: And Mike.

DR. CHERNEW: Yes.

MS. KELLEY: I don't see Karen back on. She must have dropped off. One thing we could do is ask for her vote at the start of the next session.

DR. CHERNEW: From what I understand that might...
be the only thing we could do. Jim, do you have any
suggestion here?

DR. MATHEWS: If you are willing to do that, I
think we can accommodate it. Otherwise, I think we would
mark her as not present.

DR. CHERNEW: Yeah. Well, I think we should
absolutely do that, and we will see that when we return for
the next session. See, that's the beauty of rambling. If
you ramble enough --

DR. DeSALVO: Are you all looking for me? I'm
sorry.

DR. CHERNEW: That's all right. Karen, we are
looking for your vote on that recommendation.

DR. DeSALVO: Yes. Sorry.

MS. KELLEY: Thank you.

DR. CHERNEW: And that was the other strategy for
me, just to keep talking until the problem goes away.

So we are all good. That was indeed a full
series of expedited sessions. I want to thank everybody
for their discipline and for their comments. We are now
going to adjourn until -- I think we come back at 1:45,
when we will start with the alternative payment model
chapter. Is that right? Does anyone want to add, Jim or Dana? Are we good?

DR. MATHEWS: We are good.

DR. CHERNEW: Okay. Thank you for your morning, everybody. We will be back at 1:45. Please join a little bit sooner so we can get going right on time.

[Whereupon, at 12:31 p.m., the meeting was recessed, to reconvene at 1:45 p.m. this same day.]
AFTERNOON SESSION

[1:47 p.m.]

DR. CHERNEW: Welcome back. This is our afternoon session. To orient everybody, unlike the morning session where we were voting on update recommendations, this afternoon is largely going to focus on areas where we have the policy option debate. We typically go to a policy option discussion like we're about to have. There will be a draft recommendation in this particular case in March, and then depending on how -- assuming the policy options discussion pushes it in that direction, we'll have that discussion. Then any vote or recommendation would be made in April.

So this is a topic that has been of longstanding interest to MedPAC, alternative payment models. I think we'll start with the presentation. I think Rachel's going to kick it off, and then we'll go through a set of the comments. Rachel?

MS. BURTON: Thanks, Mike. This afternoon, Geoff Gerhardt and I will discuss the Center for Medicare and Medicaid Innovation and explore policy options related to its development and implementation of alternative payment
models. Today's discussion picks up from our October discussion on this topic and fleshes out some ideas raised by Commissioners.

The audience can download a PDF of these slides from the control panel on the right side of their screen, under the "Handout" section.

Today we'll start out with some background on the Center for Medicare and Medicaid Innovation, or CMMI, and identify some of the goals, objectives, and factors it considers when selecting models to implement.

We'll briefly summarize the impacts achieved so far by its flagship models and touch on some barriers that models may be experiencing.

Geoff will then present three policy options that would change how CMMI manages its portfolio and invite your discussion of these and any other topics.

CMMI was established in the Affordable Care Act of 2010 to test innovative payment and service delivery models that reduce Medicare or Medicaid spending while preserving or enhancing care quality.

Congress included 27 potential models for CMMI to consider in its authorizing statute and appropriated $10
billion every ten years, in perpetuity, to CMMI.

CMMI models are typically implemented for three to five years, but can be expanded into a permanent, nationwide program -- without requiring an act of Congress -- if they are found to decrease spending without decreasing quality or to increase quality without increasing spending.

In 2015, Congress passed a law creating a new 5 percent bonus for clinicians in certain types of payment models that have come to be known as "advanced" alternative payment models, or A-APMs.

These models require providers to assume "more than nominal" financial risk. The models must also use quality measures comparable to those in the Merit-based Incentive Payment System, and they must require providers to use electronic health records that meet federal standards.

The 5 percent A-APM bonus is available annually from 2019 through 2024 to clinicians with a sufficient percent of payments or patients in A-APMs.

Starting in 2026, clinicians in A-APMs will qualify for higher annual updates to fee schedule rates
than clinicians not in these models.

This 2015 law also created the Physician-Focused Payment Model Technical Advisory Committee. This group, called the PTAC, assesses models submitted by the public and recommends whether to implement them, although CMMI is not bound by these recommendations. And in fact, CMMI has never implemented a model recommended by the PTAC.

The last time we talked about CMMI, at the October meeting, some Commissioners were interested in whether CMMI had strategic goals that guide the development of its models.

In response to this inquiry, we've assembled some of the key goals, objectives, and factors CMMI considers.

First, CMMI funds the Health Care Payment Learning & Action Network, known as "the LAN," which brings together payers and other stakeholders to encourage them to align with HHS' goals for payment reform. Back in 2015, when the LAN was formed, HHS' goals were simply to increase the percent of payments linked to quality and value and the percent of payments in alternative payment models. Over the years, the LAN has helped HHS develop more specific goals: first, encouraging payers to pursue
one- and two-sided shared savings models, shown in the purple column, and partial and full capitation models, shown in the green column.

Then this last year, the LAN and HHS narrowed this goal by no longer encouraging movement into one-sided shared savings models -- shown inside the dotted circle in the purple column.

The LAN conducts an annual payer survey, to measure the percent of payments in the U.S. that flow through their preferred types of payment models.

Moving from HHS' broad goals to more specific objectives, HHS has advised that when selecting models to implement, it prefers those that are transparent, in that they empower consumers to drive value through choice; simple, by which HHS means the model focuses on measures that matter, rather than check-the-box requirements; and accountable, in that they encourage risk and financial accountability, to align incentives and drive behavior change.

On a more practical level, CMMI also considers the 20 factors listed on this slide, including a model's potential for cost savings and quality improvement, the
strength of the evidence base supporting a model, the
extent of clinical transformation envisioned in a model, a
model's potential overlap with other models, the
feasibility of operating and evaluating a model, and the
feasibility of scaling it up if it is successful.

CMMI has used the goals, objectives, and factors
just mentioned to develop dozens of payment models over its
first ten years, many of which have attracted large numbers
of participating providers.

In 2020, CMMI was actively operating 24 models by
our count. This includes some successors to earlier
versions of models that were previously tested with
slightly different designs. Currently, seven of CMMI's
models are considered A-APMs, since they involve financial
risk for providers. Clinicians in these models can qualify
for the 5 percent bonus I mentioned earlier.

In CMMI's history, only four of its models have
been certified by CMS' actuaries as having met the criteria
to be expanded into a permanent, nationwide program. Only
one of these was an A-APM. It was the Pioneer ACO model.
CMS incorporated lessons learned from Pioneer into Track 3
of the Medicare Shared Savings Program, which in turn
evolved into the current "enhanced" track. MSSP is the only A-APM not operated by CMMI; instead, it is a large, permanent program created by Congress.

To get a sense of the impacts produced by CMMI's payment models, we reviewed the most recent evaluation report for each of the seven A-APMs, plus their predecessor models, and we also looked at studies of the MSSP. Among these 15 models, we found that nine produced gross savings for Medicare before factoring in new payments made to providers in these models. Among the nine models, five generated net savings once model payments were factored in.

As a side note, I'll mention that CMMI is not required to expand successful models and has the discretion to continue iterating on such models if it chooses. We also found that about seven models improved quality and that quality improvement tended to accompany net savings.

I'll now turn things over to Geoff to talk about some barriers that may be preventing models from having greater impacts.

MR. GERHARDT: It's worth taking a moment to
consider why more models have not generated net savings for Medicare or led to substantial improvements in quality.

Achieving these goals depends in large part on whether providers change their behavior in response to financial incentives in APMs to reduce the volume and intensity of services and place greater emphasis on health outcomes.

Since many APMs are layered on top of fee-for-service payment systems, the incentives in fee-for-service to increase provider revenue by maximizing volume may outweigh the APM's incentives to reduce volume.

And while incentives under fee-for-service are relatively easy for providers to understand and respond to, the parameters and incentives in APMs can be extremely complex and difficult for providers to fully understand. The complexity of models may be suppressing provider participation and limiting the effectiveness of incentives for providers to change behavior.

Certain providers, especially those who are employed by health care organizations, may be partially or completely shielded from the financial incentives in APMs. Models are often implemented as independent initiatives and
are not necessarily integrated with other APMs being tested.

The lack of alignment between models can cause performance payments from shared savings to be attributed in unpredictable ways. This unpredictability can alter incentives for providers and cause operational challenges for model participants.

Models where participation is voluntary or providers have choices about what services and spending they are financially accountable for may predominantly attract providers that expect to be able to receive performance bonuses without substantially changing their behavior.

And, finally, beneficiaries attributed to an APM may not have any incentive to change their own behavior, putting the onus for improvement entirely on providers.

At the October meeting, some Commissioners expressed interest in exploring three policy options related to how CMMI manages its portfolio of payment models.

One option is to reduce the number of models CMMI implements and ensure that a smaller group of models are
Another option is for CMMI to focus on implementing models that show the most promise, especially when it decides to develop second- and third-generation versions of models.

The third option is for CMMI to make fewer, if any, changes to a given model's parameters once it is underway. On the next several slides, I'll walk through these policy options and review a number of pros and cons for you to consider. A more extensive list of pros and cons for each option is included in your mailing materials.

The first policy option is that CMMI should seek to implement a smaller suite of coordinated models designed to support a clear set of strategic goals.

Under this option, CMMI would find it easier to create a system of models that align with and support each other more than the current models do.

By reducing the number of models and making sure they are more coordinated, this option could reduce unintended interactions between different models, including conflicting model rules and financial incentives.

On the other hand, a smaller number of models
could have drawbacks. It would likely decrease the diversity of models being implemented, which could have a negative impact on finding models that meet the law's criteria for expansion.

Similarly, it could constrain CMMI's ability to develop models that are tailored to meet the needs of subgroups of providers and beneficiaries.

As part of a desire to reduce the number of models being implemented, some Commissioners have said CMMI should focus more on models that show the most promise.

Therefore, the second policy option would be for CMMI to only develop second-generation models if one or more of a set of specified criteria are met within a given time frame.

The criteria could include clear and evidence-driven metrics related to changes in spending, improvements in key health outcome measures, and how well a given model aligns with other models that CMS is implementing.

Such a process would make decisions about which models to continue and relaunch more transparent and objective.

It could also help reduce the overall number of
models by discouraging CMMI from implementing multiple
generations of models that have consistently failed to meet
expansion criteria or other policy goals.

A potential disadvantage of this policy could be
to create incentives for CMMI to put its focus on models
that will meet the continuation criteria, rather than
achieving the statutory goals of reducing spending without
reducing quality or improving quality without increasing
spending.

The policy also might not provide CMMI with
sufficient time or flexibility to fully test potentially
promising approaches if they fail to meet the continuation
criteria.

The third policy option addresses concerns among
Commissioners that CMMI is making too many unplanned
changes once models are being implemented. Unplanned
changes are mid-course changes that CMMI makes which were
not included in the model's original specifications.

There are a range of ways this policy option
could be carried out. One way would be to simply freeze
all of a model's parameters and rules for the life of the
model once it is launched. Another approach would be to
make only minor technical changes to a model in the field, but this raises questions about what kind of changes would be considered "minor." Another option would be to apply changes only to subsequent cohorts of model participants and allow the initial cohort of participants to continue under the original parameters.

Although the specifics of this policy would need to be worked out, it should help make models simpler and less burdensome for participating providers.

The policy would also make models more stable and predictable, which could encourage more providers to make investments in infrastructure and care improvement initiatives.

On the other hand, if there are flaws with the model and CMMI doesn't address them, providers may exit models, in which case participation would drop.

If the problems with a model lead to increases in spending or other negative effects, and CMMI's doesn't have the ability to fix those problems, CMMI would either need to let the flawed model continue or shut it down prematurely.

Now that we have walked through some pros and
Based on today's discussion, any policy options that Commissioners would like to pursue will be presented for further consideration at a meeting this spring. We are happy to answer any questions you might have and look forward to your input.

I'll now turn it back to Mike.

DR. CHERNEW: Geoff, thank you, and, Rachel, thank you.

So I'll take Round 1 comments in a moment, but before going to Round 2, I have a for example people in the queue. Let me make a general introductory point, given how much I care about this topic.

The first point is the main goal that I see here is that we think through the policy directions to try and figure out where we might want to go this cycle for a recommendation. I will tell you I'm particularly interested in the first point about having a coordinated set of models, what I would call "changing the basic paradigm of what's going on." But obviously, comments on the other two are really important. So the first point is
getting to recommendations.

The second one is please understand that as we do this, I view this as a multi-cycle activity. So some of the things we might want to do, we will be picking up again in future years. There's only so much, I think, we're going to be able to do right now and lots to be done.

The third point I'd like to make is there are many important points I'd really like to hear from you all about things that might actually show up in the commentary of a chapter, even not directly in a recommendation. So I have a lot of thoughts on the literature of what we know and where we should go, but I'm going to hold them to myself for a moment and see as we go through the questions and get your feedback on those particular things.

So in Round 1, I think, from your message, you had a Round 1 question, and I see Sue has a Round 1 question. So let's go Marge and Sue before we start Round 2.

MS. MARJORIE GINSBURG: Okay, great. Thank you. I'm interested -- I don't know if we have ever talked about this vis-à-vis this whole topic, and that is the extent to which physicians are both original Medicare
and Medicare Advantage, patients that cover both realms. I ask this because I can't help but conclude that if physicians have a foot in both camps that what they do under MA may influence ultimately what they do under OM, and it seems to me it would be very interesting to see the extent to which the success of these models may be influenced by the role that physicians have across both domains.

The second question, which is sort of related to that, is on page 10 of the report that shows the LAN interest, where they show that Medicare Advantage, 30 percent, 50 percent, and 100 percent, the same as traditional Medicare, but that's their goal.

So I guess I'm not sure. I always think about this whole area as applying only to fee-for-service under original Medicare, but maybe that's not true. Maybe this, in fact, also pertains to Medicare Advantage plans, but until I saw this chart and some of the write-ups, I never got that impression.

So I don't know. Is that too confusion, the questions asked?

DR. CHERNEW: Rachel and Geoff, can I jump in
with an answer?

[No response.]

DR. CHERNEW: I'll take that as maybe a yes. Can you hear me?

MR. GERHARDT: Yeah. Go ahead, Mike. That's fine.

DR. CHERNEW: So, first of all, I would argue -- and, again, Rachel and Geoff can correct me -- that most physicians that are in APMs are probably also in an MA by the nature of the way they work, and basically, physicians serve patients from all over. If there's a lot of MA in an area and there's APMs in the area, the physicians are almost surely serving both. There may be some examples. Kaiser, for example, might be an exception, but I'm not even sure about that.

In any case, it's also true that there's clearly spillover between physician practice patterns. If you change the way physicians are practicing, in general, they will change the practice patterns for other providers. That means what MA does will spill over to fee-for-service, and what fee-for-service does will spill over to MA. And there's a lot of evidence, I believe, on that.
The third point is from an administrative standpoint, the APMs are limited to people in the fee-for-service sector. The Medicare Advantage plans, of course, can pay physicians however they want, using whatever models they want, but the models that we're generally talking about here are in the fee-for-service sector. There are some multi-payer-type models and some other things that could conceivably be broader, but I think for the most part, when we think about how Medicare is thinking about alternative payment models, I think -- and again, I'm happy if people want to be broader, but the way that I would think of the gist of this discussion is changing the way that Medicare fee-for-service pays providers, understanding that those changes will influence care not only in Medicare Advantage but frankly also in the commercial market. And I think there's pretty strong evidence of that.

MS. MARJORIE GINSBURG: Well, if I may follow up on this. So this is what I find confusing because I -- well, part of it is the use of our term "fee-for-service," which originally I thought only applied to original Medicare, but we know that in Medicare Advantage plans, physicians are paid fee-for-service.
DR. CHERNEW: Yes.

MS. MARJORIE GINSBURG: So now it starts to get a little mucky.

DR. CHERNEW: Yes.

MS. MARJORIE GINSBURG: Are we assuming that --

DR. CHERNEW: Yes.

MS. MARJORIE GINSBURG: -- this whole discussion is focusing on original Medicare, not Medicare Advantage, or are we assuming, no, it has nothing to do with which domain? It only has to do with how the physician is paid?

DR. CHERNEW: I think, Marge, the answer is we use the term "Medicare fee-for-service" more to distinguish it from Medicare Advantage as opposed to how the physician is actually paid.

So, again, I'll let Geoff and Rachel jump in, but for the most part of this discussion, you should assume this is only what we might call "traditional Medicare," the original Medicare. This is not really about how physicians are paid in general. It is how Medicare outside of Medicare Advantage pays the physicians. Medicare Advantage can pay fee-for-service, as many do. Some don't. But this discussion is the payment systems that Medicare uses
outside of Medicare Advantage and what we might call "traditional Medicare," although sometimes that used synonymally with Medicare fee-for-service, and that's not really right.

Geoff and Rachel, did I say anything wrong?

MS. BURTON: I just want to chime in that technically A-APMs include models by any type of payer. So you can get the 5 percent bonus if you are in a Medicare fee-for-service A-APM plus some other payers' A-APMs that can help you reach the percent threshold you have to hit in order to get the 5 percent bonus.

DR. CHERNEW: That's true, but the recommendations I think we're going to be talking about are largely going to be recommendations about how we should design those models in the original Medicare system because that's where CMS really has the authority of what they can do. They can encourage things elsewhere and you're happy to talk about.

But I want to keep moving along because there's some other Round 1 questions. I think I've lost a little bit of track of my list. Paul had a question, a Round 1 question, and Bruce has a Round 1 question. And I'm going
to keep looking, and I have several for Round 2.

DR. PAUL GINSBURG: Okay. I'll begin. I learned a lot from your paper and presentation, and it was really, really good work.

You know, thinking about the strategy, the strategy is to get as much of the delivery systems into good models, presumably as fast as possible, but your presentation was just talking about different models. You know, you go from first generation to second generation, and my question is, is the legislation that authorizes CMMI -- is that very restrictive, perhaps too restrictive as far as CMMI's ability to move the system into the successful model so that if there's a successful first generation, perhaps the second generation is mandatory and no longer an experiment, or is it just the way that CMMI has been run, not to be eager to progress into models that are part of the system?

MS. BURTON: I think that CMMI --

MR. GERHARDT: Well --

MS. BURTON: Go ahead, Geoff.

MR. GERHARDT: I was going to say the authorizing legislation gives CMS or CMMI a lot of leeway in terms of
implementing and testing models. It doesn't put a lot of parameters around those. It doesn't have a lot of language around what they need to do to demonstrate that a model should be tested or continued or turned into a second generation.

The restriction really comes in in terms of its ability to expand the model in scope and duration, and that's where that test comes in about saving money, improving quality, or some combination thereof, and the requirement that it be looked at by OACT and approved by OACT.

But before that stage, they have a ton of flexibility in terms of what they can do.

DR. CASALINO: Mike, very briefly on this point?

DR. CHERNEW: Go ahead, Larry.

DR. CASALINO: Yeah. I think Paul was asking, if I understood what he was asking, a slightly different question, which is fairly subtle. It's one thing to meet the criteria for expanding the model, but this could be a model that is made permanent but that not everybody has to participate in.

I think Paul was asking if CMMI had the authority
to make a model permanent and mandatory for everyone that would be -- all providers that would be eligible for the model, so to speak. I think it's a little different question than we usually talk about, which is what are the criteria for making a program permanent. Paul is asking can they make it mandatory, and I don't think they can.

Can they, or can't they?

MR. GERHARDT: They essentially can. The home health value-based purchasing model, it's not really an APM, but it was just approved to be expanded from a select number of states to all states and all home health providers in those states. So, essentially, that can be expanded not just nationally and permanently but also to all providers.

DR. CASALINO: Okay. So they have two options that are not mutually exclusive? They can do one, the other, or both? They can make something permanent -- well, they can make it permanent and mandatory or permanent and not mandatory, I guess? It partly depends on what the program is and if that providers are included, I guess. Is that correct?

MR. GERHARDT: Yes.
DR. CHERNEW: Okay. I was wrong about Bruce's comments in Round 2, but I see that Sue Thompson has a Round 1 question. So, Sue, you're up.

MS. THOMPSON: Thank you, Michael.

My question does relate to the question that Paul asked, I think, and it's probably even more basic. But do we know by model how many providers have participated in the various models that CMMI have proposed? Going back to the pioneer and then through the years, what do we know about the growth, the increase in numbers of providers that are participating? Are they employed? Are they part of a system? And what other characteristics are happening? I think that's one of the sort of basic components that would be good to understand.

And depending upon how we're going to measure success here, but certainly, as we work to get -- and it's probably a Round 2 comment, but as we're working to move to value, it just strikes me to understand really well. How are we pulling in more and more providers to this work? Do we know that? Do we know those numbers?

MS. BURTON: I can take this. We know how many providers are in each model, and usually, evaluation
reports will provide some descriptive statistics, breaking out what we know about the providers, like what types of providers they are.

What we don't know is how many clinicians in total have ever been in an CMMI model because they're kind of counted separately, and they don't kind of link up across all the models to figure that out.

MS. THOMPSON: Thank you.

DR. CHERNEW: Okay. Dana Kelley, I think that finishes our -- oh, Larry, do you have another Round 1 question?

DR. CASALINO: My other one was a clarification, but yeah, this is very brief.

Rachel and Geoff, in terms of evaluation of the model, CMS has their own evaluators, but it probably would be a useful thing if other people could evaluate the programs as well, as has been done to some extent, for example, with the ACO program.

With some of the programs I know, like the ACO program, it is possible -- you basically have to know for a program, what organizations are in it and what physicians are in it, right? You have to basically know the NPIs so
you can evaluate the program.

Is it possible -- if you know the answer to this, for all of these instant programs, is it possible for a researcher to say, okay, I want to study that, and CMS publishes sufficient information that I can identify the organizations and the clinicians involved? So that's the first question. If it's not that way, ought it to be, in your opinion?

MS. BURTON: Amol might actually have some useful information on this point.

DR. NAVATHE: Yeah. So I can jump in here. For many of the programs, the answer is yes because they publish participation lists, but there are programs for which they don't publish or at least participation lists to date haven't been posted. And it is oftentimes very hard to get access to that data because it goes through the PECOS files, and not all of those files also -- the full contents of those files are not made publicly available, even though the standard research request processes for identifiable files.

So I would say it seems like a little bit more than the majority of programs seem to be evaluable, if
you will, by these external researchers, but there are some. For example, CPC, CPC+, they have not published those lists. So if you go looking for evidence for those, you'll note that there's the evaluation reports that were done, but there are no external researchers who have been able to study that program, to my knowledge.

MS. BURTON: And it's probably above my pay grade to opine on whether the data sets should be available for external research.

DR. CHERNEW: Yeah.

DR. CASALINO: That was kind of a backhanded way of giving a Round 2 comment into Round 1, but we can talk about it later, maybe.

DR. CHERNEW: Okay.

So, actually, I will say, just as an aside as someone who's done this, there are a lot of external evaluations of ACOs. I've done a large number of them myself. I can tell you my personal view is unambiguously that population-based payment models save a little bit of money net. There's been a lot of evaluations and episode-based payment models. Amol has done a lot of those. So I'll defer to Amol who is going to talk in a minute, but my
read of that aperture is in certain types of episode, they
unambiguously save money. But across the board, it's not
clear that all episodes would save money, and advanced
primary care is a much more challenging area. That's my
view of the literature. That's based on both the official
evaluation and these external evaluations, a very, very
active academic group of researchers working on
evaluations.

That said, Amol, I hope I didn't steal any of
your thunder, but you're going to be first. And then we're
going to go to Jonathan.

DR. NAVATHE: Great. Thanks. No, no, Mike, you
didn't steal any of my thunder.

First off, let me just express a lot of support
for this line of work. Rachel and Geoff, you guys have
done a very nice job of laying out a lot of information.
As Mike just alluded to, there's a tremendous amount of
activity here within CMS but then also kind of studying
what CMS has done, and you guys have done a very nice job
of synthesizing it. So thank you for that.

I also appreciate the direction that we're going
generally, which is to broaden our aperture around APMs and
to consider APMs overall, in fact, payment reform overall, and I think that this general direction, I'm very, very supportive of.

That being said, I would like to highlight kind of six big points, and then I'll jump into them. First, I think we should be clear from a framing perspective that what we're talking about here is really Medicare payment reform. It's broader than CMMI. So perhaps we don't want to restrict ourselves to CMMI and how we frame this.

Second big point is -- and I'm going to jump into each of these with a little bit more narrative shortly.

Second big thing is I think it might be time for us as a commission to revisit and revamp our value-based payment principles that were alluded to earlier or were mentioned early in the paper.

Third point -- and we talked about this, I think, earlier in the earlier APM sessions that we've had -- it may be very helpful at this point for MedPAC to help offer a strategic plan over, say, the next decade for payment reform, maybe not that long, but I think that could actually be very helpful to Medicare and CMMI.

Fourth point, there may be some reasons to
suggest or recommend to Congress to change the CMMI, to
adapt the CMMI statute, now that we're entering the second
decade of CMMI, particularly in terms of shifting its focus
from being kind of purely a testing entity to one perhaps
that is consolidating lessons from the last decade and
trying to be more strategic against key goals. For
example, should CMMI actually be at least in part trying to
address issues around the hospital trust fund solvency or
affordability long run?

Fifth big point is I strongly, personally,
believe that we're missing equity as a focus. I do believe
there is a way that it fits into the CMMI statute, and I'll
talk about that later.

And then the last point is I think this work is
incredibly important. I think it's fundamentally critical,
and in fact, there may be some really key ways that we can
offer criteria or principles that could be fundamentally
important to how CMMI and CMS are able to run their
programs, in fact, to cancel programs because of some of
the challenging, other stakeholder and political
environment factors that exists.

So I'm trying to take each of these and not take
too long. So broader than CMMI, I won't say any more than that. I think that we should just widen the aperture here and realize that this is CMS payment reform. Many programs, notably MSSP, is not within CMMI, so I think it's just a fit issue.

Second point, so we need to revisit, revamp, and refresh the Commission's principles on value-based payment. Right now, when I take a look at those principles, they seem kind of like having blinders on and looking at one model at a time. The reality here is we have a portfolio of models. And so how would the Commission recommend, at least in terms of principles again, the way that these models should function? What should their goals be? What are the types of metrics we should use? Just like we've done other work, I think, that has been really foundational and guides all of the rest of the MedPAC work, I think we can actually take a step back and kind of revisit that in a way that would be very impactful, and, in fact, for us, as the Commission, over time be helpful to ensure that we're consistent against a set of principles that we lay out ourselves.

The three areas, the three policy options that
we've laid out here I think are three critical policy options, and I like all of them. That being said, I also think it may make sense for us to take a step back, because each of these cascades into a whole other set of issues, and it may be actually quite challenging to take on one of these issues without taking on other related issues.

So, for example, if you look at the first one, which I agree with the policy option recommendation language here, implement a smaller suite of coordinated models, that sounds great. I would be 100 percent behind it. But the question is, so what is that smaller suite of coordinated models? How do we determine whether a model is coordinated or not? What does that actually mean?

So I think there it's important that we perhaps take a step back, pick one of these, and then recognize that there's a whole litany of other factors that are at play here that we may not be able to immediately address in this chapter, for example, in 2021, but that may lay the foundation for where our work is going. For example, overlap between models would be important. We know risk adjustment, benchmark setting, mandatory participation versus voluntary participation. I won't go through a
checklist. I have actually made one and I'm happy to share it. But I think the principle is an important piece here.

The fourth point I mentioned was shifting the focus for CMMI. CMMI, as I understand it, in the first decade, was extraordinarily successful in a proof of concept of can we test models, and can we test a variety of models that touch primary care, specialty care, post-acute care, hospital care? There are so many models that it's very impressive what's been done to date.

But now we have lessons from the last decade to actually learn from and to guide where we're going in the future. And I think there could actually be some language that we could recommend to change the statute just a little bit to acknowledge that there could be more of a strategic decision-making from CMMI around which models to test and how we might select those. In particular, as I understand it, there is language in the statute now committing CMMI to testing a certain volume of models in terms of dollars. That may or may not make a lot of sense.

So I would submit to you all that maybe we should consider recommending a slight change to the language of the statute for flexibility that we could recommend to the
The next point I had was missing equity. I think COVID has obviously laid bare inequities. These are inequities that have existed. One of the challenges, perhaps, is in CMMI statute there is no specific language on equity. One thing we could do is recommend to change that. Another thing is there is quality language within the statute, and equity, I think, is fundamentally intertwined with improving quality, particularly improving quality for populations that face health care and outcome disparities.

So I think there is a way to do that, and I would strongly urge us to at least put it on the radar. Even if we don't do a whole body of work on it right away, I think we should put it on the radar that equity is an important focus that we should not leave behind.

The last point is just highlighting the importance of our work. I think in my experience working with CMMI, formally and informally, it seems incredibly difficult to cancel models once participants are in a model and you've had a stakeholder community move behind it. I'm using this as an example of why our work could be so
important. If we could lay out things like criteria on how CMMI could make decisions around that, that may actually provide the right external validation, if you will, of decision-making that could enable those kinds of difficult decisions that perhaps otherwise would be too challenging. So thank you so much for listening, and I look forward to the coming dialogue here, and once again, Geoff and Rachel, thank you so much for a great chapter.

DR. CHERNEW: So we are about to go to Jonathan but Amol, there was a ton there, so I want to jump in to help direct the conversation. Many of your points -- and we'll consider all of them -- are things that we can write about in the chapter about things that are important but don't necessarily flow into a recommendation. There were some things that were very specifically I can see them going into a recommendation, things like coming up with a somewhat different paradigm for how they think about APMs as opposed to test and launch, test and launch, and discuss that. I very much believe that, and it sounds like you believe that too, and I think we can continue to go in that direction.

The issue about the specifics, exactly what that
set of models should look like, my personal view is that's going to take us another cycle to get to, because that's going to require a lot of analysis. I'm scared of your checklist, Amol, but I'm not going to dwell on it now. We will have to get there, but it will probably require a lot to get to real recommendations.

So that's my current thinking. So for the other Commissioners, as you talk, it would be useful for me to understand how you feel about that one particular point, which is a sort of not just fewer models but fewer models done in a harmonized way, if that makes sense, as opposed to test-launch, test-launch, test-launch, and introducing an ever-expanding number of models. I would like people's thoughts on that.

The first person who is going to give thoughts on that, plus any other thoughts, is going to be Jonathan.

DR. JAFFERY: Great. Thanks, Mike, and I also want to just thank Rachel and Geoff and the rest of the staff for the chapter and the discussions we've been having this whole cycle. This is a really important topic, one I care a lot about, and I think there's a ton of interest and excitement across the provider community as well, and so
it's really important that we keep helping make this work better.

I want to make a few quick comments about sort of three different areas, and then jump into, quickly, comment specifically about these two policy options, including addressing exactly what Mike just asked about.

The first thing is around some thoughts about program design and evaluation. This kind of builds on a number of things that Amol was saying about helping form a strategic plan for CMMI, or I think one of the things we've talked about is a concern over it's not clear what the overarching vision is at this point. And like Mike was saying, I don't think that we're going to get to all of those specifics this cycle but we can start to. And there may be some elements that we want to be very specific about, like should models be mandatory. You know, Paul has commented in the past, I think, about DRGs, and I don't want to say that these are exactly the same kind of thing, but if DRGs hadn't been mandatory -- if they were voluntary we still wouldn't have them in the way we have them now. So we should think about that.

My understanding, in looking on page 5, the
figure in the reading, it seems to suggest that the evaluators, thinking about the question about researchers doing evaluations, the evaluators are selected after the model design and implementation approach is described. And I'm not sure to what extent that is, in fact, how it works, but if it does, I think there is a specific thing that might be helpful for us to think about evaluation. It's always struck me that that has been an issue policy program implementation, that if those evaluators aren't involved in discussions up front it makes it more challenging to get some good evaluations.

And then I think one other principle is thinking about, when we talk about net savings how holistic can we really be? I mean, we've had some discussions about that but, as an example, when we look at ACOs, what is the impact on MA benchmarks? We've talked about that with the Commission before, but I don't know that I've seen that as a principle in terms of evaluations. And so that's a factor.

The next area is about the too many models. And so I absolutely think there are too many models. I wonder about PTAC's role and if that kind of exacerbates this
notion of lots of different models out there. And I worry that it might be a little bit disengaging for providers and others to be asked to put in ideas for models that, as was noted, don't get taken up. So obviously they could be taken up in the future, but I think that complicates things.

The issue about MSSPs is key. The reading speaks to the fact that 20 percent of beneficiaries now, approximately, are in MSSP. So if we don't harmonize the CMMI portfolio, at least of ACOs, with MSSP program, I think that's a serious barrier.

And then finally the issue of the models and rules just being too complex. There is the text box on pages 14 to 16 that talked about when providers can participate concurrently, and as you read through that it's very confusing. They are inconsistent when they can and they cannot. And as an on-the-ground, frontline person trying to tease out what to participate in or opportunities as providers, it takes a lot of time and resources to try and keep track of these things.

Also talk about the payment model incentives being hard to understand, and I think to quote the chapter,
it may require substantial changes in provider workflow, infrastructure, and behavior in order to be successful, and that's absolutely true. So every time we change these models that does end up causing people to think about altering their workflows, and that's very difficult to keep track of.

So to speak to these three policy options, I think they are all important to be thinking about. Number one is the clearest to me, that implementing a smaller suite of coordinated models, to me, a set of strategic goals is super important, and I just want to make sure we call out that that needs to include MSSP and how CMS runs that.

I'm a little less confident about the second-generation model issue. I do think we need to think about specific criteria. Clearly we don't have those fleshed out now. But I think there might be a first-order question here as well, and that is, what does it mean to be a second-generation model? So if direct contracting is a second-generation model after Next Gen, I'm not sure that's always clear to me how one thing follows, because as we were talking about direct contracting earlier today, there
are a number of elements that are sort of brand new and very, very different. And I can see how a Next Gen program could build on some of the direct contracting but in other ways I struggle to think about that as a second-generation model.

And then the final point, reducing or eliminating changes, again, I think we will need to flesh out how exactly we would set those criteria of what a reduction would mean and how big a change could be made. But I think that's absolutely true as well, that it's very challenging. And this gets to a previous comment about infrastructure changes and workflows. Every time these things change it causes providers to have to rethink some of those things, and some of the issues may just be timing. So if there's going to be a programmatic change, what's our philosophy about how long providers would need advance notice to eliminate those changes? Sometimes we get significant changes that are going to be in place just a couple of months ahead of when they're announced, and that makes making those adjustments very, very challenging.

So again, thanks for a great chapter and for the opportunity to comment.
MS. KELLEY: Mike, we can't hear you.

DR. CHERNEW: I was saying we have Brian, and then after Brian we have Betty.

DR. DeBUSK: Thank you, and I'd like to echo the other comments. This is a great chapter and I'm really excited that we're addressing this topic.

I think the chapter touches on a pretty interesting tradeoff between trying to address the model fibrillation that's going on right now, because to me that's what it feels like, is sort of a fibrillation, without hamstringing CMMI so that it can still pursue its mission of innovation. So there is a tradeoff there, and it gets specifically to the policy options.

I like and support the fewer models idea. I'd like to propose an adjustment to that. I think when you say "fewer models" there's broad agreement that we need fewer models. But I think everyone who agrees is going to make the assumption that it's not their model that gets cut. And Amol, I'm going to pick on you. You know, I think if we said, "Gosh, we need fewer models, let's cut episodes," that probably wouldn't be the direction -- that isn't the cut that you're envisioning.
But what I would propose is maybe we consolidate,
and this is just illustrative because, Michael, I realize
this is a downstream cycle issue, but just illustratively,
let's say we agree, number one, that we're going to
standardize everything that we can standardize. So, for
example, the waivers. Why don't we go ahead and
standardize the waivers across all the models, and maybe
even do that in statute, so participants know that those
aren't going to vary from model to model?

But beyond that, what if we had, say, three --
and again, this is illustrative -- three categories, maybe
an episode category, an accountable care category, and some
type of primary care or chronic care category. And then we
focus on standardizing how those three compartments work,
so, for example, how the savings are split between the
models. And if you did that, I think you'd get some of the
feature, you'd see a lot less sprawl, you'd see a lot less
complexity, because if a new episode model was launched, I
would know it still has to adhere to the rules, when it
interacts with an ACO model, for example, with attribution
or shared savings or whatever facet you want.

So maybe we categorize models, standardize the
interaction between categories, and then just see what the
appropriate number of models in each category would be.
Because, for example, episodes might have quite a few
submodels within that broader category.

The second policy question, about doing a second
generation or a second launch of a model, I'm not sure that
that's something that we can even effectively work on,
because how do we differentiate a model that maybe
struggled and they want to relaunch it in a second phase
versus an all-new model? You know, let's say there was
something that would keep you from doing, say, CPC+ once
you've done CPC. Well, what's to keep them from launching
something that looks a whole lot like CPC or CPC+, just
calling it something differently?

So I was a little concerned about that second
policy option, because it almost seems like we could get
into hair-splitting over, well, what's the definition of a
new versus a relaunched model.

And then for the final policy option, this idea
of doing model changes. I saw this in BPCI. A lot of the
orthopedic physicians got really frustrated with
adjustments to the original BPCI program. And here's what
I would propose. Let's steal a page from the Medicare Part D midyear formulary change procedures. If I remember correctly, plans can make midyear changes to formularies that are beneficial, but they can't necessarily make changes that are detrimental.

So imagine if you're participating in an APM, if an adjustment needs to be made that is beneficial to the participants, let's create a very easy track to do that. But then if an adjustment had to be made that was detrimental, I don't think you allow those midyear -- I mean, if a model is just so fundamentally flawed and we missed it that it needs a dramatic midyear adjustment for financial solvency, my question would be just cancel the model and relaunch it.

But those are my three comments on the policy options, and again, thank you. I really enjoyed this chapter.

DR. CHERNEW: Brian, thank you. We're up to Betty.

DR. RAMBUR: Thank you so much. Thank you so much to the staff and the comments from the Commissioners I've heard so far. Of all the many important pieces of
work that MedPAC does, I personally think this is one of
the most important for the longest potential impact, and
I'm just going to limit my comments for now to the first
item.

I would definitely support smaller, coordinated, provided it's associated with unrelenting momentum towards
mandatory models with substantial risk sharing or full risk
bearing. I think that that -- I strongly support that. I
know there's a lot of work to figure out how that would
work, but I strongly believe until providers have to do it
many won't, and when they have to they will.

One of the things I liked a lot about the MIPS
piece -- and I wasn't there for the conversation of your
earlier decision -- is that one way or another, providers
were going to be taking on more accountability for costs
and outcomes. They either might do it consciously through
a qualified alternative payment model or over time through
the rewards of the penalty in MIPS. And so I think that
that clarity is so important, and obviously MIPS didn't
provide the clarity, but to have fewer and clearer and have
that momentum be really unrelenting towards real change
would be something I'd be very excited about.
Thank you.

DR. CHERNEW: Betty, thank you. Next we have David, who is going to be followed by Bruce.

DR. GRABOWSKI: Great. Thanks, Mike, and thanks to the staff for this great work. I'm also very supportive of the direction that this is going.

It seems like when it comes to testing these APMs, CMMI is taking an approach of trying to maximize the shots on goal with the hope that at least one goes in. That seems great if you're playing soccer, not so great if you're trying to reform payment.

You know, a large number of poorly coordinated programs is obviously creating issues with overlap, conflicting incentives, constructing comparison groups, agency and provider bandwidth, issues around fixed costs and probably lots of other things that are on Amol's checklist. I feel pretty strongly, to use Amol's word of "portfolio," that really a coordinated approach in which we consider the entire portfolio is really the way to go.

And just to make one other comment, beyond the construction of the portfolio, when do we make changes to the programs that are in that portfolio, I've been very
confused over the last several years about why we've made major changes to some of the programs, and I realize that the MSSP, for example, is now permanent, but I think some of the more recent changes to that model haven't been steps forward necessarily. And Mike mentioned a lot of the work that he and others -- I participated in some of that research as well. All of that, Mike, predated the changes, the pathways -- maybe there's been some more recent work, but I think this evolution of the model and why the program has taken the steps that it has isn't always clear. And so it's not just the sort of fewer models and more coordinated models, but also thinking about why we're making the changes that we are. And I don't think that we've been very deliberate in some instances, and I don't think we've made changes that have necessarily moved the program forward.

So I'll stop there and say thanks.

[Pause.]

DR. MATHEWS: Mike, we can't hear you.

DR. CHERNEW: Thank you. We have Bruce and then Jaewon.

MR. PYENSON: Thank you, and my compliments to
the staff for putting together some really valuable information. I have to say in listening to the discussion that I'm not sure that these three points are quite the options that we want, but I think the discussion is heading in a very useful direction. And what jumped out at me is the need for a clear set of strategic goals and the role MedPAC could play in helping that develop.

You know, I have to say that the quality of thinking that has come out of CMMI is much better than what you find from private payers. But part of that is because they have a billion dollars a year, so CMMI perhaps in the world of real-world health care could be seen as like one of the national institutes, like the National Institute of Health, funding a certain kind of research and a certain kind of development that the private sector wouldn't.

So it's kind of fascinating to see that emerge. The question is: Are we getting the value that we should or are we optimizing that? And there are a couple of things, I think the strategic goals is really important to optimize that. And part of that -- I've got a couple of thoughts on that. One is really the necessity for that kind of thinking to incorporate the non-Medicare population.
as well. But that somehow has to be part of the work they
do, and I think in so many ways, if the programs for
Medicare are going to be successful, they'll be successful
if they also are useful to the commercial world or the
Medicaid world.

I think another issue from a program evaluation
standpoint is that understanding the value to the providers
is critically important, and I don't just mean shared
savings. I have the view -- perhaps it's an informed
anecdotal view -- that many of the advanced alternate
payment mechanisms are of immense value to the providers
and that CMS doesn't get as much value as the providers do
because they're looking at it from a shared savings
perspective.

Now, that's anecdotal. I think there's enormous
value in some of the behaviors and the ability to expand
markets or -- which is -- sometimes the term used is
"coordinate care." So I think the value to the provider
and understanding that is something that the assessments by
CMMI have to get into. And I haven't seen a lot of that.
Some of that probably gets into issues like related party
transactions or transfer pricing or a strategy and market.
But I think that's properly some of the work that program evaluations need to do, especially if the thinking is to transform the system.

Finally, I think an important issue that I haven't seen a lot of work done on is scale and scalability. And by that, I don't mean whether a demonstration can be expanded nationally. What I mean is what size organization do you need in order to have the resources and the wherewithal to actually succeed? And in that, people talk about the capital investment and other kinds of investment, but I think probably bigger than any of those is the need for leadership and the ability to devote time and expertise, which is very hard in small organizations to do that, which is one reason why something like the Geo direct contracting entity might become much more successful than others because of the kinds of scale that Medicare Advantage plans, many Medicare Advantage plans have.

So just to wrap up, I really think the discussion that we've been having is really very good. I'm not sure it's that consistent with these three policy options, but I think putting them up there has created a really useful
discussion. So thank you.

DR. CHERNEW: Thank you, Bruce. I think now we're going to Jaewon and then Pat.

DR. MATHEWS: Hey, Mike, can I jump in on this point?

DR. CHERNEW: Yes.

DR. MATHEWS: So, Bruce, could you say a little bit more detail surrounding the first things that you raised? I think you said something like these are not necessarily the policy options that we want. And the reason I'm pressing on this point is when we last discussed these, you know, the set of issues at the October meeting, from my perspective at least, these were the three that had the most support among the Commissioners to pursue to the policy option and then potentially the recommendations stayed. So if we've missed the mark, you know, just say that, and I can take responsibility for that. But we did indeed try to characterize where the Commission was in October.

MR. PYENSON: Well, I don't think you mischaracterized where the Commission was in October, but I think these three points perhaps generated conversation. I
think Amol has offered, you know, perhaps six options or six points, so I would say -- compliment the process that these three points have created a terrific discussion. I am especially struck by the interest in a clear set of strategic goals and other roles that MedPAC can play. Does that clarify?

DR. CHERNEW: Yeah, so let me jump in. Bruce, that is helpful, but let me say, again, we will take this whole discussion and see where we're going, and I plan to summarize at the end. But given your comment, I'll say something quickly now. Where I'm hearing a consensus develop is, if you look at Option 1 in the blue there, it's not just about what the strategic goals are. And, frankly, I think the broader strategic goals of improving quality, access, equity, whatever you want to say is the actual goal, the key thing that I'm hearing is that we want to have a system of payment models that will help us achieve those as opposed to -- and I've said this before, and I think Amol said this, but I honestly can't remember given all that was said -- moving away from a test, test, test, test, test to try and accomplish a specific thing. I actually think at the end of the day the strategic goals
are not going to be that different from the overall strategic goals that we would have CMS or CMMI have, which is helping to control spending, helping to improve quality, helping to make sure access is okay.

I think Amol's point about equity is very well taken, but more broadly, getting them to develop strategic goals or CMS to have strategic goals is important. Where I hear a consensus working around is to develop -- and this is the key word. I said this, I think, the last meeting in October -- a portfolio of models to meet those goals as opposed to a paradigm of just test, relaunch, test again.

I don't want to have a big debate on that point right now. This is the policy option side. We will look over the whole transcript and come back with something when we come up with actual wording for a recommendation. But that's the connection that I hear, at least for the first one. Some of the other ones we'll also hear when we look back in the transcript at what other people have said.

But I would like to move on to Jaewon.

DR. RYU: Thanks, Mike, and like many others, I think this is a great discussion and great topic for us to be tackling. I also feel very passionately about the area,
and thank you for the chapter, Rachel and Geoff.

I think these policy options feel directionally like the right ones to me. I think just a couple reflections as I go through them.

I think number 3, it feels like that should have a little bit of a balance to it because I think it is important, especially to the extent there are models that are not as proven -- or not as established or mature, I should say, for there to be an ability to be somewhat nimble and agile and course-correct mid-flight, if you will. And I don't know if that looks kind of like what I think Brian was saying where maybe there's some caveats if a change can be beneficial, either to the participants, to the program, you know, maybe it limits the circumstances in which those changes can happen. But I do think that there's a balancing between setting it and then leaving it for a while versus the ability to have some capability to correct as you go.

I think on the first one, I firmly believe that the smaller, simplified and, I think, Mike, you may have used the term "harmonized" is exactly the way to go. I think it helps to focus attention. And if we were to say
that a lot of these alternative payment models are intended
to spark the right delivery system transformation and
initiatives, I think the fewer, the better; the more
focused, the better.

I also think, though, it gets back to our MA
discussion earlier, where ideally it would be nice to have
better line of sight into how providers are paid by health
plans in MA because if we're trying to harmonize programs
and harmonize them so that the right care transformation
can happen in a more focused way, I think that goes hand in
hand with how the MA world pays providers and what
providers have as far as incentives in that world.

So those are just the couple comments that I had.

DR. CHERNEW: Jaewon, thank you. We're now going
to go to Pat, and after Pat will be Dana.

MS. WANG: Thanks so much. I echo the comments
that have been made about the quality of the chapter and
also the discussion, which has been great.

Two sort of high-level points, I guess, or
statements about the topic. One is it's been referred to
in terms of other payers. If the goal here is delivery
system reform, at a minimum the number of payment reform
experiments that states submit through 1115 waivers that really are not kind of in sync with some of the things that CMMI have done -- maybe they are, maybe they aren't. It would be wonderful if -- and I realize fully that Medicaid is a completely different legislative structure with the states having so much more discretion on how they run the program, how they set payment rates, et cetera. But I think that one of the things that is missing from payment reform overall, whether it's an 1115 waiver, CMMI, and MSSP, is that there are not consistent signals to the delivery system.

So I was going to suggest that, you know, within this bucket of strategic goals, because I'm not sure what that means, that we should seriously consider that signals to the delivery system are consistent or thought through and intentional throughout whatever models CMMI in the future develops, and that the Medicaid side of CMS at a minimum have these in mind, also somehow to bring some perspective into some of the other demonstration projects that are happening, because, you know, everybody has a different experience with this, but if you're in a state and you're doing Medicaid commercial and Medicare, the
delivery system has so many administrative burden on the
delivery system, which is in all these things is
unbelievable. And, you know, if the quality metrics used
were the same, if the sort of end expectation about, for
example, being able to manage a global risk arrangement in
the following area were the same, I think it would go a
long way to sort of moving the needle for the entire
delivery system, not just Medicare. And Medicare, of
course, is kind of the gold standard when it comes to
payment, so it has an incredibly important role to play in
leadership here.

I really appreciate Amol's inclusion explicitly
of strategic goals around equity. I think, you know,
people could talk about it being sort of implicit in all of
-- in access and all the rest, but I think it's very worth
sort of calling out and evaluating different general models
around whether or not they advance health equity.

I think that in the -- so the first principle
here I think is very much a good one. I would include in
strategic goals, as I said, perhaps more specificity around
signals to the delivery system, which would include how
things are administered, quality metrics, risk adjustment,
if there's consistency, and one message to the delivery system, I think it will go a lot harder personally -- you know, I run a Medicare Advantage plan, I run a Medicaid plan. The quality metrics are more aligned between those two programs, but when it comes to the ACOs, you know, it's very burdensome because the providers are chasing a bazillion different quality metrics, and it would be wonderful if we could sort of align around the core set.

Some of the other principles, I guess, that I would suggest just off the top are in the strategic goals, you know, increased coordination of care, reduction of avoidable per value care, inclusion of resources outside of the medical delivery system. We have -- and I think it's related to the equity conversation, but not limited to the equity conversation. There are many other resources that affect people's health that are not explicitly in these models, and I just think it's something that perhaps could be considered going forward.

The access, the desire to increase access is critically important. I would love to see a little bit more specificity around how that actually gets measured. I think it's a critically important challenge for many
populations, appropriate access to care, and those are just a few off the top of my head.

One hopes that the second and the third principles here flow from the first, if it's done correctly, and Amol and others have pointed out the complexity of what coordinated models means. But just speaking of -- so I hope that those -- like once you have your base portfolio, that the second and the third buckets become less volatile in changing your program.

I personally on the third point of eliminating sort of mid-course corrections, it makes me a little nervous because I think that people should always be able to tweak if they see that something's not working. But hopefully if the first bucket is set correctly, there won't be as much need for it.

Thanks.

DR. CHERNEW: Pat, thank you very much, and I very much agree with your point that, hopefully, the second and third would flow from the first.

Dana Safran, and then we will have Paul Ginsburg.

DR. SAFRAN: Thanks, Mike.

And just piling on with my appreciation with
Rachel and Geoff for the excellent work here. This is so important.

I'd like to make three points, and then I'll comment on the policy options.

The first point I want to make is I think we undersell a little bit in our tone, if not in our substance, the real significant accomplishment that APMs represent. You look across your Table 1, and you see far more of the models than not did achieve gross savings. Only a few didn't achieve any savings.

When we contrast that with the conversations we've had over the past several meetings about the fact that Medicare Advantage now in its third decade, fourth decade still hasn't produced savings, I really think that we can't have that double standard.

In addition, in the years that Michael and I were working together on evaluating the Blue Cross Massachusetts Alternative Quality Contract, there was always controversy around gross savings and net savings, and absolutely, both are important. But one of the things that I think we rightly emphasized was when you see gross savings, you know that behavior is changing, and that is an absolutely
critical accomplishment. I don't think we have any other interventions we can point to that are producing behavior change in the delivery system leading to gross savings.

The net savings are a function of how smart the incentive models are, and that, we can adjust. But the gross savings tell us we're pointing in the right direction. So I want to make that point.

Second is that I think that the way that you summarized the literature so far is very impressive and helpful but still needs some enhancement, because all of us know that there's been a lot of thought about, written about, to some extent, studied on different features of models and what makes a model work or not work. And to some of the points that other Commissioners have made and that I think Amol tees us up with in his thinking about the future of CMMI, you really have to start to be able to synthesize the lessons learned.

So I'd really like to see what do we know across these models about two-sided versus one-sided risk, about physician-led versus hospital-led models, about global versus episode-based accountability, and also about single- versus multi-payer, right? So I think there's a lot that
we need to start synthesizing about those kind of characteristics. And also, that will actually help us with your question about what some of the barriers to change have been.

One of the barriers that I didn't see you mention and that I know I mention almost every time we talk about APMs, but I'll say it again, is that many organizations have very mixed incentives. In particular, we've seen more and more consolidation over this past decade. We have so much of payment reform happening in the context of hospital-led organizations, and hospitals for sure still continue to have incentives that are volume-based.

So at least in the experience that I had when I was leading this work at a large commercial plan, it was very clear that those organizations would do as much as they had to do to win in the model and achieve some savings but not enough to actually hurt their own revenue that they get from volume in the hospital side of the business.

Ultimately, we, MedPAC, and CMS have to address payment for hospitals and the mixed incentives there. I have pointed to that, I know, before, but I'll just continue to.
Then the third point is -- one thing I didn't see us address that I think is really critical is the importance of the next generation of quality measures, because we all understand that we're trying to get a more outcomes-oriented system. We've been saying for, going on a decade at this point, that we need that next generation of measures, but I don't see us making progress on that. And it will be very hard to justify continuing to do value-based payment if our measures of value continue to be largely focused on processes of care as opposed to outcomes.

On that point, I'll just make one small thing about global payment versus global budgets. CMS and LAN both really emphasize that fourth, whatever they call it, Stage 4, Level 4, whatever it is, where it's capitated payment, and I know there are many, especially our provider colleagues, who will say how liberating and how important that is. We can't lose sight of the fact that with that, we lose access to claims data unless we can successfully deal with dummy claims in ways that we haven't so successfully done yet in the MA system.

So those were my three points, and then I'll be
very quick on your three policy options. I would say
absolutely yes to number one. Like the other
Commissioners, I'm all in favor of more coordinated models
and in fact really loved Amol's articulation of offering a
strategic plan, and Michael's reference to that is
harmonizing. I'd say let's also harmonize with Medicare
Advantage. Pat started to point to that. We shouldn't
have just different ways that we do risk adjustment,
different ways we set benchmarks, different ways we measure
quality. We can harmonize some of those things, and we
should.

Second, I think it depends on your number two,
and so I'll just leave it there on that.

And then on the third, I'd say we should reduce.
I don't think we can eliminate changing model features once
they're in the field, and I kind of thought your Points 3B
and 3C on your slide were right based on my own experience.
And what I mean by that is we had five-year contracts, and
we made a commitment not to change things midstream once it
was in motion for a provider cohort unless there was
something we discovered that was really wrong with the
model. Honestly, the only things we changed were things
that were wrong that we could see were hurting provider success, and so I think those are where your 3B point about making tweaks once things in motion, but not planning to, not the way that quality benchmarks were at least in the early years designed to change every year because the way that they were set were based on last year's performance. That just makes such an impossible task for those who are trying to plan the resources for improvement.

And your point 3C, I think, is exactly right, that as you launch the next cohort, then you can, you know, change the model and continue to evolve it with lessons learned.

So I hope those are useful points. Thanks very much for the opportunity to comment on this important work.

DR. CHERNEW: Dana, thank you.

We're going to go to Paul Ginsburg, then Sue Thompson.

DR. PAUL GINSBURG: Okay. Thanks, Mike.

I think in this area, what we're seeing and what I'm very much in favor of is MedPAC shifting its focus from some very concrete details issues to strategies? Because as Amol said, I think there is a need to change the CMMI
approach away from just doing a lot of testing and coming up with better and better models towards seeing itself as having a strategy to get as much of the delivery system as possible into an environment where they'll perform better potentially as quickly as possible.

So when I look at the three policy options, I see number one as really a strategy, something I'm very enthusiastic about, but numbers two and three, with your tactics -- and I don't think it's worth as much of MedPAC's time to be focusing on them as on strategies. I really like the idea that AMOL suggested other strategic plan for not just CMMI but for CMS, for the entire effort.

And final comment is on equity. I'm intrigued with adding equity as one of the key goals. To me, it seems as though the legislation that authorized all the work on alternative payments was enacted today rather than saying years ago it would have included equity. It's an issue about how to operationalize that.

But, anyway, I think we've had a wonderful discussion today, and I think with the work in the papers, it really set us up to have some better impacts.

DR. CHERNEW: Paul, thank you.
So we're going to go to Sue Thompson and then Larry.

MS. THOMPSON: Thank you, Mike.

Yes. Thank you for this very good chapter.

There's been a lot of great conversation. I feel as though I have the battle scars of having worked with CMMI since its inception, having been a part of the Pioneer ACO and then Next Gen and continuing on to today, working to come to some conclusion about where do we go from here.

I know when we discussed this at our last meeting, I was quite enthusiastic about the suggestion of reducing the number of models and putting a lot more framework around it, and as I read the chapter, I'm going to maybe come up 40-, 50-, 60,000 feet, what's -- and as I listen to the conversation today, I am conflicted about the intention of the beginning of CMMI to be a warehouse of innovation and to come up with as many good, great ideas as possible about how to structure payment reform for our country and how excited we were.

And yeah, as an innovation center, they've done, I think, what they were asked to do. This was through two very different administrations. We have a lot of ideas.
Some, we like; some, we don't. Some, we've tested. Some, we've been very confused about. I've lived the war of trying to figure out is this beneficiary in that model or that model. Are we under some mandatory obligation to be in this bundle, and if we are, is that in the context of this ACO contract? And it is confusing, but that's the messy business of innovation when we're trying to innovate this payment structure in our country.

So as I listen to us attempt to put framework and constraint and definition and strategy construct around this innovation model, I just want to make sure that we are aware of the consequences.

If you do any reading about innovation, roughly, 6 percent of ideas that come out of any innovation group actually get to production -- 6 percent. In CMMI, according to my rough checking into, I think they have actually had 40 models, and of those 40 models, two of them -- two of them have made it into actual CMS Medicare. This is the real world we're going to go. That's 5 percent. So they're operating at about roughly what innovation centers do.

So as we think about these policies, I want to
make sure we're ready to move from innovation to mandate and be very thoughtful about that. I feel conflicted even saying these things out loud because I've lived the ugliness of the difficulty of having to fit and sort and wonder and be confused about where we're going to end up at the end of the year. It is a front-line battle scar that I feel I have on my chest.

So doing fewer models, we certainly need clarity about the overlap that happens. So I would fine-tune the fewer models to making very clear about where overlap exists in these beneficiaries and in which world are we operating.

There's certain criteria, I think, that follows nicely in the question of fewer models. I don't have a great deal more to say about the particular suggestion around certain criteria, but in terms of limiting change during implementation, when operating in these models, we desperately needed to be able to constantly run PBCA and modify and go back to CMMI with recommendations on what we were finding and what we were learning through modifications too. So I'm very cautious about supporting limiting change during implementation.
So those are my comments, and I thank you for the opportunity to make them here.

DR. CHERNEW: So let me jump in before we go to Larry. Sue, that was very helpful.

I will say it is important, I believe, to continue having CMMI be able to innovate. I appreciate what you said about overlap. My concern has been that in a world in which you want to let a thousand flowers bloom, you won't get any of them to work. Even if you find four that are great, they won't work if you plant them all in the same hole.

Another thing to say is you might like the steak, you might like the fish, you might like the pasta. Your meal won't be that good if you have to eat all of them at the same time. So I think that's sort of how I view the thinking about this bit of coordinating and where to go. That doesn't mean to stop innovation, but understand we don't live in a world where the success of Model A, even if it seemed to work well versus placebo, will work well if you introduce in a world with Models C, D, E, and F for a bunch of reasons. And I think we have to think through that, and that's kind of the spirit of where we have to go,
I believe, on Policy Option 1, and a lot of that will have to be in the text.

Relatedly, there's been a big discussion about whether things should be mandatory or not or if we move towards mandatory, and I think that's been a very good and useful discussion. I think it's a very important discussion to have.

I think we're not quite ready yet to talk about that. That will have to be a next-cycle issue for two reasons. One of them is I think we have to do a lot more assessment and analysis, but also we can't mandate something until we know what set of things we have so we can decide what to mandate. So I think it is a sort of second stage, not second order, but second stage thing that fits a long with all the other issues, how do we set benchmarks, how do we set quality measures, how do we set risk adjustment, how do we set attribution, a whole slew of other things.

So my hope is that at this cycle, we can get to sort of -- I will have to spend some time thinking about what strategic goals means or vision or harmonizing. There will be some semantics in the next thing you read, but the
point is once we get that big sort of, what I would call
"paradigm shift recommendation," broadly speaking, don't
test launch, test launch, but instead, think about where
you want the system to go. We will then have a series of
strategic, much more concrete discussions, I hope, in
future cycles.

I don't know if that was clear. I didn't mean to
get into such a big summary before getting to Larry, but
you triggered me.

So, Larry, I'm sorry that you're post my being
triggered, but, Larry, you're up. As far as I can tell,
you also get the quasi-last word.

DR. CASALINO: Thanks, Mike. I'll try to leave
some time.

Geoff and Rachel, a big chapter to write. A lot
It's very informative. But I agree very much with the
first option as a direction. The further two, I think,
give us, as Paul said, some tactical thoughts for further
discussion, if and when we want to go there.

I do just want to give a compliment to CMMI, and
frankly -- well, let me just put it this way. I think more
is happening than we think, if we just look at the evaluations. Provider behavior is changing, and Dana talked briefly about the evidence for that. But more broadly, at a higher level, I think that CMMI has been instrumental in what I would call organizing an atmosphere, and that is really important, even though it's kind of fuzzy.

What CMMI has done -- and it's not just CMMI, but I think CMMI has been probably the most important -- they've made it kind of a taken-for-granted thing in U.S. health care that change is coming, that people have to pay attention to costs and value, that population health defines narrowly as your population of patients is important, and you're going to have to get good at it. I think that's really widely recognized now, and that's a really important achievement.

Along with that there has been development of the infrastructure within the delivery system, and within the payer system, to some extent, to foster better results with population health. So there's a concept in institutional sociology called "taken for grantedness," and when something becomes taken for granted, yes, of course, we do
that, that sends a signal of major change even if we don't
have evaluation data yet to show it. So I think that is
important.

Also, CMMI has given a cover to commercial
insurers, and I think that, in some way, we should point
this out early on in our chapter, first of all because it's
true and important, and secondly because I honestly think
CMMI will be much more interested in what we have to say if
we say this.

CMMI leadership is really important. If you look
at individuals' incentives, which I think is always
important to do, you know, if you're a CMMI staffer, what's
your job? Your job is to create models, right, and then
your job is to make them better. And if you're not doing
that, what are you doing?

So it's not surprising -- I think there are other
reasons, but it's not surprising that is we had large
tests, large tests, large tests, and I think the only way
that will change in an organization that has a billion
dollars a year is if leadership is cognizant of this
problem and really believes that the first option that
we're offering is the way to go.
I think, as Paul said, this work that we're starting to engage in is a bit different from the work we usually do. At least our most important goal here, the first option we're talking about, is not recommending a payment update or some relatively narrow thing. It's much broader than that. I actually don't think we want to advocate putting constraints on CMMI. So even if we could come up with a good rule about thou shalt not launch a second-generation model unless -- I'm not sure that we actually want to do that, although it's worth talking about when one should be launched, and then we may want to have a role in that. So I would try to give them cover and ideas for their strategic direction as more than narrow constraints.

I just want to mention a couple of other things real quick. One thing that hasn't come up, but I think is important, early in the chapter when we talk about CMS's three goals for models, one of them is transparency for consumers. I think it's pretty easy to say that the models that we have out there now, by and large, don't have a lot of transparency for consumers. I understand the reasons for that, but that's something we might want to give a
little attention to, and really in thinking about strategic
directions even.

Yeah, one that didn't come up is the size of the incentives. They haven't been very large, and that can be
a reason for things not working very well. One or two
people have mentioned, and Dana, for sure, the problem with
when hospitals are involved it's always going to be pretty
hard to reduce utilization unless the hospital is part of
something that is fully capitated, if we want to call it
that way, to use that term, or fully budgeted or fully
paid. This is a huge issue and I think it gets mentioned
in a sentence in the text, but I think it should be called
out more explicitly.

And the last thing I'll say -- well, two last
things, very briefly. One is we haven't really talked
about how difficult it is, on the one hand, to limit the
number of models but on the other hand to include all kinds
of providers, you know, this specialty, that specialty that
wants to be included. I think that's a really important
issue. It's a hard one to solve, and I don't think we can
just talk about Option 1 without, in some way, coming up
with some ideas about that, if we can.
And the last thing I would say is that -- and this is kind of a completely separate point -- I think a lot of pressure should be put on CMS to make the data available so that outside evaluators can evaluate models and not just the ones they contract with. I realize there are some issues with that with PECOS and so on, but I think we would get better evaluations that way. And that's it.

DR. CHERNEW: Okay, Larry, that was terrific. I would wrap up, although I think I already wrapped up. So I'm just simply going to say to everybody thank you for all of your comments. There is a lot for us to chew on. We will be revisiting this with some text around a draft recommendation come March, and I think, at least in my mind, I have a direction to go which will prioritize building on some of these comments and becoming more specific around where we are on this Policy Option 1, and I think we'll review those discussions with the staff and see where we go on 2 and 3. There's obviously a lot of tradeoffs but I do hear a lot of support for the idea of putting a stake in the ground about where the paradigm of CMMI should go going forward, and for anybody listening, you should understand I'm a huge supporter of CMMI and what
they have done, and the progress that's been made. And the
question now is the most productive way to go forward, and
how we can be constructive in that.

    DR. CHERNEW: So with that I'm going to say thank
you, take a deep breath, and we're going to move on to
another incredibly important topic, where I know there's a
lot of passion, which is telehealth. Ariel, are you
kicking us off, and it's Ariel, and is Ledia here?

    MS. TABOR: Hi, this is Ledia. I'll be starting
off.

    DR. CHERNEW: Oh, Ledia is starting off, and then
we'll go to Ariel, perhaps. But okay. Ledia. Telehealth.
You're up.

    MS. TABOR: Great. Thank you. Good afternoon.

The audience can download a PDF version of these slides in
the Handouts section of the Control Panel on the right-hand
of the screen. We would like to thank Bhavya Sukhavasi,
Rachel Burton, and David Glass for their input into this
work.

    During the COVID-19 public health emergency, CMS
has temporarily expanded coverage of telehealth services,
giving providers broad flexibility to furnish telehealth
services to ensure that beneficiaries continue to have
access to care and reduce the risk of exposure to COVID-19.
The PHE has been extended several times and is currently
expected to end in April. Without legislative action, many
of the telehealth changes will expire at the end of the
PHE.

The Commission has been discussing this topic at
length since fall and have been developing a policy option
for telehealth expansions after the PHE. Most of these
topics we have discussed in the previous meetings, but some
reflect new materials based on the November discussion.
Today we are seeking confirmation that the policy option
reflects your discussion, for inclusion in the March 2021
report to the Congress.

We know from several sources that physicians and
other providers have responded to the PHE and the
telehealth expansions by rapidly adopting telehealth to
provide continued access to medical care for their
patients. Even before the COVID-19 pandemic, there was
growing interest in expanding Medicare telehealth coverage.
Advocates assert that telehealth can expand access to care
and reduce costs relative to in-person care. However,
others contend that telehealth services have the potential to increase use and spending under a fee-for-service payment system. Telehealth has recently been implicated in several large fraud cases related to the ordering of durable medical equipment and cancer genetic tests.

Current evidence on how telehealth services impact quality of care is limited and mixed. A key issue is how to achieve the benefits of telehealth while limiting the risks.

Based on your discussions, we present a policy for expanding Medicare’s coverage of telehealth services that would apply to all clinicians billing fee-for-service Medicare after the public health emergency. We would now like your confirmation that this policy option reflects your views to include it in a chapter in the upcoming March report.

Overall this policy option seeks to balance improving beneficiary choice and access with program integrity. We also assume that policymakers will continue to gather more information about telehealth services during the public health emergency.

During previous meetings, some Commissioners

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expressed interest in allowing additional flexibilities for alternative payment model participants. Under this policy option, we assume that CMS will continue to offer waivers for alternative payment model participants. For example, Next Generation ACOs currently have a waiver to offer telehealth services outside of an originating site and in urban areas and can waive Part B beneficiary cost-sharing.

I am now going to begin describing the potential permanent policy option for telehealth expansion. Prior to the PHE, Medicare paid for telehealth services provided to beneficiaries who lived in rural areas and who received the service at certain facilities, known as "originating sites." During the PHE, Medicare temporarily expanded payment for telehealth services provided to all Medicare beneficiaries, including telehealth visits to patients at their home. Under the potential policy option for your discussion today, the expansion would become permanent.

In our focus groups in the summer of 2020, clinicians and beneficiaries were generally supportive of maintaining expanded access to telehealth services with some combination of in-person visits. The Commission has
discussed potential benefits of using telehealth for follow-up visits with patients with chronic conditions. Since about 70 percent of beneficiaries have at least one chronic condition, this would mean covering telehealth services for the majority of beneficiaries.

Because this option would allow all fee-for-service beneficiaries to receive certain telehealth services from their homes, companies that offer direct-to-consumer telehealth services for urgent care and behavioral health, primarily to new patients in their homes, will be able to bill Medicare. Although these DTC services would potentially improve access, they also raise concerns about care fragmentation. In response to the Commissioners' discussion at the November meeting, we have added a text box to the paper that discusses this point in more detail.

Prior to the PHE, CMS allowed clinicians to bill for about 100 services provided by telehealth to beneficiaries in rural areas. CMS has temporarily added over 140 services to the list of telehealth services during the PHE. Under this policy option, after the PHE, CMS should revert back to the formal review process that it used before the PHE to decide whether to cover telehealth
services including the ones temporarily added during the
PHE.

CMS has established criteria and a process to
review whether a service should be payable as a telehealth,
which can include if there is clinical benefit. Because of
the rapid adoption of telehealth during the PHE, this is an
opportune time to better understand its effects, so CMS has
allowed some telehealth services to be billable for all of
2021 to gather more evidence of clinical benefit.

Consistent with our 2018 report to the Congress
that telehealth services should be added when they balance
the principles of cost, quality and access, CMS should be
given the authority to consider the impact on program
spending when determining whether to add a service.

According to CMS, there is a statutory
requirement that telehealth services payable by Medicare
must be furnished using an interactive telecommunications
system that includes two-way, audio/video communication
technology. Under authority during the PHE, CMS
temporarily allows audio-only interactions to meet the
requirements for some telehealth services based on the
agency's clinical assessment. For example, CMS pays for
most behavioral health services that are provided through audio-only interaction, but not audio-only physical therapy or eye exams.

Under this policy option, the Congress should give CMS the authority to continue covering some telehealth services when they are delivered through an audio-only interaction if they meet criteria established by CMS, which should include evidence of clinical benefit. This would improve beneficiary choice and access to care, particularly for beneficiaries who do not have access to technology for a telehealth visit. CMS can implement criteria and a review process similar to the review of allowable telehealth services which includes evidence of clinical benefit.

Prior to the PHE, Medicare only paid for telephone communication as part of a brief virtual check-in of five to ten minutes between a clinician and an established patient. During the PHE, CMS began temporarily paying for three audio-only E&M services. Under this policy option, Medicare should permanently cover audio-only E&M visits or virtual check-insurance, which are similar to audio-only E&M visits, for established patients.
During the November 2020 meeting, Commissioners supported the continued coverage of audio-only E&M visits with established patients to improve beneficiary choice and access to care. These services would not go through the CMS review process mentioned on the previous slide. Limiting these services to established patients would help ensure that beneficiaries receive care from clinicians that have access to previous medical history and diagnoses from a previous in-person or telehealth visit.

Consistent with the code descriptions, these services should not be covered if they originate from a related E&M service provided within the previous 7 days or leads to an E&M service within the next 24. This restriction would increase the likelihood that these services would be provided as substitutes for, instead of in addition to, in-person and telehealth visits.

I will now turn it over to Ariel to continue the discussion of the policy option.

MR. WINTER: Prior to the PHE, CMS paid for telehealth services under the physician fee schedule at the lower, facility-based, rate, in all cases. But during the PHE, Medicare pays either the facility rate or the higher,
in-office rate, depending on where the service would have been provided if it were furnished in person.

Under this policy option, Medicare would pay lower rates for telehealth services than for in-person services, after the PHE. The rationale is that services delivered via telehealth probably have lower practice costs than services provided in a physical office, because they require less space, equipment, supplies, and staff time. Therefore, continuing to set rates for telehealth services that are equal to rates for in-office services could distort prices, and could lead clinicians to favor telehealth over comparable in-person services.

In the short term, CMS should return to paying for telehealth using the fee schedule's facility rate. But in the long term, CMS should collect data from practices and other entities on the costs of providing telehealth services, and use this information to set payment rates.

In addition, under this option, Medicare would pay less for audio-only services than for telehealth services, because they don't require video technology.

During the PHE, the Office of Inspector General allows clinicians to reduce or waive beneficiary cost
sharing for telehealth services. Under this policy option, we would encourage OIG to discontinue this policy after the PHE.

Requiring beneficiaries to pay a portion of the cost of telehealth services could reduce the possibility of overuse. Because telehealth services are more convenient for patients to access, they have a higher risk of overuse than in-person services. This is particularly relevant in a fee-for-service payment system, because providers have a financial incentive to bill for more services.

At the last meeting, Larry raised a concern that requiring clinicians to collect cost-sharing for telehealth services with low payment rates could impose a burden on them. But we don't think this would be the case because clinicians currently collect cost-sharing for in-person services with low payment rates, such as electrocardiograms. In addition, clinicians don't need to bill beneficiaries with Medigap coverage for cost sharing. Medicare sends the claim information to the Medigap plan, which then pays the clinician directly.

After the PHE, CMS should establish additional safeguards to protect the program and beneficiaries from
unnecessary spending and potential fraud related to telehealth. On the next three slides, we describe four types of safeguards that would apply after the PHE.

At the November meeting, we talked about setting a flat limit on the use of telehealth services, either at the clinician or beneficiary level. But we decided that this policy would be problematic because it would probably impose a burden on clinicians, and confuse beneficiaries.

Therefore, we are suggesting a different approach here. CMS should apply additional scrutiny to outlier clinicians. Outlier clinicians could be those who bill for many more telehealth services per beneficiary than their peers, or those who bill for a very high number of telehealth services in a week or a month. This option does not assume that all outliers are providing unnecessary care. It only means that they would receive more scrutiny from CMS.

CMS could perform a targeted review of claims submitted by outlier clinicians to ensure that they are billing appropriately, for example, reviewing medical records to ensure that their claims meet billing rules. The second safeguard would require clinicians to
provide a face-to-face, in-person, visit with a
beneficiary, before they order high-cost DME items or lab
tests. As we discussed in November, telehealth companies
have recently been implicated in very large fraud cases
involving unnecessary DME, genetic tests, and pain
medication.

The third safeguard would prohibit incident-to
billing for telehealth services that are performed by any
clinician who can bill Medicare directly. This would
improve transparency and make it easier for CMS to prevent
overuse. Under incident-to billing, Medicare pays the full
fee schedule rate for services that are billed by
physicians, but actually performed by other clinicians or
non-physician staff, even if the person who performs the
service can bill Medicare directly.

For example, Part B drugs administered in a
physician's office by a nurse or therapy exercises provided
by physical therapists in a physician's office can be
billed by a physician as "incident to." Under this policy
option, any clinician who can bill Medicare directly would
have to bill under their own billing number when they
provide a telehealth service instead of allowing a
physician to bill for the services they perform.

In 2019, we recommended that the Congress eliminate "incident to" billing for services provided by advanced practice registered nurses and physician assistants. This policy would expand this recommendation by applying it to other clinicians who can bill Medicare directly -- such as physical and occupational therapists -- when they perform telehealth services. It would give CMS more information about the clinicians who provide telehealth and enable CMS to better monitor the use of telehealth to prevent overuse.

The fourth safeguard would require clinicians who bill for "incident to" services to provide direct supervision in person, instead of virtually.

Under the rules for "incident to" billing, the billing clinician must provide direct supervision for the service in most cases, which means that they must be present in the office suite and immediately available to furnish assistance and direction.

However, CMS temporarily allows clinicians to provide direct supervision virtually through real-time, audio and video technology, instead of in person. This
policy applies until the end of 2021 or the end of the year
in which the PHE ends, whichever comes later.

There is a concern that virtual supervision could
pose a safety risk to beneficiaries because the clinician
is not physically available in the office suite to provide
assistance.

Allowing virtual supervision could also enable a
clinician to "supervise" multiple individuals in multiple
locations at the same time, which could raise safety
concerns and lead to higher spending.

I want to note that there are two key differences
between the policy on this slide and the policy on the
prior slide.

First, the policy on the previous slide would
only apply to "incident to" services performed by
clinicians who can bill Medicare directly; whereas, the
policy on this slide would apply to "incident to" services
performed by any individual, whether or not they can bill
Medicare directly.

Second, the policy on the prior slide would only
apply to telehealth services, but the policy on this slide
would apply to supervision of both telehealth and in-person
For your discussion, we are looking for confirmation that this revised policy option reflects your views, and we are planning to include it in a chapter on telehealth in our March report.

This concludes our presentation, and I will turn things back over to Michael.

DR. CHERNEW: Thank you, Ledia and Ariel.

I think we will go -- Larry mentioned that he had a Round 1 question first, and then I have one from Bruce and Jonathan, so, Larry.

DR. CASALINO: Yeah, Ariel, nice work. Just one quick question. In the chapter and also when you presented just now, you mentioned high-cost DME and clinical lab tests. I just want to confirm. Do you mean high-cost DME and high-cost clinical lab tests, not all clinical lab tests? Is that correct?

MR. WINTER: That's right.

DR. CASALINO: Okay. You might clarify that because it stopped me each time in the chapter, and even when you said it today I was listening to the way you -- just the nuance of your voice, and it made me not sure
which you meant. So maybe just "high-cost" twice.

MR. WINTER: Sure. Thank you.

DR. CHERNEW: Great. Bruce and then Jonathan.

MR. PYENSON: Yeah, thank you. This is really terrific work, my compliments. Just a technical question on the very last bullet here. Clinicians who bill "incident to," I'm struggling to understand how -- what that would look like, like a case example of that in the context of a telehealth service. So there would be a clinician that can bill Medicare directly that would be doing the supervision, but who would be doing the interaction with the beneficiary on the phone? I'm struggling to understand how that would happen and why we would let that happen.

MR. WINTER: An example would be if a mental health counselor is providing a telehealth service to a beneficiary and that counselor was being supervised by a physician who is in a different location and is being supervised virtually through a two-way real-time communication system. But this might apply more frequently, more commonly when a service is being provided in person. For example, an RN is administering a Part B
drug to a beneficiary in a physician's office and is being supervised virtually by a physician who's in a different location.

MR. PYENSON: So could you give a case example of direct supervision of the sort you're proposing to require? What would that look like physically?

MR. WINTER: In the case of telehealth?

MR. PYENSON: Well, the patient -- the person in contact with the patient and the direct supervisor.

MR. WINTER: Sure. So in the case of an in-person service, going back to the one I gave earlier, an RN is administering a Part B drug to a beneficiary in a physician's office. The physician who is billing for that service under "incident to" is physically in the office suite and available to provide direction and assistance if necessary.

MR. PYENSON: Okay. Now, what would that look like if the patient were getting a telehealth service?

MR. WINTER: Right. So going back to the example I gave earlier, if a mental health counselor is providing a telehealth service to a beneficiary, then the physician who's billing for that service under "incident to" would be
in the same office suite as that mental health counselor.

MR. PYENSON: What would the supervision consist of?

MR. WINTER: It's hard for me to answer that, not having a clinical background, and CMS does not specify what supervision is required for each individual service. It just says that they have to be available to provide direction and assistance if necessary. So if a mental health counselor needed -- you know, had a question come up or needed assistance in some other way, I imagine that's what would be -- that's what supervision would involve in that circumstance.

MR. PYENSON: I'm wondering if any of the clinicians could give an example of how that might work in their system. I'm just struggling to understand why we -- how that would -- why we would even permit it or why anyone would want it.

DR. RAMBUR: I guess I could go on that. I can imagine a situation where I'm doing some sort of complex, you know, wound care piece or something, and I have questions or problems, and so if the physician is there, the physician can come and assist. So that's how I would
envision it. But I in general have been opposed to "incident to" billing because oftentimes it's a way of enhancing revenue, in my view, without the physician actually being there to provide the service. And I know many clinicians who have been required to bill that way, even though there's just no exposure of the physician to the patient.

MR. PYENSON: Betty, in that example, you would be dealing with a wound care patient by telehealth.

DR. RAMBUR: My understanding in this first example, as a nurse practitioner, if I can bill directly, I would not be able to do the "incident to" billing through telehealth because in a sense it's just an additional charge or additional delta. My understanding, if I'm reading this correctly, the difference in the second is that we're in the physical space where I really may need help for something that feels uncomfortable or something untoward that happens.

MR. PYENSON: So it would be -- and, Mike, feel free to cut me off because I'm getting in the weeds here.

DR. CHERNEW: I'm just about there, Bruce. We've got a lot of things we really have to get to.
MR. PYENSON: I'll cut myself off. Thank you.

DR. CHERNEW: All right. The irony about that is Brian wants to extend something that you were saying, so, Brian, please, quickly, because I have Jonathan next in the queue. But I know you wrote that you wanted to talk on this particular point.

DR. DeBUSK: Okay. Well, one quick aside. And the clinicians here, please, please, correct me if I'm wrong. But, Michael, I will be brief, to your ask.

For example, a patient goes into a clinic, sees a physician. They have a wound. The physician does an assessment. They do a dressing change. The physician decides that the patient needs to come back in two days, three days, for a dressing change.

Let's say on the next visit that physician, the original physician, isn't even in the building, so the patient comes back in, sees the nurse practitioner or a PA. Normally that would be billed at 85 percent of the fee schedule.

Now, if by just some coincidence there happens to be a physician in the building, maybe this physician has never met the patient; maybe this physician doesn't even
know the patient exists. That billing automatically escalates to 100 percent of the fee schedule simply by virtue of that person being physically present in the building. And the concern there with telehealth is watch what happens with telehealth. You could have a nurse practitioner or a PA in a building doing telehealth visits one right after another, and it just so happens that a physician happens to be physically present. Again, the physician has no knowledge that any of these patients exist. And you're automatically paying a 15 percent premium simply because that person's in the building. And I believe that's how it works unless I'm badly mistaken.

DR. CHERNEW: Okay. That was helpful. We are going to move on. Jonathan.

DR. JAFFERY: Yeah, thanks, Mike, and thanks, Ledia and Ariel. Great work. It took a huge amount of policy considerations and distilled them into something really digestible I think both for the chapter and the presentation.

My question is, when we're thinking about audio-only visits versus video visits, and, you know, we're still in a place where, of course, we've talked about the
technology is a big iffy for beneficiaries and Internet access is challenges in some places, and so I know a lot of places have a very well prescribed default mechanism; if the video technology fails, then it will default back to an audio-only.

So have you thought about what the implications of that might be in terms of a differential payment for an audio-only visit versus a video visit?

MS. TABOR: I think we did think about that and landed on that it still requires less technology to do an audio-only visit. But I would also ask the Commissioners as part of that to discuss whether audio should be paid less than telehealth because of the difference --

DR. JAFFERY: I may come back to that in Round 2, but just to finish that thought, thinking if the idea is that it costs less to make the investment in the infrastructure in the scenario just described, the investment on the provider's side had to be made up front, and it was -- regardless of what the visit ended up being, as opposed to a group of providers or telemedicine group at least only doing audio visits.

DR. CHERNEW: Okay. Ledia, Ariel, we're okay?
MS. TABOR: I look forward to the discussion about that issue.

DR. CHERNEW: Yeah, well, good. So we're going to go to Amol, and then we're going to kick off Round 2.

DR. NAVATHE: Thanks. In the paper, I think on page 10 and page 11, we noted A-APM flexibility around telehealth when there was a comment about whether it would be -- that flexibility would be designated at the clinician level or the provider level or whether it would be at the beneficiary level. And I noted that we don't have anything about A-APM flexibility in the recommendations here, so I just wanted to ask, was that deliberately set aside? Is that showing up somewhere else? Just so we don't lose that whole train of thought, because that's obviously important.

MR. WINTER: Sure, and Mike maybe would want to address this, too. So the feedback we got after our initial presentation in September was to focus more on flexibilities that would apply to all fee-for-service clinicians and kind of set aside, for now at least, whether there should be additional flexibilities for advanced APM clinicians. And as we thought about it more, it seems to us that because advanced APMs, at least those under CMMI --
CMMI already has authority to grant all kinds of waivers for telehealth. They've done that in the case of Next Generation ACOs, as you know, as we talk about in the text box, for example, allowing them to bill for telehealth provided to beneficiaries in any location, even in their home. And a similar authority exists for certain kinds of MSSP ACOs.

So because CMMI already has the authority, it seemed to us why should we -- does it make sense for us -- if we're already expanding fee-for-service pretty broadly, as we're proposing to do in some cases, does it make sense to -- and those expansion would also apply to advanced APM clinicians. So what additional flexibility should we be offering to advanced APMs that they wouldn't already have either through fee-for-service or through waivers under CMMI? So that's kind of why it ended up as a text box.

DR. CHERNEW: So can I jump in on that? The challenge was whether the flexibility was for the APM provider or for APM patients or for the APM patients when the service is provided by the APM provider. There's problems with all of those -- right? -- in various ways. If you make it for the APM provider for all patients, it
becomes problematic if they're just in one APM and they're treating a lot of patients that aren't part of it. If you make it for only APM patients, you really want that limited to the APM provider so they're not getting a lot of care done by, say, other direct-to-consumer type people, providers, for example, people that aren't part of their APM. And if you try and make it both, it becomes problematic because some of the APMS might have retrospective assignment, so you don't even know who the APM patient is until you're sort of after the fact.

All of that made it hard to get to sort of a policy option on APMS, and given that CMMI has the authority to do things where it makes sense and, in fact, they do use that authority, we've sort of been a little more silent on that point. But it's a much more complicated point than where we could get to.

That brings me to the last thing I want to say before we jump into Round 2. These are policy options, but they're slightly different than where we were in the previous discussion of APMS because the APM policy options we're going to try and mold into a draft recommendation and a recommendation for a vote. There will be a March chapter...
on telehealth, but we are not going to be taking these
policy options and voting on them in a future month. Our
goal is to get, for lack of a better word, a rough
consensus on where the Commission is to help the staff and
me when we engage with folks on the Hill or other
policymakers. But we're not going to have the same process
we often do going to a draft rec and then a vote. So that
means that the sort of comments here are going to be
important in shaping a general sense of where the
Commission is.

That is a little complex -- is at least enough
complex of a statement that I'm going to pause and see if
Jim wants to see if I've mischaracterized where we're going
or add anything to that to make sure we have the ground
rules right about what this discussion is about. Jim?

DR. MATHEWS: That is exactly right. Nothing to
add.

DR. CHERNEW: That's just the type of thing you
say to someone who's loosely your boss.

So, in any case, I hope that is all clear about
where we're going. And just so you know, everything I said
was just stuff Jim told me to say, so just to make sure you
understand who's really the power here.

Anyhow, so we have a few people in Round 2, and I'm going to begin to work through the queue. But we're going to start with Larry, and then we're going to go to Dana and Marge.

DR. CASALINO: Thanks, Mike.

So Ledia and Ariel did a great job, I think, in taking a big and controversial topic on responding to the Commissioners' comments from previous meeting and previous paper. I thought it was really good.

I actually agree with all the recommendations on the slide, except for the last sub-bullet, the second "incident to" sub-bullet. The first "incident-to" sub-bullet, I do agree with. The last one, I think, just needs more specification and discussion. Bruce was pushing on that, but I'm not going to comment on that.

I just want to comment on three things that actually are recommendations. I think it's fair to call them that. They're in the chapter and to some extent in the presentation today, even though they don't show up explicitly on the recommendation slide.

The one to make for me that's the most important
is the direct-to-consumer telehealth vendors. I know we
brought that up, I think, kind of toward the end last time,
and you guys did a nice text box on it. But I think they
needed more thought. They're a pretty big deal already,
and they are poised to become -- if the recommendations
here are followed, for example, and they are allowed to
deliver services to people at home, for example, which I
think they should be, they could really take over the
industry.

Now, I'm not going to talk about impact on
fragmentation. You mentioned a possible impact there. I'm
not going to talk about quality or what the implications of
the lack of having a history on the patient, the lack of
access to the patient's EHR from their provider
organization. I'm not going to talk about those things,
although they are important.

I want to talk about what they get paid. So at
the bottom of the text box, on the bottom of page 13, you
say the policy option contemplated in this paper would
allow providers to bill for telehealth services for new
patients plus allowing the direct-to-consumer telehealth
vendors to bill Medicare. And then here's the key
sentence: Payer rates for DTC telehealth providers would be the same as payment rates for other types of providers. And that's something that, you know, certainly, I'm open to being convinced differently, but as I see it now, I would be strongly opposed to that.

My concern is — and I'm leaving quality and fragmentation out. Just costs and structure the industry. Pure telehealth companies, companies that don't provide bricks-and-mortar care, they have much lower costs than clinicians who work in an organization that provides brick-and-mortar care, right? So if you're a Teladoc or another telehealth direct-to-consumer vendor, you don't have to have -- or you don't have to rent space to see patients. You don't have to have supplies. You don't have to have nursing. You don't have to have medical assistants. You don't have to have receptionists. Your costs are way, way lower to deliver the service you provide.

So if they're paid at the same rate as I am, say, if I'm at Weill Cornell delivering the telehealth service, they're basically going to drive a lot of brick-and-mortar providers, especially ones that provide a lot of primary care or cognitive care, out of business, because the cost
difference in delivering the service would be so huge, and
therefore, the profit for the telehealth company so much
greater.

And we talk often in the Commission about wanting
to get a sense of what the costs are for a provider and
then paying them a bit more than that, but we don't want to
pay them 15 percent more or 20 percent more or 25 percent
more. In fact, this morning, when it looked like we were,
in fact, doing that for certain kinds of providers, we
recommended actually pay cuts. So I don't know why we
would treat telehealth vendors differently from that and
pay them the same price for general brick-and-mortar
provider. We need brick-and-mortar providers, right? I
mean, some things have to be done in person.

So I'll just leave it at that, but I do think
this is really important and worthy of further discussion.
Again, I think it would take a lot for me to believe that
it would be a good idea to pay them both equally.

The second thing I wanted to comment on, I can
comment on very briefly, is the issue of audio-only versus
-- payment for audio-only versus video visits. Jonathan
discussed that briefly.
I can see reasons to pay a bit more for video visits. There may be a somewhat higher up-front cost and maybe even in an ongoing way somewhat higher cost for video visits, but if there's a big difference in the payments, I think this would discriminate against beneficiaries who are blind, for example. But more commonly, there's so many beneficiaries who for many kind of a multitude of reasons may have trouble doing video visits. We hate to discriminate against them by having a big differential between audio and video visits, and I'm sure other people will probably want to comment on that issue.

The third thing and last thing I'll mention is this virtual check-in issue. I actually have a -- well, I think I agree with endorsing virtual check-ins, although it's a little complicated distinguishing them from a regular E&M telehealth visit, I think. Let's just say there's a role for them. CMS has required that they be delivered to an established patient. That's fine, but as is in the slide, I think, and also in the chapter, they can't be delivered to someone who's had a related E&M service within the previous seven days. And they can't lead to an E&M service within the next 24 hours or sooner.
That to me reflects a profound misunderstanding of a very important way in which physicians take care of patients. If I see a patient for an acute care visit or even a chronic care visit for diabetes or hypertension or atrial fibrillation or whatever and I make a change in their medication, potentially a change that could lead to bad things or good things, I don't want to just say come and see me in a month. I'd want to call them a few days later, and if it's a chronic care visit, I want to see what happened because of the change I made. If it's an acute visit but something I was a little uneasy about, I want to call them, sometimes the next day, but certainly sooner than seven days and say, "Is the person getting better, or are they getting worse?" This could be a patient with COVID, for example, a little short of breath, but you don't think they have to come to the emergency room. But you want to see how they're doing 24 hours later.

So to me, to say you can't do that, that's exactly like the main purpose for a virtual check-in. To say you can't do that, we won't pay for it, we'll pay for things if they're not related to the service you've just given the patient in the previous seven days, to me, it's
like cutting the legs under out from one of the most important things physicians can do.

Now, good physicians do this anyway and haven't been paid for it over the years, but God knows if we're going to pay for other kind of virtual check-ins, to me, these would be first on the list to pay for.

I know this was CMS's idea, not yours, but I would strongly recommend that we -- I'll be interested to hear what other people have to say, but my feeling now is I strongly recommend that we actually go against that CMS rule as it stands now.

Just to finish up, then, you know, that phone call, that virtual visit is very likely to eliminate the need for another office or ED visit, or it may lead to a very appropriate office or ED visit that may not have happened otherwise. So I see the concern for overutilization, but I think you have to deal that through a cost-sharing and outlier perspective rather than not letting physicians do this, I think, very important service.

And that's it.

DR. CHERNEW: Okay. Larry, thank you.
I made a mistake in missing Wayne. So, Wayne,
you are now up.

DR. RILEY: Great. Well, let me just react to
Larry's scenario. As an internist, I can't tell you how
many times I recall calling a patient to check in, and
either they degraded a little bit and I said, "No. You got
to come back," or I tell them, "No. You got to go to the
evacuation room." So I have some concerns about the
delimiting of how you can use the virtual visit, telehealth
visit, whether it's virtual or telephonic. So I second
Larry's concern. As a physician, we do this all the time,
you know, the quick check-in. Good clinicians, good
nurses, good NPs, good PAs develop a sixth sense when their
patient doesn't look good, even over video or that they're
doing just fine. Right, Larry? So I'd worry about that
delimiting.

The other issue is the cost-sharing discussion.
I do have some concern about that and I believe we talked
about in November. Obviously, we don't want to encourage
fraud, waste, and abuse, and I thought we had mentioned
something about maybe limiting a number of telehealth
visits per beneficiary a year.
Ledia, Ariel, do you recall that? Did you guys chew on that issue a little bit?

MR. WINTER: Yeah. And we supported that idea, and there was a lot of concerns raised by Commissioners, which I mentioned, some of which I mentioned in my presentation that it would be kind of arbitrary to set up flat limits and would it apply -- it might pose a burden on both clinicians and beneficiaries, and it might be unfair. So we would place that with the notion of applying additional scrutiny to outlier clinicians. You're not saying everything you -- you're not setting an arbitrary cap. You're saying if you meet certain thresholds, we're going to apply additional scrutiny to you, but we're not going to deny your claims unless they're appropriate.

DR. RILEY: Okay. I missed that nuance. Thank you, then.

The last point is in terms of -- I'll have to defer to Brian on this. Again, a common thing that we do as internists, I may call a patient, a new diabetic, and they're worried about their blood sugar. I say, "Okay. I'll send you a prescription or call in a prescription for a home glucometer or ambulatory blood pressure..."
measurement." I don't think that kind of primary care-based equipment should necessarily trigger a revisit with me. So is there some consideration about the threshold of cost of DME equipment?

Brian, this is -- Brian is the expert on DME. So I'll defer to him if those two, sphygmomanometer and a glucometer meet the technological definition of DME. I don't recall.

Wheelchairs is another one, I know that once upon a time, I did order over the phone. So was there any discussion about that? And, Brian, you weigh in also, please.

DR. DeBUSK: Wayne, a great point on the primary care items.

You know, I really don't know that space like the glucometers and that space that well. So I'll have to be a little deferential on that.

On the bracing, it can really get out of control quickly. I mean, I would recommend at least for items that are discretionary, spine braces, knee braces, particularly functional knee braces, I really do support the measure of requiring some type of in-person visit. Again, it's just a
little bit out of my field to get into diabetes and blood sugar management.

Thank you.

DR. CHERNEW: Paul, did you want to make a comment just on this point? Because I put you at the end of the queue, and in doing so, that would make Dana Safran next.

DR. PAUL GINSBURG: Yeah. You can go to Dana.

I'm still formulating my thoughts.

DR. CHERNEW: Okay. Then, Dana, you're next, and you're going to be followed by Marge.

DR. SAFRAN: Great. Thanks. I'll be very brief. I really appreciate this work and how it's evolved over the last couple of months.

My only questions really have to do with the recommendations around payment rates and specifically the lower rate for audio, audio only. I had some concerns about that just because it seemed like it could drive disparities in access, you know, if providers feel like it's not worth it to bother with audio calls for the populations that are going to be disproportionately poor, but who don't have access to broadband for video. That was
a concern to me.

I wondered if instead we could make certain services, services where Medicare only pays if video is used and based on, then, clinical necessity for that service, where you have to be able to lay eyes on the patient.

Similarly, I do have some concerns. I know we have a lot of mixed feelings about what the payment rate for telehealth should be post public health emergency. I do worry about having it be lower than in person because I think we could expect a shift away from telehealth right at a time where it's really helping to drive some innovation that, I think patients probably appreciate greatly.

At the same time, I know we've worried -- and I've worried a lot -- about the inflationary effect of telehealth, if it sits there as yet another service for fee-for-service providers.

So I don't have a great answer to that. I just wanted to reflect my concern that we will kind of undercut this technology and the way it's evolving, its important role that's taking shape in the delivery system if we, post emergency, say you get paid less for it.
Finally, I really agree with Larry's point around really being careful around differentiating providers who are telehealth only. We really don't want to promote this discontinuities of care. So I think we really have to delineate those providers as different.

That will get really tricky really fast as to, you know, as soon as we make that differentiation. Then what do they do to be able to have a facility or do whatever the requirements are to meet the criteria to be an established provider? So I think that's a gnarly problem, but I think it's one we really have to take on because we know the importance of continuity, both for quality and for costs.

So thank you. That's all I have.

DR. CHERNEW: So before we jump to Mark, I want to say one thing because, Dana, you raised a lot of important issues.

The tension here which seems to come up repeatedly is we really do want to promote access, and we understand we want to promote access. We're very worried about things like disparities, and so we want to make sure that the entire population gets access to these type of
services. But in the same breath, we're worried that, for example, if we pay too much for something like audio-only, all of a sudden, not just the appropriate people will get the call after the service, but everybody will get the call. And they'll get a call two days after that. It's not what the right sense is.

One way to think through that as we go through this is to include some aspect of these changes being made temporary or understand that we're going to have to make changes. I realize there's some need to give organizations who have to invest in telehealth some direction, which way to go, but my personal view, I guess, is I see enough uncertainty about the potential for abuse and what's going to happen that we wanted to make sure we don't put something in permanent status without a full review.

So I don't know what people think about that. So I'll be quiet, and we'll go on with Marge. Marge?

MS. MARJORIE GINSBURG: Thank you, Mike. Your comments actually were a perfect lead-in to my comments. Some of you may remember I have been an outlier on this topic since it first came up, and nothing has changed in terms of my being a curmudgeon, if you will.
So our endorsement of the plan to embrace it with what I see as so few restrictions post the pandemic really concerns me, and I want to reflect back to page 37 of the report. And I want to refresh your memory by reading the short part.

If you recall, the Commission did look at telehealth back in 2018, before the pandemic, to see whether we should be covered or expanded. Let me just read this. This report did not make -- the report that we did -- did not make recommendations about specific telehealth services. Instead, the Commission recommended the policymakers should cautiously expand coverage of telehealth services by evaluating whether individual telehealth services balance the principles of cost, access, and quality. In cases where evidence exists that these services balance these principles, policymakers should consider adopting them more broadly under Medicare. However, when such evidence is lacking, policymakers should consider pilot testing these services before adoption.

I don't think what we've done with the pandemic can be considered pilot testing. So I think a lot of this is likely to go forward, on matter what we do, because the
gate has been opened, and I think it's going to be very hard to close it. But my recommendation is that we take out permanence and we make this a pilot test, and whether it takes one year or two years to decide whether we're getting the cost and the quality benefit that we expect, then they can talk about permanent later.

But, oh, my gosh. I see this just exploding into more fraud and abuse than we can even begin imagining. So thank you.

DR. JAFFERY: Mike, we can't hear you.

DR. CHERNEW: I was just looking at Larry and he wasn't reacting. I thought I pissed him off.

Larry, I think you wanted to make a point on this, a comment on this point, so jump in quickly.

Larry, now you're muted. You're passionate but you're muted.

DR. CASALINO: Passionate and eloquent, but muted. Okay. That's the story of my life.

The report comes down pretty hard in several places on CMS should use its usual review process. It even talks a little bit about what that would involve before making something permanent. But then if you really read
it, it kind of sounds like, I'm not sure if this is what
was meant, but that by the end of 2021 or by the end of the
pandemic we'd have enough evidence to make a decision about
making things permanent or temporary. And I agree with
Marge, who is shaking her head there. That's likely to be
true, I suspect, for almost nothing.

So I think that we should maybe be more along the
lines of recommending that things be done temporarily,
while CMS is gathering evidence and making a decision,
rather than say -- well, we don't really say, except we
kind of act like that can be done by the end of the
pandemic, and I don't think that's true. So that's an easy
change to make, I think, and it probably makes sense.

DR. CHERNEW: Okay. Larry, thank you. Next up
is Jonathan and then Bruce.

DR. JAFFERY: Thanks, Mike. So I'll be brief on
two points. The first one has to do with, again, the
differential between audio visits and video visits, and
Larry spoke to some of this, and Dana, quite eloquently. I
am just also going to voice my concerns about some of the
potential unintended consequences of having a payment
differential, and wonder, you know, over time, I don't know
if there are other options, you know, if we think about the difference in investment that is required that kind of prompted that idea, and if there's an opportunity to require providers to provide both, and then there's sort of something analogous to a site-neutral payment approach that might get adjusted over time.

Maybe related to this, and particularly this conversation about testing things and them not being permanent, and going back to a point that Amol made about advanced APMs, I understand -- or APMs, in general -- I understand how, you guys explained well, how we got to this point in this discussion. But I do think we have this threat of APMs being -- sort of this being a carrot for APMs, to go into an APM, and have the opportunity to use this technology. At the same time, particularly if there is an APM with downside risk, that helps mitigate some of our concerns about overutilization of these activities in a fee-for-service model.

So I am concerned that we completely lose the thread of the opportunity for telehealth within APMs, and recognize that maybe there are some other flexibilities or reasons why those haven't been taken up very much, because
I think the report mentions that only four Next Gens took advantage of the opportunity to use the telehealth waiver. So I just want to put that out there, that I would hate to lose that, and again, it may tie back to some of these concerns about opening up Pandora's box. Thank you.

DR. CHERNEW: Thank you, and just to emphasize, we're about to move on to Bruce, but, of course, APMs or any provider can do whatever they want. This is just what they get paid for, in a very particular way. And the challenge for some APMs, as I mentioned before, is operationally it's very tricky. If you're a physician-only MSSP, even if you're taking downside risk, and a patient of yours gets a surgery, does the surgeon who might not be in your ACO get to do whatever telehealth they want, that then you're on the hook for, for example. So it's very tricky when you have a fragmented system, who gets to apply what to which patients, particularly when the assignment might be retrospective.

But nevertheless, I do want to move through now, so let's go to Bruce, and then we're going to have Jon Perlin and Paul Ginsburg. We hope we will have some time to come back and continue that part of the discussion.
MR. PYENSON: I want to echo others in thanking Ariel and Ledia for just wonderful work here, and I agree with Marge and others that anything that we do has to have a time limit of perhaps two years, because the telehealth services are moving just so fast with IT companies, and in areas that we're not even discussing here. On one hand it's very exciting, but on the other hand there's enormous potential for taking away resources from things that we really need.

I would raise the question of whether some of what we're considering telehealth perhaps shouldn't even be considered physician services, and try to put some definition around that. What is a physician service and what is something else, even if it might be delivered by a physician or a robot or hard to tell?

Other challenges that come up with the IT approach are how to do the regional adjustments. IT companies are likely to base their physicians based on optimizing net revenue, financial gain. That might mean low-cost, low-wage areas. It might mean high-wage areas, and that might move around, depending on how wage indexes
change. So there's a whole series of issues around that, that, in my mind, mean that the current framework and infrastructure we have for physician services don't even work very well.

Looking ahead to where the technology might be going, I could envision a set of services that may be covered under a Medicare Part E, that are put out to bid for companies, that any beneficiary can call up and get a certain set of services, and maybe that's on a bid basis on a capitated basis. So that could be where we end up in a few years that would solve some of these other problems.

But I don't think we're going to decide that now, so I think putting a short time limit on extension of the telehealth would really be important. Thank you.

DR. CHERNEW: Bruce, thank you. We're going to go Jon Perlin, then Paul Ginsburg.

DR. PERLIN: Yeah. Thanks to the staff for a really thoughtful chapter, and also deeply thoughtful discussion.

I want to really make three comments, one of which was triggered by Bruce's comment. But let me start somewhere else, this notion of trying to delineate what is
a direct-to-consumer telehealth entity. Dana described that as a really gnarly problem, at best as a really gnarly problem. At worst, it's beyond that.

We've already received overtures about things that you'd think are offering direct-to-consumer being the infrastructure or the intel inside of practices or health systems, et cetera. And so it's not only not projectable that there will be circumventions if there are a set of rules that try to determine outside-inside, but that's already part of the infrastructure today. So it's kind of akin to a staffing company. So I think that's going to be extraordinarily problematic to determine utilization on the basis of this sort of corporate structure of the entity and its relationship to a practice, because the nature of practices is changing.

Which gets to the second point. I think -- and this is in response to Bruce -- I appreciate where you're going with that. However, I would also project that if you actually pulled that away from a linkage to licensing practitioners, providers with authority, et cetera, then the ultimate extension of that is that it becomes offshore and becomes something that's even more commoditized. Now
if that's what we want, that's fine, but what we're really
talking about, I believe, are ways to both increase the
quality and access to care as well as ultimately reduce the
cost. So that leads to the third point, that we really do
have to figure out what's waste and what's value.

And, you know, when I think about this, we are
accumulating a lot of data with respect to the pandemic,
but to Marge's point, it's not organized, it wasn't
structured in terms of trials or determination of value,
and where that comes up in other places, you know, CMS
embraces coverage with evidence determination. Again, I
think it would be retrogressive to say, okay, let's take
all the stuff done and throw it out. I wonder if there
really isn't an opportunity to recommend a technical
advisory panel that looks at the 160 or so additionally
approved telehealth interactions and determines which ones
actually are offering the greater utility and the others
that, in fact, need that greater evidence determination.

Because these technologies are such a part of the
environment of commerce and personal interaction at this
point that I fear that it would be not only anachronistic
not to accept the reality that they're part of that
environment, but counterproductive to the broader notions.

I think we can find controls. Last time we had some discussion about it, the linkage of number of virtual visits to in-person visits, some sorts of ratios there, may be the sorts of checks that supersede whether that entity is a staffing solution that's embedded or whether it's the primary care provider themselves who is offering the service.

Thanks so much.

DR. CHERNEW: Jon, thank you. Paul?

DR. PAUL GINSBURG: Yeah. Two things. First, I'm really glad that Marge brought up the point that we're not ready for permanent telehealth policy once the public health emergency ends. And I would think that the next stage should be a, say, two-year pilot, which reflects all of the policies we're talking about today, and it only continues for two years unless it's extended, and would be advised at that point.

I've also been thinking a lot about Larry's point about obviously Teladoc companies do have lower costs than a bricks-and-mortar practice that does a proportion of his time on video visits or audio and the rest on in-person
visits. And I think if we see -- I don't particularly see
value in continuing the brick-and-mortar practice of
continuity of care fragmentation, you know, where the same
physicians would be seeing the patient in person as opposed
to on a video call.

So I think there are ways of making the
distinction, particularly using the Medicare claims data,
that volume of in-person visits that go on. So I think
normally the economist would say pay everything at marginal
cost, but if you have an entity that's not going to be
competitive with 100 percent televisit company, you've got
to do something to allow them to continue, which would be
at higher rates, or if you think the rate may be high
enough already, a lower rate for the Teladoc company.

DR. CHERNEW: Great. Okay, Paul. So now we have
Karen and then Pat.

DR. DeSALVO: Thanks. I just wanted to start by
saying how much I appreciate the work that the staff is
doing on this seemingly simple but very complicated topic,
to thread the needle of improving access, drive equity, but
also prevent fraud and abuse, and just complete disruption
of continuity of care. So I just want to say thank you. I
think the iterations make a lot of sense, especially some of the things that relate to trying to prevent the fraud and abuse side.

But I just have a general comment to say, which is I think what we saw in the last year is that given the option there's a lot of pull for leveraging technology and virtual services, digital services. That's going to be a continued push for health systems in the existing framework to have a digital front door, but for consumers to want to look for other pathways that don't require them to take off work or school or find a sitter or someone for their parent and take transportation to go park and then go to the doctor's office at the doctor's convenience.

And so I think we got a little taste of the pull, is what I want to say, and this is, I think, the beginning of what could be a super complex journey if we try to build all of that payment for technology on the fee-for-service chassis. And I know we can't shift overnight and we need to solve for this, so I think we're on a good pathway for it. But it's going to happen sooner than we know, that the digital signals world or the internet of things, you know, the ways that we're tracking and monitoring people with
their consent in their home environments, and just the wave of ambient computing incenting that's on the horizon will make it quite difficult to figure out what's the fee schedule and how to mitigate against it.

I think there's this other pathway the Commission has been on about thinking about global budgeting and sort of packing all that into what is the way that we hold systems or providers accountable for the total cost of care and outcomes for individuals will become increasingly important as more of these technologies come on the market, because they're just going to add cost and be confusing. And this is the beginning of what I think will be a pretty busy journey for the next few years.

So that's just my caution for all of us as we're setting a foundation here. This is the backbone that a lot of that stuff will get built on.

DR. CHERNEW: Karen, thank you. And I agree with you. I think the challenge here is some of these services provide really tremendous value, particularly to certain populations, and we need to find a way to provide access. But if we're not careful we will be in some huge cat-and-mouse game, where we'll open the door to all of the good
things that we really, really want, and what will flood
through will be a bunch of things that we don't want and
don't want to pay for, and we're really struggling with how
to create the boundaries. Payment, of course, is only one
way. There's a bunch of other things, if you look at some
of the fraud cases, on ordering things. Those things may
have happened without even paying for the telehealth visit,
because the business model involved services that went back
to the telehealth amount.

So I guess part of the complexity here is why
we're not going to specific recommendations, and for those
of you that feel like we have a lot more of this mountain
to climb, that's absolutely true. And so I expect you'll
see more of this continuing in future cycles as well. It
is intellectually, I think, a real challenge. So I
appreciate your comments.

Let's go to Pat.

MS. WANG: Thanks very much. I also echo the
appreciate for the work and really for the discussion. I
think my sentiments are very much the same as what's been
articulated by a lot of the Commissioners.

I am torn between excitement at innovation,
technology. We all crossed the digital divide in the last year. My personal opinion is it won't be the same again. I don't know what it's going to be like, but it's not going to be the same. And so the potential for a completely different health care experience is tremendously exciting.

On the other hand, my fear is that this candidly just becomes like urgent care again, where you have duplicative, fragmented services that folks are paying for in addition to, not instead of. So I appreciate all of the sort of safeguards that folks have tried to build in, but that's the fear.

So I guess, at a minimum, in the chapter as it's written, I think it would be great to articulate the sentiment that I think has been expressed by the other Commissioners, that this is kind of what we see. This is the immediate question in front of folks. What should we extend? What should we pay for, but that we do anticipate that this is going to be -- this is a completely new modality in health care? I mean, will there be folks who decide to get their health care entirely in a virtual world?

What are the implications of that? So it's just
sort of -- I think it would be good to frame that we think it's quite important to examine. I mean, payment policy is almost the last thing. It's like what is the role of telehealth in the Medicare system, and then how do we pay for it?

I think that some of the considerations there include, I mean, what commissioners traditionally talk about. How do we encourage care coordination by PCP, or we should do a care coordination fee? There was that temporary thing that got put in place by the ACA. What happens to something like that? I think that telehealth companies are moving from what used to be kind of like a really convenient, kind of urgent care model of calling somebody, "Oh, I've got a rash. I'm home. I don't know what to do," to kind of provide primary care. We'll arrange for lots of things. We'll take care of your chronic condition. It's kind of moving to a different world, and as I said, that might be a really good thing if that's what beneficiaries want or produces quality, but it then gets -- another thing to think through is, so how does that connect back into the ability to manage the total care of a person? Are telehealth companies going to be subject
to interoperability rules? Is there an obligation to plug
back into the information highway so that someone's
information, if they get hospitalized in emergency, that
the information that comes up is not just what happened at
a traditional health care provider but also what happened
within telehealth? I think those things need to be thought
through a little bit.

I worry that -- at the same time of feeling like
this might be a great thing for beneficiaries, I really
worry about disturbing the primary care physician
relationship. I feel like these are services that people
will avail themselves of without understanding that their
PCP actually has no idea who they're talking to and the
advice that they've given because there is no feedback
loop. It's like urgent care. You walk in. You get what
you need, and your PCP never knows you went there. How
much more is that going to happen when it's so convenient
when people are pushing to sign up for this and you can
call this telehealth doctor anytime you have a problem?

I don't know what the answer is. I think it
would be good to be very conscious of this is the first
step, and I think the whole world of how digital health,
telehealth fits into the future of the Medicare health care system, it's going to be things are going to change.

Thanks.

DR. CHERNEW:  Great. So, Pat, I think you may have had the last comment in Round 2. Others may be on the sidelines. So I'm going to pause to see if anyone comes off the sidelines.

DR. CASALINO: Mike?

DR. CHERNEW: Okay.

DR. CASALINO: I know I'm talking a lot this session, but if I could just build a little bit on what Pat said, since we have a little time yet? I'll just --

DR. CHERNEW: I'm hoping you would, Larry.

DR. CASALINO: Thank you.

DR. CHERNEW: We have some time, and that's why I paused. Go on.

DR. CASALINO: Thank you.

Now, Pat's comments were great, I thought. I think this is tricky. I don't think we want to -- I think a lot of us have concerns about fragmentation and about the quality of care that would be delivered by telehealth, but I don't think we want to prejudge that or tell somebody who
feels that the convenience is so high that they want to use that service. So I think it would be worthwhile to talk about the issues maybe a little more than we do with quality fragmentation and say we need more data on that, because obviously Medicare doesn't want to pay for things that have no value. But I don't think it's going to be the case. I think the quality somewhere probably might be okay.

But my concern is -- and I do think that there are companies, if they're paid at the same rate as bricks-and-mortar providers, they will move into primary care. They will move into chronic disease. They'll take over a lot of it, and that may or may not be okay from a quality point of view. But it will kill bricks-and-mortar providers, and when someone actually needs to see someone in person because they need their knee drained or they need an ambulatory procedure or whatever, there aren't going to be any around. So that's a concern.

Now, if the market makes that happen, that's the way it is. It wouldn't be very good, in my opinion, but that's the way it is. But if Medicare makes it happen by paying one provider way, way above their costs, their
marginal costs, than another provider, then I think that's
a problem. I'll just leave it at that.

All day long, we talk about we don't want to pay
hospices or ASCs or whoever way, way above the cost them to
provide service. Why would we want to pay telehealth
companies way above what it takes to provide a service? So
that's what we'll do if we pay them at the same rate as we
would pay a bricks-and-mortar company for telehealth.

Jonathan raises a good problem that the
complexity of separating bricks-and-mortar from telehealth
companies is relatively easy now, but it could get harder.
But I think that's a problem that can be dealt with, and I
think it's going to have to be dealt with or we're going to
have problems, in my opinion.

DR. CHERNEW: I'm waiting for reactions.

DR. RAMBUR: If there's time --

DR. CHERNEW: So I agree with --

DR. RAMBUR: Go ahead.

DR. CHERNEW: Someone said something. I didn't
hear.

DR. RAMBUR: Go ahead. I was just going to say
if there's time, I'll comment, but go ahead, Michael.
DR. CHERNEW: There is time. Comment.

DR. RAMBUR: So I really appreciate this very rich discussion, and just a few comments from my perspective. There was a really interesting article written by a primary care provider about mourning the lack of or the reduction in face-to-face visits, and all of us, I think, who are clinicians have in that model.

But I'm not so convinced that people will miss it so much, and if you think about the enormous disruption for people to do certain kinds of things -- taking off work, taking elders, something I've just been through, a lot of complexity -- and there's so many, I think, very exciting things happenings that we should be learning, natural language processing, more remote monitoring. So I really like the idea of a two-year or some period of trial, because I think there's going to be an explosion in things that I personally can't even begin to think about.

And Bruce said something about physician or robust or whatever, but there's also very simple things like registered nurses, not nurse practitioners, not physicians, not PAs, giving virtual support for families who are doing chronic condition management. Unless there's
a certain global budget, those kinds of things are easily reimbursed. So I think there's really a lot of opportunities.

So I continue to feel that the audio-only has value because of the number of people who are sort of out of the picture without it. I'm very, very concerned about the dialing for dollars and the potential for fraud, so the enormous amount of scrutiny, that that needs to happen.

So that's my thoughts for now. Thanks.

DR. CHERNEW: Thank you, Betty.

Let me just try and summarize as we're coming towards the end here. This is going to sound a little hypocritical. We're really supportive of telehealth broadly, and we very much understand that these technologies are coming. And in many ways, they're the way of the future and offer great value. With great value comes great potential for abuse, and we're struggling with how to deal with that in equilibrium.

We have a few things in the safeguard portion there. I think there's some broad things we may be able to say going forward. One of them, as several people have mentioned, is we could keep this temporary as evidence
develops. We can experiment with different safeguards in a whole variety of ways. I think there's a bigger issue about how to separate out types of providers. That's much more difficult. There's some operational issues about how to build into APM.

There's always a case just to emphasize that this whole discussion is, in many ways, what we pay for, not what we permit. So organizations like in Medicare Advantage plans and whole bunch of things can do this without having to address these things because they -- ACOs could do this without having to worry about what we're paying.

So I think what's going to happen, just to give you some idea going forward, is we're going to take this discussion and try to continue to strike at its balance in the chapter going forward, so we can provide some set of advice about how to expand, which I think I would say broadly we think is important, and then some set of advice about how not to expand too much or how to keep the bad away from the good. I'm sure there's a clever analogy that I would have been better at coming up with earlier in the day, but I think just so you understand, that's, I think,
what we're going to do.

I want to give the last word actually to Ledia or Ariel, if you have any reactions to any of this. It's been a far-reaching conversation, and you're the two most important people here.

MR. WINTER: Well, thank you for the feedback.

We'll go back and see what we can do.

Ledia, go ahead.

MS. TABOR: I was going to the same things, for a rich discussion.

DR. CHERNEW: So we got the thumbs-up from Jim, a whole bunch of thanks. We've all had a wonderful day. I will say to the staff for all of the topics, but certainly this one and the others, you guys put a ton of work in. This is a really, really, really difficult nut to crack, and I'll add my appreciation for all the work you've done and all the information you've provided.

I'd like to thank the Commissioners for navigating this sort of really good but kind of worrisome kind of topic.

So we will go from there. Stay tuned, and again, thank you.
In absence of any other comments, we are at the end of our day. We'll be starting tomorrow at 9:30. I think we're going to kick things off. Other than that, I'll pause for a second to see if anyone wants to say anything else. I will thank the people here and very much thank the audience.

I want to add one other point while people ponder if they want to say anything else. To the audience, we very much want to hear your feedback. There's many ways to provide feedback. Reach out to the staff. Send messages. There's a website where you can contact us. So in a normal public meeting, we would have time for folks to talk here. Please do reach out and give us feedback. You should know that at the beginning of every meeting, we get some summary of what the feedback was, and we do take it quite seriously.

So, again, thank you to the public for joining us. Thank you for the Commissioners' comments, and thank you to the staff for all of their work.

Jim, anything else?

DR. MATHEWS: No. All good.

DR. CHERNEW: All right. Thank you, everybody.
We'll see you tomorrow morning.

[Whereupon, at 4:45 p.m., the meeting recessed, to reconvene at 9:30 a.m., Friday, January 15, 2021.]
MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Virtual Meeting
Via
GoToWebinar

Friday, January 15, 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
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
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SUSAN THOMPSON, MS, BSN
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PROCEEDINGS

[9:31 a.m.]

DR. CHERNEW: Welcome, everybody. This is the Friday morning meeting of MedPAC. We had a very productive and I thought very interesting day yesterday. I think we have three great sessions today. We're going to kick it off with a status report on Part D, and so I think I'm turning it to Rachel, who's going to be first. Rachel, you are up.

DR. SCHMIDT: Okay. Thanks. Good morning.

Today Shinobu and I will present a status report on Part D, Medicare's outpatient drug benefit. This material will be a chapter in the Commission's upcoming March report. We would like to thank Eric Rollins for his contributions to this work. As a reminder to the audience, a PDF of the slides for this session is available at the right-hand side of your screen.

Part D is complex, so we're going to spend part of our time providing a high-level overview of the program's approach and the role of manufacturer rebates. We'll describe the effects of COVID-19 on Part D, then provide a snapshot of the program and key trends. We'll
look at growth in drug prices and in the number of enrollees with catastrophic spending. Finally, we'll review the Commission's recommendations from last year and open things up for your questions and discussion.

Prescription drugs are a critically important part of patient care, and policymakers created Part D to expand beneficiaries' access to drug coverage. Part D uses a market-based approach: private plans compete for enrollees based on the drugs they cover, premiums, cost sharing, and pharmacy networks. The program was intended to have plan sponsors bear risk for enrollee spending so sponsors would have financial incentive to manage benefits. Sponsors use the same management tools in Medicare as they use for commercial clients, including formularies with tiered cost sharing. However, CMS must approve Part D formularies, and CMS requires certain beneficiary protections. For enrollees with low income and assets, Medicare subsidizes most cost sharing and premiums. Separately, Medicare subsidizes about 75 percent of premiums for basic benefits for nearly all enrollees. Part D has other features that encourage broad participation of plans and enrollees.
Some of the reasons for Part D's complexity are that there are thousands of drug products and multiple actors with key roles in providing drug benefits. Drug manufacturers develop, produce, and market medicines. Plan sponsors provide some insurance protection, enroll beneficiaries, and administer benefits with the services of a pharmacy benefits manager. The PBM operates the plan's formulary, negotiates with manufacturers and pharmacies, and adjudicates pharmacy claims. Pharmacies take physical possession of inventories of drugs and dispense them to beneficiaries, so plan sponsors and PBMs develop pharmacy networks. When a beneficiary picks up her prescription, the PBM pays the pharmacy an agreed upon amount. For some brand-name drugs, the PBM later receives a rebate from the manufacturer.

Private plan sponsors must be licensed to bear insurance risk for their enrollees' spending. Most large sponsors are vertically integrated and own their PBM, but smaller sponsors contract for PBM services. Plan sponsors and their PBMs take part in a couple of sets of negotiations. One is with pharmacies, to set up networks and agree on payment rates for prescriptions and post-sale
fees. The other negotiation is with manufacturers of brand-name drugs over formulary placement and rebates. Under Part D law, the Secretary is prohibited from interfering in these negotiations, from requiring plans to use a specific formulary, or from setting up a specific price structure.

To focus on rebates for a moment, again, these are payments from brand manufacturers to plans and PBMs after the beneficiary has filled her prescription. They aren't paid for every drug. It's generally when there are competing drugs in a class and when plans can exclude some drugs from their formularies. Manufacturers use rebates to price discriminate -- to charge higher prices to some plans over others. Plans that can help the manufacturer achieve a larger share of the market over competing drugs pay a lower net price. In Part D, plans generally use rebates to keep their premiums lower than they otherwise would be. This benefits the plans' enrollees and, because Medicare subsidizes the premium, the Medicare program.

Rebate amounts are proprietary. Plans and manufacturers don't want competitors to know what rebates they've negotiated because it would affect the deals.
they've struck. So this system allows some plans to get steeper discounts than others, but it also means that prices are not transparent. Over time, rebates have grown faster than prices at the pharmacy, and there's been an expanding gap between pharmacy prices and net-of-rebate prices. When plans design their cost sharing as coinsurance, it is based on a percentage of the higher pharmacy price. As a result, beneficiaries can end up paying a higher share of their prescription costs. This is one reason behind calls to reform rebates. In November 2020, the Department of Health and Human Services Office of Inspector General finalized a rule that would prohibit rebates in Medicare Part D as they are used today. The rule would withdraw rebates' exemption from the Anti-Kickback Statute effective January 1, 2022, but would permit rebates if they were used to reduce drug prices at the point of sale. We can provide further detail about this if you have questions.

So Part D is complex because there are multiple actors because of the use of rebates, but also because it has a complicated benefit design. Actually, there are two distinct standard designs: one for enrollees without low-
income subsidies, such as shown on the left, and another for those with the LIS, which is shown on the right. Last year, the Commission recommended changes to these structures for several reasons:

First, note that plan sponsors bear risk on the sections in blue. For either type of beneficiary, plans don't bear much risk at all in the coverage gap -- 5 percent on the left and zero on the right -- or in the catastrophic phase where Medicare pays 80 percent of costs and plans bear 15 percent. Rebates on some drugs can be larger than the plans' liability. This structure undermines plans' incentives for managing spending.

Second, beneficiaries without the LIS receive a 70 percent manufacturer discount on brand-name prescriptions in the coverage gap, which is shown in yellow. That discount makes brand-name drugs look artificially cheaper relative to generics, and the discount gets counted as though it were the beneficiaries' own out-of-pocket spending towards reaching the catastrophic phase.

Third, note on the left-hand side that there's unlimited cost sharing for enrollees without the low-income subsidy who have very high drug spending, 5 percent.
Switching now to the status of the program, obviously 2020 was an extraordinary year because of the COVID-19 pandemic. Relative to the effects of the pandemic on use of other medical services, Medicare beneficiaries' access to prescription medicines had comparatively less disruption. When state and local jurisdictions put restrictions in place, pharmacies and grocery stores were often permitted to remain open. Initially last March, beneficiaries stockpiled medicines with 90-day supplies and filled more prescriptions at mail-order pharmacies. CMS encouraged Part D plans to loosen some management tools to make those supplies available. After drawing down those stocks, peoples' patterns of filling prescriptions returned closer to those of the previous year. Unlike providers who rely on billing Medicare for their revenues, throughout 2020, Medicare paid monthly payments to Part D plans based on bids the plans had submitted in June 2019. If a plan's actual benefit spending was lower than what they had anticipated in the bid, Part D's risk corridors would help the Medicare program to recoup a portion of the profits that the plan would otherwise keep.

Let me quickly go over the current snapshot of
the program. In 2020, among 63 million Medicare beneficiaries, nearly 75 percent were enrolled in Part D plans. Nearly 2 percent got drug benefits through the retiree drug subsidy, in which employers provided primary drug coverage to their retirees in return for Medicare subsidies. The remaining 23.5 percent was divided fairly equally between those with other sources of drug coverage as generous as Part D and those with no coverage or less generous coverage.

Medicare program spending for Part D totaled over $88 billion in 2019, predominantly for payments to private plans, with less than $1 billion for the retiree drug subsidy.

In addition, Part D enrollees directly paid nearly $14 billion in premiums, as well as additional amounts for cost sharing and supplemental coverage. More than nine in ten enrollees say they are satisfied with the program and with their plans.

And now Shinobu will take you through key trends we've seen in Part D.

MS. SUZUKI: Part D enrollment has grown by about 5 percent per year, faster than the overall growth in

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Medicare beneficiaries. As a result, today a higher share of Medicare beneficiaries is in Part D than at the start of the program.

In 2020, nearly half of the enrollees were in MA-PDs, a shift from earlier years when most enrollees were in stand-alone PDPs; 27 percent received the low-income subsidy compared with 39 percent in 2007.

More beneficiaries are in employer-group waiver plans as many employers switched from receiving RDS to operating Part D plans, and today about 15 percent are in these employer-group plans.

In 2020, monthly premiums averaged about $27, a 7 percent drop from the prior year. Average premium has remained stable at around $30 since 2010, but there's a lot of variation around that average.

For 2021, the number of plans offered are up, providing broad choice of plans. A lot of that growth is in enhanced plan offerings, including the new model run by Centers for Medicare and Medicaid Innovation, which I'll talk about next.

The number of PDPs that are premium-free to LIS enrollees increased by 6 percent, and all regions have at
least five such plans.

Last year, CMMI introduced a new voluntary model called Part D senior savings model that would cap beneficiary cost sharing for insulins.

Participating plans must offer at least one of each type of insulins at cost sharing of no more than $35 per one-month supply.

The model is limited to non-LIS beneficiaries who enroll in participating enhanced plans. About 1,600 plans are participating this year.

The model allows plans to offer enhanced benefits for insulins without losing manufacturer discounts in the coverage gap.

By ensuring cost sharing of no more than $35, the model could improve access and adherence to insulins. But it does not address high insulin prices, and enrollees in participating plans may face higher supplemental premiums.

This table shows indexes measuring prices at the pharmacy before post-sale rebates and discounts. The first two columns show price indexes for 2018 and 2019 relative to prices in January 2006. The last two columns show growth rates.
As shown in the top row, overall prices grew more slowly in 2019, growing by 2.6 percent compared with an average annual growth of 5.3 percent in prior years. This slowdown is also seen for brand-name drugs, shown in the second row. But the growth rates for brand-name drugs are much higher than for all drugs and biologics.

When generic substitution was taken into account, prices decreased by 2.1 percent, reversing the inflationary trend before 2019.

But the change in price indexes varied widely across therapeutic classes. Prices decreased for classes with new or increased generic competition such as anticonvulsants, while prices continued to rise for therapeutic classes dominated by brand-name drugs or biologics such as anti-inflammatory drugs.

And these high-priced specialty drugs and biologics are one of the main factors driving Medicare's reinsurance spending, which we'll turn to next.

This table shows Medicare's spending on Part D. It includes Medicare's payments to plans, including the low-income subsidy that pays premiums and cost sharing for LIS enrollees and less than $1 billion for RDS.
I want to focus on the top two rows: the direct subsidy, which is a monthly capitated payment and reinsurance, which is a cost-based reimbursement that covers most of the catastrophic costs.

In 2019, reinsurance grew to just over $46 billion, up from $40.6 billion in 2018 while the direct subsidy declined from $13.5 billion to $11.6 billion.

This pattern has persisted over the years. Between 2007 and 2019, reinsurance grew by an annual average of nearly 16 percent compared with a 3.4 percent decrease for the direct subsidy.

This rapid growth in cost-based reimbursement means that a disproportionate share of risk is borne by Medicare and, therefore, taxpayers. The contrast between 2007 and 2019 highlights the diminished role of the capitated direct subsidy payments that was supposed to provide market-based incentives.

Total Part D spending at the bottom shows an increase of about $5 billion between 2018 and 2019. That increase is almost entirely driven by the growth in Medicare's payments for reinsurance.

As you saw earlier, Medicare's reinsurance picks
up 80 percent of the cost once an individual reaches the catastrophic threshold. 2019 saw the largest ever increase in these high-cost beneficiaries, with 4.3 million, or about 9 percent of all Part D enrollees, reaching the catastrophic phase of the benefit.

That's a 12 percent increase from 2018, and most of that increase was among non-LIS enrollees shown in blue.

The surge in high-cost, non-LIS enrollees was driven primarily by two factors.

First, the recent law change that increased the manufacturers' coverage gap discount from 50 percent to 70 percent. That meant many people reached the catastrophic threshold with lower spending than in 2018.

Second, the use of prescriptions for which a single claim is sufficient to reach the catastrophic phase continued to grow, with more than 480,000 enrollees filling such claims in 2019 -- this is up by more than 100,000 in 2 years, from 380,000 in 2017 and just 33,000 in 2010.

At the same time, general indicators of access show improvements in formulary and coverage decisions, and more than 80 percent of the surveyed beneficiaries report high satisfaction, saying that their plans provide good
value with reasonable cost sharing.

So the trend reflects dichotomy among beneficiaries without the low-income subsidy. For them, access depends on their medication needs.

For those taking generic drugs for common conditions, Part D provides good coverage and access.

But for those who need many brand-name drugs or high-priced specialty drugs, high cost-sharing requirements may pose barriers to access.

These trends in program cost and access highlight two main issues in Part D: the decline in plan's insurance risk that undermine their incentives to manage spending and the increasing role of drugs with very high prices.

Last year, the Commission recommended changes to restructure Part D.

To address distortions in plan incentives created by rebates and discounts that increase Medicare's reinsurance costs, the Commission recommended eliminating the coverage gap discount and increasing plan liability in the coverage gap and the catastrophic phase of the benefit.

To address high prices and high-cost sharing, the Commission recommended creating a new manufacturer discount
and providing a complete insurance protection in the catastrophic phase.

The recommendations included other provisions to restore market-oriented incentives while providing greater flexibility to manage benefits.

Here's a list of items for your discussion.

Based on your feedbacks from the fall presentations, we plan to continue our work on Part D's risk adjusters and LIS benchmarks. We also plan to focus on Part D's for all in long-term care settings.

We're also excited to report that the recently passed Consolidated Appropriations Act included a provision to provide MedPAC with access to Part D rebate data. We're hoping to begin exploratory analysis as soon as we have the data in-house and update you on the progress during the next cycle.

We're interested in your feedback regarding the mailing materials and our future work plan.

With that, we'll turn it over to Mike.

DR. CHERNEW: Great. Thank you all.

I will just emphasize how excited we are about getting the rebate data. I won't take more of your time to
emphasize that.

But Dana is going to manage the list. I know there's some people on it. So, Dana, you should call folks out.

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

DR. DeBUSK: Yes. First of all, thank you for a great report, a really, really good read.

I had three questions, and they're all tied to this rebate rule, the November rebate rule. Just to clarify, if a manufacturer is offering, let's say, a 20 percent discount and that discount is reflected at the counter when the beneficiary purchases the drug, is there any way that even with this new rebate rule -- is there any way that that process could run afoul of this new rule? Would it still stay in the safe harbor?

DR. SCHMIDT: I think the intention is for yes. That would be within --

DR. DeBUSK: Okay. There is. Okay. I just wanted to make sure I wasn't missing.

Now, similarly, let's say that same 20 percent was tied to some year-end purchasing goal. Let's say as
long as you don't put drugs on there to compete against me, then you get the 20 percent. Well, you wouldn't know if you had it or not at the time of the purchase. Is there any way a rebate structure like that should make it through the rebate rule, this new rule, and enjoy safe harbor?

DR. SCHMIDT: I think that's the crux of it.

There is a wide variety of estimates that affects this rule, and I think that's getting towards the crux of the reason there is a wide range of estimates. The key question is --

DR. DeBUSK: Based on your -- I'm sorry.

DR. SCHMIDT: I'm sorry.

DR. DeBUSK: No. Please, please go ahead.

DR. SCHMIDT: Just a key question is would, for example, the Office of the Actuary argue that because the manufacturers would no longer be able to look at what was attained in terms of market share of your product. They would not offer as large rebates, and so in order to structure and negotiate a rebate, sort of the structure that would provide as much of a discount as they've been getting under the current setting, how rebates are used.

But the flip side of that is that other people
are arguing, well, plans, if they're not receiving these rebates, if they're going to the beneficiary of the point of sale and maybe they'll have different kind of formulary incentives, you know, with the weird benefit structure that Part D has, sometimes those rebates are larger.

That's kind of the two sides of the coin, and there's just a lot of uncertainty about what the behavioral response is.

DR. DeBUSK: Thank you.

I have one last question, and I share Michael's view on the excitement over getting the rebate data. Will we have any insight into how those rebates are structured? For example, that 20 percent rebate, when they share that data, will we know if that's a proportional rebate or some type of punitive rebate?

DR. SCHMIDT: I don't know that we'll know, and we've never --

DR. DeBUSK: We'll say the 20 percent.

MS. SUZUKI: My -- or our general sense is we'll know the amount, and usually that would be reported at the drug level. However, I don't think we would have insight into exactly how the contract was structured.
DR. DeBUSK: Okay. Well, thank you, and thank you again for a great report. That answered my questions.

DR. PAUL GINSBURG: I'd like to come in with a follow-up to Brian's first question. Given the rebate rule along with the Most Favored Nation rule for Part B drugs were kind of a series of last-minute rules issued by the Trump administration, all of which have been sued to block, and I think many of the lawsuits are going to prevent them because often the administrative procedures were violated. So we shouldn't assume if that is part of the permanent landscape.

I think now that we have the rebate data and we can identify some issues to work on in rebates, we should probably assume clean slates, though we may come up with a much better idea for dealing with the problem that beneficiaries that use highly rebated drugs pay a lot for them, other than the rebate rule. And when we get down the road, I have my own ideas, which I've published on.

Thanks.

DR. SCHMIDT: I understand people are having a little difficulty hearing me. Is this any better? Okay.

Yes, Paul. You're absolutely right. I think there's
already been a legal challenge to this rebate rule on the administrative procedures aspect but also because part of the rule said that it would only be implemented if it wouldn't increase program spending or beneficiary premiums.

The Secretary of Health and Human Services says that that will be the case. It won't increase spending, but prior estimates of the effects of this by both the Congressional Budget Office and the Office of the Actuary said that it would increase both beneficiary premiums and program spending. So we shouldn't necessarily assume it will be implemented.

In our comment letters, we've also argued that our fundamental restructuring of the beneficiary structure, the benefit design of Part D would go far away towards providing better formulary incentives and might overcome some that choose with rebates.

DR. PAUL GINSBURG: Thanks, Rachel.

MS. KELLEY: Okay. I have Bruce next.

MR. PYENSON: Thank you very much. This is a terrific chapter.

As you've indicated, the industry is highly concentrated. I'm wondering if you have thoughts on
justifying a three-year phase-in for some of the biggest corporations in America that dominate Part D. Do we have support for that? I know that's part of our recommendation, but I wonder if you could discuss a little bit on the thinking of the need for that, given how consolidated the industry is.

DR. MATHEWS: So, Bruce, that was, indeed, part of the Commission's recommendation last year. I would be hesitant to start to second guess that or reopen that recommendation on the basis of this one element.

DR. CHERNEW: And just to jump in, so for people listening, we are not -- I was not part of the Commission when that recommendation was made, for people who don't follow all the MedPAC goings-on, but nevertheless, I think we're not relitigating that recommendation for now for focus. I mean, that recommendation stands, just to make that point. We'll see where it goes.

Obviously, it hasn't been taken up yet, but I think there's a lot there that was outstanding work. But back to you, Dana.

MS. KELLEY: Sue?

DR. CHERNEW: Dana Kelley. I think she's going
MS. THOMPSON: Yes, she did. Thank you, Dana.

And, Rachel and Shinobu, it's so nice to see your faces, so good morning. Again, thank you for all of your good work in this arena, and again, it was great to see your chapter.

I'm going to go back to a comment that's within your chapter that we haven't seen much benefit as it relates to medication therapy management programs. I'll prepare you. My question is on how did you assess it. How are we assessing that? How many programs have we looked at?

My strong belief here is that the root of this big problem around drugs is we're prescribing way too many drugs, and we've got a whole lot of beneficiaries out there that are overmedicated, and so talk a little bit about, again, your assessment of the MTM programs that exist.

MS. SUZUKI: I can start. I think one of the things we reported is on the enhanced MTM program, which gave certain plans more flexibility than are available to them under current law. Under those enhanced MTMs, there was a requirement for CMS to do an evaluation. In our
paper, what we discussed is some of the results of evaluation reports that come out.

The intent of enhanced MTM, in addition to looking at medication used, is to see whether there were effects on health outcomes as measured by Parts A and B spending, and overall they did not see effects on Parts A and B spending from investing more in these MTM services.

It's hard to discuss how the other, current law, MTM programs are working. There's not a lot of data that measures what those programs are doing. We know that plans are required to provided MTM services. They do try to reach out to eligible beneficiaries who are taking multiple medications or meet certain condition requirements, and there are some take-up of medication reviews. It's just not clear whether that's resulting in health outcomes.

DR. CHERNEW: I think --

MS. THOMPSON: One follow-up question, Mike.

Is it clear about the extent of their investment in MTM?

DR. SCHMIDT: I think there's a variety of different approaches that plans are using. Some are more invested than others. It's not entirely clear. Some are
using mail, phone calls, that sort of thing. Others are
getting the pharmacist more directly involved. It's just a
wide variety of approaches. So we don't know the extent to
which any of those are successful or some are more
successful than others.

I think we generally share your concern about
polypharmacy which we've written about in the past with the
Medicare population. So we've raised this as a problem.

MS. THOMPSON: Thank you both.

DR. CHERNEW: Yeah. So let me just jump in and
say two things, and this is just building on what Rachel
said. The screen is so small, I can't see people's
reactions. So I'm going to watch you, Rachel and Shinobu,
who I actually don't see on my screen.

In any case, there's a few things. The first one
is all of the analysis -- and this is more than just this
Part D chapter or medication therapy management services.
Our conclusions are based on averages. So in no way does
that mean there aren't potentially successful programs that
are working very well. When we say they don't work of
something is not giving us savings, for example, that's
really more comments on averages. That's the way research
works in general.

The second point is I think there's a lot of things where we've realized there's a problem, and we're not quite as successful at solving the problem, even though we've put in place policies where we would hope we would be able to address the problem. And then after the fact upon the evaluations, we aren't as impressed with the results as we might have been going on. Sometimes that's an execution issue.

I'm not sure exactly what's going on here, but you should interpret the findings as an assessment of where we are in the literature, not a belief that polypharmacy is not a concern, because I think in many ways it is.

MS. KELLEY: All right. Then, Amol, you're next.

DR. NAVATHE: Thank you for a great chapter.

My questions, hopefully, is a simple one. In the LIS, in the policy option recommendation, where I'm trying to make the LIS part more -- there was a suggestion to allocate the auto-assign, randomly assigned beneficiaries proportionately based on the premium. What I was curious about is what -- where is there variation, if at all, in the benchmark plans based on their premium variations and
knowing that they do vary, obviously, in their premiums?
Are there any other factors around coverage or benefit
design or anything else that actually does have variations
that may be correlated with their premiums?

DR. SCHMIDT: You can feel free to jump in here
too.

So they're all basic plans -- basic benefits.
They're not plans, but not hardly any at all use the
standard benefit design. So there is variation. Whether
they're charging the copays, exact copays they're charging,
they all have to be actuarially equivalent to the basic
benefit. But the formularies and the cost-sharing
structure can differ from plan to plan, as long as they
have that same average value.

So I'm not sure if that's addressing the
question.

DR. NAVATHE: I think that is addressing the
question because I think, in part, because -- I expected
you to say there was some variation there around those
factors. That's what I guessed, and if that's the case,
then I wonder a little bit about the wisdom of auto-
assigning proportionately, because we could actually have
some more -- "generosity" may not be the right exact word, but there could be differences around how chronic condition medications are on the formulary or what have you. It might behoove us to look a little bit more deeply at that to ensure that there's not any unintended effect like heard in LIS bene.

DR. SCHMIDT: That's a good point, I would say, but I would also just remind everyone that there is a review of the formularies that CMS does to try and ensure that there's pretty broad coverage, and in fact, in an evaluation that CMS does, they found that most of the drugs needed by LIS beneficiaries tend to be widely available across, among the plans.

DR. NAVATHE: Thanks, Rachel.

MS. KELLEY: Dana?

DR. SAFRAN: Thank you.

I have two questions. One is I didn't see anything in the chapter about quality measurement, and I know that Medicare Advantage plans have prescription drug measures that they're accountable for through stars, and I'm curious whether we have similar measures that are applied for Part D plans, and regardless of whether we do
or we don't, what we know about the comparability of quality and member experience in the MA plans with Part D versus the Part D plans for members in original Medicare. That's my first question.

My second question is a kind of bigger, broader one, and that is as we think about the fact that this is the newest part of the Medicare program and looking at the spending trends, thinking back to the rationale for introducing Part D and the importance of access to drugs for seniors particularly as medications were starting to and continue to play such a larger and larger role in managing health and health conditions, I'm curious whether there have been any analyses by MedPAC staff or otherwise that really try to stand back and look at the value that has been brought by having Part D. For example, in commercial, we think all the time about the value of managing chronic conditions to avoid the complications and longer-term effects that can land people in hospitals and with very serious health complications of chronic illness. And I'm curious because I don't think I've ever seen it in my years on MedPAC whether there have been analyses that really stand back and look at sort of the
value of Part D, both from a financial perspective for the
program and for kind of health and avoided health
complications for beneficiaries.

Thank you.

MS. SUZUKI: I'll start with the quality
measures. We did discuss the star rating that's comparable
to what's in MA-PDs but measure somewhat different items.
It used to be focused on adherence, with most weights
coming from adherence to, say, statins or hypertensive
drugs. I think in recent years they've switched to more
beneficiary experience measures, so the weights on those
measures have gone up.

So there are 14 metrics, a much smaller number
than for MA-PDs. For MA-PDs they have combined MA measures
plus the 14 metrics for Part D. It's hard to compare PDPs
versus MA-PDs directly, but typically there are substantive
plans that are doing well, in terms of star rating. It's
hard to know what that really means in terms of quality of
the plans. Some of it measures, are the prices listed on
Plan Finder accurate, or how's the -- adherence continues
to be some of the measures. And I think patient access and
process and that sort of thing is also measured. That's
based on CAHPS survey results.

So we haven't put a lot of work into trying to figure out whether those measures correlate with anything in the Part D program. Part of it is it's hard to measure how the outcomes and the relationship between what Part D is doing -- so a couple of years back we tried to look at, for example, adherence and outcomes, and we found that figuring out what outcome, measured by, say, Parts A and B spending, is really affected by better or worse adherence to certain medications, even when we limit it to certain beneficiaries with same conditions.

So this is an area where we've tried, but the health outcomes is a difficult thing to measure, especially in a population where they're aging and adherence seems to drop off when there's some health even that's unrelated to the adherence happens. So that's one.

DR. SCHMIDT: On your question about the overall benefits of Part D, I don't think there are a lot of studies, and I don't know that they've focused particularly on Part D. I've seen studies, for example, that just talk about broader availability of medicines that treat cardiac conditions and the broad benefits associated with those,
especially since so many of those medicines right now are available on a generic basis and so the costs are way low, so there's usually large social benefits associated with that. And given our population [inaudible] a benefit associated with that. But I'm not very familiar with studies that have looked at the social value of Part D per se. I haven't been looking for it, but we can probably do that.

DR. SAFRAN: Thank you both.

MS. KELLEY: Jaewon?

DR. RYU: Yeah. I had a question that's a little related to that topic and maybe the MTM topic as well, and it gets to the interrelatedness between standalone PDP and APM models. And I was just curious if there is any analysis along those lines, meaning could it be that bigger uptake in APM models has enhanced medication adherence and driven up standalone PDP cost, and the benefit is sitting over on the A and B side? I think the MA-PD, it's a lot cleaner because all of it is bundled together into a single program, but I wonder -- and I'm curious if we have any information that ties, in a standalone PDP, with the activity of APMs.
And the other question that's kind of related is
I think to the extent programs have, like in bundles where
they've put drug costs in together, I believe it's mostly
just on the Part B, as in boy, side, but I was curious if
there's any interrelatedness or interface, interaction
between the two programs.

DR. SCHMIDT: I'm sorry. I'm not -- oh, I'm
sorry. Go ahead, Shinobu.

MS. SUZUKI: Go ahead, Rachel.

DR. SCHMIDT: I was going to say, I'm not
familiar with studies that have looked particularly at the
intersection between PDPs and APMs, but a few generally
thinking about -- we had some discussion within the
Commission in past years about ACOs and PDPs, and the fact
that there are some plan sponsors of PDPs that have
actually tried to establish some relationship with ACOs.
But it's always been on an informal basis. But I'm not
aware of studies of that per se.

DR. RYU: Thank you.

MS. KELLEY: All right. I think we are ready to
move to Round 2, and I have Brian first, unless you want to
start off, Mike, with anything? We can't hear you, Mike.
DR. CHERNEW: That's all right, because I wasn't saying anything of consequence. I think we should jump right into the Round 2 comments and then we'll see where that takes us, and I'll make comments at the end, depending on how long they go.

MS. KELLEY: Okay. Brian then.

DR. DeBUSK: Thank you, and first of all, Rachel and Shinobu, thank you again for a wonderful chapter. Still, I want to compliment the work on the restructuring of the reinsurance benefit. I mean, that literally predated my time even on MedPAC. I think that was a 2016 work, analysis, but it was very, very impressive work. And I also want to compliment you on your work on the LIS last year. I think last year's work, taking on LIS in the Part D drug benefit was also very, very impressive work.

I want to encourage everyone, both of you but the whole staff, to keep digging into this rebates issue. I've been hung up on rebates for a very long time and I just want to take a moment and point something out. These aren't 2 and 3 and 5 percent discounts that we're talking about here. To give you a feel for the scope, according to my math, you've got about $14 billion a year in premiums
coming into Part D. You've got about $17 billion in cost
sharing. Now consider that against the backdrop of $28
billion in rebates. When you consider that cost sharing
presumably is to influence beneficiary behavior, and we
feel that $17 billion in play is enough to influence
beneficiary behavior, well, how much influence does $28
billion buy? I mean, the money that's changing hands
behind the scenes is almost double what we spend in cost
sharing.

So I would hope that we continue to dig into
rebates. I do think that the current rule -- and Paul, I
agree with you; I think there are a number of legal
challenges and some issues with the current rule as it
stands -- but I think this idea, directionally, this idea
of cleverly dissecting beneficial rebates, pure discounts,
dissecting those from these more punitive and predatory
rebates I think is very, very important work. And I think
there's a clear distinction between the two. And I think
lumping all rebates into one bucket is very flawed.

And so again, any work that we can do to try to
define what is a beneficial rebate, what is a punitive
rebate, and then dissect those from the policy so that we
keep the good and we shun the bad. I really hope we'll continue to do work there, and again, Rachel and Shinobu, fantastic work. I always enjoy reading your work. Thank you.

MS. KELLEY: Bruce?

DR. CHERNEW: Can I step in for one second first, before Bruce? Brian, I'm sorry. I was muted again. First of all, our excitement about the rebate data is not because we wanted the data to work and we can work with the data. It was because we wanted the data and we will work with the data. So you don't have to worry about us digging into some of the rebate activities. We certainly will.

I might add, there are a lot of other institutional things that are related to discounts that aren't necessarily considered rebates. A good example would be 340B and what's going on in 340B where there's a serious of other discounts that are given, and I imagine Bruce would know something about 340B. But the point is this discrepancy between the amount that's paid to the companies, the amount that's charged to patients, how the money is flowing in complex ways is an important topic. And so to the extent that your comment was we should
continue to dig into that, the answer is yes.

MR. PYENSON: And I also agree with that, Michael, and I want to echo Brian's compliments for the team on this work.

My comments are about the future work. I think that we should examine the consolidation of the industry in a bit more detail. It's difficult because of the vertical and horizontal consolidation of the PBM and Part D industry and drugstores and other elements there. But I think that's a critical element of understanding what's happening in Part D. In particular, I think a look at this would identify where the risk issues are and where the role rebates and other kinds of transfers perhaps related parties.

So I think I would put that onto the work issue. I don't think we can come close to understanding Part D if we really don't do that. Only part of that is the rebate issue. As you know, an important part of direct and indirect reimbursement are the fees that are paid by drugstores to Part D plans or PBMs, which weren't affected by the change in the interpretation of the Anti-Kickback Statute.
So to put that as a bullet point, I think, looking at the industry structure and the consolidation of the industry I think would be an idea I have for future work. Thank you.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Thanks. You know, on the slide in front of me, Questions and Discussion, the first one, feedback on the draft chapter, really outstanding chapter and presentation. I'm just really, really pleased with it. And I'll endorse Brian's statement about the past work in this area has been very strong.

I have two ideas for future work. One which has already been brought up by Brian is rebates. I think this is an area we haven't worked on. Now that we have better tools we can do better work. I think that the immediate problem is solving the issue for the beneficiaries who happen to unfortunate enough to be using, or need to use, for their illness, the highly rebated drugs and wind up basically subsidizing their colleagues in the benefit pool in Part D.

There are some simple solutions that Medicare could consider such as what UnitedHealthcare is doing in
its commercial plans, which is providing at the point of service an approximate amount of rebates, which still shields the secrecy, which I think does have value. And, of course, there's a premium increase when that happens, but it's a legitimate premium increase because basically the benefits are hollowed out as rebates grow along with list prices, and it's really a way of restoring. And that's really happened in Medicare. That's why, as you've shown in your presentation, you have what the beneficiary pays has been roughly unchanged for a decade now. It's not that this insurance is doing great. It's just that it's being hollowed out.

My second ideas is I'd like us to look into various approaches to provider limits on prices for brand-name drugs that don't have competitors. There's been a lot of policy discussion and activity in the Congress and in the administration about these limits. I think the initial movement towards taking prices to those in other countries is not the best way to proceed. I think a much better way to proceed would be to set up expert panels to opine on value and set payments according to value.

And so I think the Commission has the potential
to look at what some of the other countries who use this
approach have done, and also look into the unexpected
consequences, shortcomings, of pegging prices to prices in
other countries rather than having the United States come
up with its own judgments as to what prices would be
appropriate. Thanks.

MS. KELLEY: Larry?

DR. CASALINO: Yeah, two quick things and a
question. First of all, I'd like to second Bruce's thought
about looking more at concentration, and especially
concentration and its relationship to rebates and whether
the rebate rules are making there be more concentration.
Secondly, I think it might be good to know more
about the relationship between plan sponsors and PBMs.
You've written some about that already, but it seems like
such an important relationship, and the role of PBMs more
generally seems so important, and it might bear more
scrutiny. And that's, I know, a very general comment but
that's the best I can do.

And then question I wanted to ask is, we did talk
about influencing beneficiary behavior, in this context as
well as others. And I wonder, in Part D, how important
that is. I know we had some discussion, quite a bit, and some recommendations even, about influencing the behavior of beneficiaries with a low-income subsidy, possibly very small changes in their copayments, for example.

So again, it's a question of whether -- well, I'll just put that aside for a second. For everybody else, though, what are we trying to influence exactly? I think the generic prescribing rate is quite high, if I understand correctly, for the non-LIS beneficiaries, and maybe the LIS as well. So if we already have a high rate of generics, then there are the really high-cost drugs, but it's not really a beneficiary choice to say, okay, I want a drug that costs $200,000 a year, or whatever. I mean, presumably they really need it, and I'm sure it's the prescriber, the physician's decision.

So I think when we talk about influencing beneficiary behavior in Part D we need to think a little bit more, not just take that for granted, think about what are we actually trying to influence, how much effect we would have, and is the game worth the candle, so to speak. That sounds like a rhetorical question but I actually mean it as a real question. You know, what are we trying to
influence? What should we try to influence?

DR. SCHMIDT: So you are right that generic
dispensing rates are quite high, but I wouldn't say it's
uniform. I think there's still room to improve on that.
Preparing for last year's recommendations we did a series
of stakeholder interviews, including with some plans that
have a lot of LIS enrollees. The reason that we had that
part of our recommendation of having somewhat higher cost
sharing for LIS enrollees was because we heard that there's
still room for change along those lines. So that's one
area that I think we still want to continue is trying to
affect beneficiary behavior.

DR. CASALINO: And Rachel, for the non-LIS
beneficiaries, does it make sense -- again, not a
rhetorical question. I'm really asking this -- how big an
issue is it for the non-LIS beneficiaries to influence
their behavior?

DR. SCHMIDT: Again, generic dispensing rates are
high, but I would say it's probably not uniform. There are
still people who are going to want a brand name and when,
you know, it's not necessarily much better when there are
perfectly viable alternatives. I think that maybe there is
room for more generic use, especially higher with the LIS population than the non-LIS. And you're right, with respect to the high-cost drugs, many beneficiaries don't feel they have much choice. So I think we'll have to keep looking at this issue. It may be that the mood for effecting behavior is changing, but I don't think it's absent entirely as you might be saying. I'm not sure.

DR. CASALINO: Okay. I would like to second also Paul's comment, I think it was, about can we look more closely at the really high-cost drugs. There's obviously a lot of people, a lot of opinion pieces written about this, a lot of people thinking about what to do with really high-cost drugs that don't have a substitute. I guess my question here would be: Is there a role for -- does MedPAC have something to contribute to that discussion? Which is pretty wide-ranging right now.

DR. SCHMIDT: One other issue --

DR. CASALINO: I would ask that question -- I would deliberately ask that question, asking that the staff and leadership try to decide is there a role for MedPAC in that or not; and if so, you know, what is it? Because it is a pretty urgent issue.
DR. CHERNEW: Can I -- I'm sorry. Let me -- so
two related things, Larry. The first one is Part D, unlike
the other parts of Medicare -- well, unlike Part A and B,
anyway, is structured on the back of private plans, which
means a lot of the activities that are done to influence
patient behavior, use of generics, a whole bunch of things,
are actually not made by Medicare. They're made by the
private plans.

As was noted by you all, not me, in the Part D
chapter from last year, the structure of the program could
be better in terms of encouraging the plans to do certain
things, particularly, for example, around reinsurance. And
a lot of the recommendations that were made by MedPAC were
to address that type of behavior.

The other role that we clearly have, of course,
is as CMS publishes various types of rules, including, for
example, the international pricing rule, we make comments
on those. So everything you see that MedPAC does isn't
limited to what you see in a MedPAC chapter or, for that
matter, in a MedPAC recommendation. So I think we do have
a clear role to think about how the Part D program is
structured. It is a slightly different role than we might
expect in Parts A and B because of the role of private
plans and what goes on. But I think with the rebate data
more broadly, in the spirit of, I think, of what Bruce
said, the more we can shine a light on what's happening,
identify where there's inefficiencies, identify where
changes in Medicare policy might encourage private actors
to behave in a way that we think would be better for the
beneficiaries in the program, I think that's absolutely in
our role, and we will continue to do that.

And your point -- Paul, you may be in this
category -- that many have written on things to do about
this is well taken. This is not an area that people have
shied away from, and I think certainly think we will try to
contribute, when we can constructively, about that.

Jim, do you want to add something? I'm sorry. I
want to see if Jim wants to add anything about the MedPAC
role that I may have missed in that response to Larry.

That's a no, so thank you for moving on.

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

MR. PYENSON: Yes, and I'm very sympathetic to
Larry's point of not blaming the patient or putting
pressure on the patient, but I think overall Rachel is
right about the opportunity. This is tied up with the
rebate issue often, and although the particular issues, the
particular drugs where this happens are perhaps relatively
few, they may account for lots of dollars where particular
brands that pay rebates can be preferred over generics.
Likewise, I think on future work on biosimilars and what
can be done to make sure that the value of biosimilars are
realized for the Medicare program and for beneficiaries
would be important.

So my personal view, as others may recall, is
that our expectation for prices should be deflation because
of the commodity nature of the industry -- the industries
that we're working with here. So I would just like to see
that as incorporated in future work as the expectation.

MS. KELLEY: I have David next.

DR. GRABOWSKI: Great. Thanks, Dana.

DR. CHERNEW: David, can I respond to Bruce?

Again, just very quickly. So I understand your comment,
Bruce. I think one of the things that hasn't come up
enough in this discussion makes it complicated to figure
out what to do, and I understand all of the concerns and
all of the dysfunctions in this sector, they're enormous. But I think we would be remiss if we didn't acknowledge the core difference in that innovation is fundamental here, and so there's a tension between how we plan our policy for a given set of drugs once they've been launched and how we think about the incentives to innovate.

This whole area, again, and the whole area of drug policy is going to be quite bigger than Medicare, and we'll have to think through that. So back to what I answered to Larry, we absolutely have a role, but it is going to be a role that is going to be complicated by balancing a bunch of things, and we'll try and pick our places where we can make the system work more efficiently, recognizing that we'll be balancing a bunch of market dysfunction with a core desire to support innovation. I think there's no time like this year to understand the importance of drug innovation. But I'll leave it there.

MR. PYENSON: Mike, did you just imply that the rest of the health care system is not so interested in innovation?

DR. CHERNEW: No, not in the least, but I do think there is a fundamental difference in innovation
across the sectors. We could have a broader debate about that, but I think the role of innovation, patent policy and new products, and a bunch in the drug sector I think is qualitatively different.

Again, I'm happy to allow you to disabuse me of that notion, Bruce, but that's kind of what I think is partly what makes -- I guess I can't use the word "unique" now, although I'm an economist and no one expects me to use words correctly, but special, different, qualitatively at least. And I think we will have to sort through how that influences what our recommendations are. And, frankly, I think what bedevils a lot of policymakers because there's a ton of dysfunction. And I should say one more thing if people are listening. I believe strongly that it's important for us to support innovation. I believe strongly that does not mean that the drug sector should get a blank check to do whatever they want, and as soon as you use the word "innovation" you're given a pass for all other types of behavior.

I think it is just one consideration that weighs here more heavily than it does in our debates about many of the other sectors.
MR. PYENSON: I agree.

DR. GRABOWSKI: Okay. Part 2 or Take 2, I guess.

So, first, great work, Shinobu and Rachel. I really appreciated the chapter and the data you presented today in the presentation. I have kind of three quick thoughts.

First, I share others' enthusiasm for the rebate data and what we can do with those data. I was taken by Bruce's earlier comment about concentration, and there's probably other kind of interesting analyses there. So I'm super excited about being able to unpack some of what we haven't been able to unpack in the past.

My second comment, I'm always struck by just this shift in terms of spending with the reinsurance, almost 500 percent increase since 2007. We made the recommendation in the June 2020 report about the catastrophic phase. We saw since that report, you know, a $6 billion increase, I think in the most recent year, if I read that correctly. This problem isn't going anywhere, and so I just wanted to emphasize again just the importance of that recommendation and the work that we've done there, and anything we can do to continue to kind of keep the pressure on there would be great.
A final comment involves the future work here, and I'm incredibly pleased to see long-term care pharmacy on the list. This has been a long interest of mine. Long-term care recipients, Medicare beneficiaries in these settings, are different. They're higher users, so it's certainly important. But there's also some other interesting kind of market dynamics here in terms of competition. It's a highly concentrated market. It actually intersects with Part A given, you know, all of our drugs for those -- those SNF patients are bundled in their Part A, and you have these long-stay residents who are under Part D. And so there's some really interesting dynamics there as well. So I look forward to work there and kind of examining a lot of those issues. Thanks.

MS. KELLEY: Pat.

MS. WANG: Okay, thank you. So also tremendous compliments to the MedPAC staff. Rachel and Shinobu, it's a great chapter and it's great work.

This topic of Part D is complicated enough, plenty complicated, so I don't mean to muddy the waters here by just raising an observation, I guess, that the next thing that we're going to discuss in our meeting is payment
for vaccines, because the same vaccine -- or some vaccines are paid by Part B only, some by Part D only, and some by both. And so there's going to be an effort very soon to try to figure out what the best approach is to pay for vaccines.

I kind of think that it would be at a minimum useful -- and I don't mean to burden you with more work. The relationship between Part D and Part B is not so clear-cut anymore. As the pharmaceutical world does innovate and evolve, for example, there are chemo agents that are taken orally now as opposed to infused, but the disease condition is -- they may wind up getting paid -- there are different generations of drugs that I think some are expected to be paid under B, some under D. I think that there is some pushing back and forth. So I don't really know if that's true. It's just that -- or how big an issue that is. It's just something that has been -- I've heard comments to that effect in my own work: Well, that used to be B, now it's D, now it's both.

To the extent that when we're talking about drugs that are sort of prescribed or given to treat conditions and it's a gigantic balloon of cost and efficacy that we
keep squeezing, which we kind of did when we talked about
Part B restructuring. In my mind is, you know, how do we
squeeze the balloon? All the cost is in there. How do we
squeeze the balloon differently? There might be another
balloon that is connected here, which is Part B, which is
paid completely differently, obviously, has many other
dynamics going on.

I just wanted to raise it because I understand
that the structure of the programs appears to give a very
clear dividing line, but I just wonder -- it's part a
question and I guess part a comment. I just wonder whether
you see some permeability in that line that is of interest.

Thanks.

DR. SCHMIDT: I'm not sure if you're looking for
a response now or not, but that's definitely an area of our
work, and, yes, there is permeability. There are some
therapeutic alternatives that are [inaudible] and so
certainly some issues around [inaudible].

MS. WANG: I guess the question is, does it make
-- can you hear me? Does it make sense to at least keep
that in the peripheral vision of the future work around
Part D?
DR. MATHEWS: Yeah, Pat, obviously we would do that, and, you know, to the extent we have been concerned about drugs landing in both components of the program, in recent years we have made specific recommendations to address spending growth in Part B, most recently in 2017. And, you know, we anticipate doing some additional work in Part B over the next cycle. But your point about, you know, the lines between the two programs not necessarily being as clear as they once were is something, of course, we will keep in mind as we continue to do work in both parts of the program.

DR. CHERNEW: Yeah, so let me -- there's been several comments around the table, and obviously it's because the plan of this presentation is think about our future directions, and so there's been a lot of discussions about possible future directions. So let me make a big-picture comment.

We will continue to work on topics that some might view as small technical fixes in this state. A good example could be risk adjustment and rebates and how that matters. That's a topic we've dealt with. There's a range of things in Part B. We've been worried about biosimilars
and biologics, how they're bundled. And there's a slew of other things one might think are smaller. Frankly, in the Part D discussion which we're having now, there was an enormous amount of work done last cycle, and I think that was terrific. And there's some cause that -- that's one reason we haven't really gone after it strong in this cycle is to see how that recommendation sort of moved along and let it sit a little bit.

But we will continue not only to think about areas where there are sort of what I would call, for lack of a better phrase, smaller -- that doesn't mean small -- relatively smaller technical fixes. In addition, now that we have the data, we will try and shed light on where some of the dysfunction is. There's obviously a lot here. And then the last point, building on, I think, where Paul and Larry and others were, so I apologize to those of you that I'm not lumping in this group, there's some really big directional things about how much we pay for drugs and particularly how much beneficiaries, therefore, have to pay and a whole -- what I would call much bigger things, like the topics that we're taking on last cycle, and we won't shy away from them when we find constructive places to
I don't think we're going to have as comprehensive of a Part D summary in the next cycle, for example, just because we had one last cycle, and I think that will have to wait. But that doesn't mean we don't look at some of the issues here, and certainly there's going to be a lot of effort around rebates and other types of discounts and the impact on beneficiaries of some of what I would call dysfunctions that are going on in the market. And there will obviously be some connection between the B and D and the Part B plan and the MA-PD plan; those types of issues are always on our radar, as I think they should be and will continue to be.

I hope that was a comprehensive enough answer.

MS. WANG: It is, and just to put a period at the end of the sentence, my sentence, as between D and B the goal is to pay for the drug in the most efficient setting/way. That's all. That's where I was trying to go.

DR. CHERNEW: Yes, that's true. As I said, I think in response to another comment, one of the challenges, of course, is that B and D are structured fundamentally differently. It's not quite the same as
site-neutral might be and we're thinking about different
services in Part A or in Part B. They're just structured
fundamentally differently because of the role of the
private plans, and for that matter the role of the MA-PD
plans, which obviously you know well. So the way we have
to engage has to be cognizant of the institutional
differences in this space relative to other spaces, but
your main point, Pat, I agree with you completely. And
we're going to continue to work in those types of areas.

MS. KELLEY: Okay. I have Dana next.

DR. SAFRAN: Thank you.

Adding my compliments to Rachel and Shinobu, this
is ever complicated, extremely important, and you do such a
good job of distilling it and making it as clear as it can
be.

My comments go back or build on the question I
was asking earlier about value, and I guess, first, to
point out the obvious, what's so different about this
sector from the other sectors is Medicare doesn't get to
set the rates, that we're relying on the market to set the
rates here. So this wasn't part of our annual percentage
increase, and so we see the increases just going and going
And what's more, as you were saying in your response to my question, we don't really have any good measures of the value being produced out of this really important and costly area of coverage that's been added. So it's very unclear how we know if the market is working in the ways that we've asked it to.

So that really causes me to think about the work I've been involved with in the private sector, where in the private sector, self-insured employers are looking to take back control of the full end-to-end value chain from the PBMs, and they're looking to do that because analyses have shown that at every point along that continuum, there are profit pools being called by the PBMs that purchasers are frankly just fed up with and they want to take back control of their money.

And they're doing that in part by beginning to work with new innovator PBMs who are willing to just be claims processors, which is how the PBM industry started, to do fully passthrough pricing without rebates, and it does cause me to wonder whether Medicare could begin to experiment in a similar way.
Now, these platforms are small, and there's no way they could accommodate significant volume from Medicare, I think, my knowledge of them at this point, but it certainly would send an interesting new signal to the market if Medicare started to do some pilots with those innovative PBMs. So I offer that for consideration.

Then also, just to build on my other question from earlier, I do think it's important that we begin to have a better ability to compare what we're getting from the PDP and the MA-PD. What MA-PD brings that PDP doesn't is the total cost of care accountability that those plans have, and so, in theory, we should be seeing not just smarter purchasing but also better uses of medications to deliver better control and outcomes because those plans are accountable for that, so really thinking about how to begin to accomplish the same thing on the PDP side, leveraging our ACO programs, but also just an ability to compare the value that we're getting in PDP and MA-PD, not just based on adherence but also based on actual outcomes.

So those are my thoughts. Thank you.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you so much.
So, as a person who hasn't been on MedPAC until this year and who has not had responsibility for thinking about Part D until now, I just want to thank the staff for an absolutely brilliant chapter. It was very eye-opening to me, and I really appreciate the illuminating comments from my fellow Commissioners.

A few thoughts from me, in terms of international comparisons, it seems to me that that's sort of you're looking at a quadrant, but I really did resonate with what Paul said about value and also Dana's and other comments about value, really looking what's the outcome of this huge expenditure.

I tend to resonate with Bruce's comment on deflation, understanding, of course, the need for innovation as well, but I tend to resonate with that. Certainly support the comments about long-term care pharmacy that is in the recommendation and that David brought up.

Then there's other pieces of homework that I need to do. For example, I don't understand how the reinsurance attachment point was initially set and if there's any opportunity there, but that's something I'll study offline.
So thank you very much. I'm very enthusiastic. I appreciate the hard work.

MS. KELLEY: And I think the last comment I have is from Amol.

DR. NAVATHE: I just want to echo comments from the Commissioners about the great work here, Rachel and Shinobu. Very complicated. You guys always somehow pull off making it quite understandable. So thank you for that.

I just wanted to amplify a couple of comments that the Commissioners have made, so I think just recapping, I think, pulling you here. The chapter did a nice job of discussing the RxHCC risk adjustment model and the impact that the rebates, presumably getting access. The rebates data could give us a better understanding of how many distortions we get because of that.

I think even the sort of sample analysis that you guys did was very provocative. It's almost definitely true that there is a whole variety of different distortions that we're actually seeing in terms of how the risk adjustment system works and, therefore, the way that premiums are determined.

So I think that part is fundamentally really
important. So I think that was tucked in a couple of Commissioners' comments, but I think didn't perhaps receive its own singling out, if you will. So I wanted to make sure that we do that.

I also wanted to just say I, of course, support the general work around competition here. I had a question earlier about the competition for the LIS side. I think looking at the distribution that you guys showed, it's pretty compelling that the more competition that we can produce under the LIS side also is important and could save the program a considerable amount of dollars in terms of efficiency.

Lastly, I just wanted to also echo support for not only the general pieces, but there do seem to be some pockets of just particularly obvious value that we should be focusing on, such as the use of biosimilars and why that hasn't taken off. That suggests, I think, an interaction between some of the points that Larry has brought out and others have brought out between the kind of interaction between plan and beneficiary.

So thank you for a great chapter, and I really look forward to pursuing this work further.
DR. CHERNEW: So we're just about at time. Thank you all for your comments. There was actually, I think, a lot of enthusiasm and a lot of consensus about where we will go. We will review all of the comments, and I've made some of my summary comments at various points along the way so I won't make them again. But it's certainly an area that is, A, very important, B, increasingly important, C, really important for the care that beneficiaries get and the quality of care that they get. So I don't think you have to worry that we will not be spending time looking at this. I think as I may have said to some others of you, the challenge is always going to be matching our tools to our aspirations, what we would like to have happen with tools, that we have to try and make that happen, and we will continue to do that both for smaller and bigger issues.

So, again, thank you, and I think if there's nothing else that Jim or Rachel or Shinobu want to add, we're going to move on.

[No response.]

DR. CHERNEW: Once, twice, sold.

I think we are now going to talk about the SNF
value-based purchasing program and some work that we've
done on our proposed replacement.

Carol, are you leading off? Sam or Ledia?

DR. CARTER: I am. This is Carol.

DR. CHERNEW: Okay. Carol, take it away.

DR. CARTER: I will. 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're going to continue our conversation
about MedPAC's mandated report on the SNF value-based
purchasing program. The Protecting Access to Medicare Act
of 2014 requires MedPAC to review the program's progress,
assess the impacts of beneficiaries' socioeconomic status
on provider performance, consider any unintended
consequences, and make any recommendations as appropriate.

Our report is due June 30th of 2021. We plan to
include it as a chapter in the June report.

To meet this due date, we have been working on
the following time table. Last September, we reviewed the
current program's design and summarized the results for the
first two years of the program. You discussed the shortcomings of the design and concluded that the program should be eliminated.

In October, we outlined an alternative design, estimated its potential impacts, and compared the impacts of the current and alternative designs.

Based on these discussions, we've outlined policy options for your consideration.

Based on your discussion today, we expect that the Chair will draft recommendations for you to consider at the March meeting and to vote on in April.

So to quickly review the results of the program, in each of the first two payment years of the program that was fiscal year 2019 and 2020, the majority of providers had their payments lowered by the program, 73 percent in 2019 and 77 percent in 2020. We will add the third-year results once we have completed our analysis of them.

Many SNFs earned back essentially none of the amount that was withheld, the 2 percent -- 21 percent of SNFs in 2019 and 39 percent in 2020. Few SNFs received the maximum increase. In 2019, 3 per of SNFs earned the maximum, which was 1.6 percent.
In 2020, fewer SNFs earned the maximum, but the maximum was larger, 3.1 percent.

The trade press has observed that these incentive payments may not have been sufficiently large to motivate improvement.

We also found that incentive payments were generally higher for larger providers, for providers whose patients had lower risk scores, and for providers that treated fewer patients at high social risk, as measured by share of fully eligible dual beneficiaries.

We also found that providers' performances were fairly inconsistent across the two years. These patterns suggest a couple of revisions to the program. First, social risk factors should be considered in making the payment adjustments. This would counteract the fact that it is harder for providers that treat a high share of patients at high social risk to have good quality outcomes. Second, raising the minimum counts would help ensure that the results are more reliable and less variable from year to year. Third, expanding the measure set would also help smooth out inconsistencies in performance that is gauged using a single measure.
In considering how the program might be restructured, we looked at the current flaws of the program and the ways to correct them, and in the next two slides, I'll be comparing the current flaws and the design features of a proposed value incentive program.

First, instead of a single measure, the alternative design uses a small set of measures tied to outcomes and resource use.

Second, raising the minimum count to meet a widely accepted reliability standard will help ensure that the measure results are reliable, especially for low-volume providers.

Third, the value incentive program establishes a system for distributing rewards without the cliff effects. The scoring encourages all providers to improve.

Social risk factors should be considered in assessing performance because it is harder for providers that treat a high share of patients at high social risk to have good outcomes.

While the current VBP does not consider the social risk factors of a provider's patients, the proposed design does. The alternative design would account for
differences in patients' social factors, risk factors, when tying performance to their incentive payments.

Finally, the alternative design with SNF VBP would distribute all funds back to providers as rewards and penalties.

As we were working on the design to address the shortcomings of the current program, in late December the Congress made changes to the SNF VBP.

The Consolidated Appropriations Act made changes that are consistent with what we've talked about. It gave the Secretary of Health and Human Services the authority to expand the measure set and requires that the data are validated. This would apply to the provider-reported measures.

It also bars the program from applying to providers that do not meet a minimum volume for each measure. Depending on how this measure is implemented, that is, if the current minimum volume remains the same, the results may still be unreliable.

The legislated changes do not address three design flaws: the scoring cliffs, the lack of consideration of social risk factors, and the fact that the
program retains a portion of the incentive pool as savings.

So while the changes are a positive development, there is more that needs to be done to improve the program.

And now I'll turn it over to Ledia to review the VIP design in more detail.

MS. TABOR: The first key element of the SNF VIP is that it scores a small set of measures. The Commission has stated that value incentive programs should use measures of outcomes, patient experience, and resource use to gauge provider performance.

The design we modeled used three claims-based measures: hospitalizations during the SNF stay, successful discharge to the community, and Medicare spending per beneficiary.

In October, we talked about the need for patient experience measures. Measures and surveys to collect this information have been developed but not finalized for implementation. These measures need to be finalized and used in public reporting and included in a value incentive program.

Second, the VIP incorporates strategies to ensure reliable results. The proposed design uses a higher
reliability standard to set the minimum stay counts. For
the measures we modeled, 60 stays are required, which
translates to a .7 reliability, compared to the .4 percent
the VBP uses. By using a higher reliability standard, a
provider's results are more likely to reflect actual
performance and not random variation and will be less
likely to vary from year to year.

To include as many providers as possible in the
program, the performance period could span multiple years.
Although there are pros and cons to this approach, as
discussed in this paper. In our modeling, the performance
period spans three years.

Third, the proposed design establishes a system
for distributing rewards without cliff effects.
Performance on a measure is assessed against the national
performance-to-point scale. In the SNF VIP modeling, we
set the scale using a distribution of all SNFs'
performance.

By applying a continuous performance-to-point
scale, every achievement is recognized by earning
performance points. There are no cutoffs, no minimum
thresholds to meet to earn performance points, and no
topping out for the best performers.

Fourth, the VIP accounts for differences in provider patient populations. The Commission has said that Medicare should take into account differences in provider populations through peer grouping. Like other MedPAC VIP programs, in our modeling, we set peer groups based on a provider's share of fully dual-eligible beneficiaries.

Within each peer group, incentive payments are distributed to each provider based on its performance relative to its peers. The peer grouping is a way to compare the performance of providers with similar mixes of patients at high social risk. As the share of fully dual-eligible beneficiaries increases, providers have the potential to earn larger rewards for better performance. With this approach, performance rates remain intact, while payments are adjusted.

Finally, the design would distribute entire provider-funded incentive pools as rewards and penalties and would not be used to achieve program savings. The Congress has other policy levers, such as updates to payment rates, to lower the level of payments, if warranted.
Each year, the payment adjustments tying performance points to payments would be calculated to fully spend out the incentive pool of dollars. We compared the performance of the current program with the illustrative value incentive program. Here, we look at impact on providers with different shares of patients at social risk.

On the left are the payment adjustments under the current program. We show five peer groups, with low shares of fully dual-eligible beneficiaries in yellow and high shares in red. On the left, the incentive payment adjustments get more negative under the current program as the share of dual-eligible beneficiaries increases.

In contrast, on the right are the adjustments under the VIP. Under this design, the average adjustments are much smaller, and they are more equitable across peer groups. This would counteract the disadvantage these providers have in obtaining good outcomes and would dampen the incentive to avoid patients with more social risk factors.

Now we look at how the alternative design would affect payment adjustments for providers treating patients.
with different average medical complexity.

On the left are the results of the current program and on the right are the results of the illustrative design. Under the current program, on the left, providers with low average risk scores have positive payment adjustments, on average, while providers with high average risk scores have negative payment adjustments. This could result in patient selection, where providers avoid admitting medically complex patients.

In contrast, under the alternative design, on the right, the average payment adjustments were not related to medical complexity of the patients. As a result, providers would have less incentive to avoid medically complex patients.

The paper includes other results by provider groups. Most notably, nonprofits and hospital-based providers would have higher payment adjustments than other SNFs.

In summary, the SNF VBP is flawed. The VIP design addresses these flaws. Compared to the VBP, the VIP design better motivates providers to improve their quality and dampens the incentive to avoid beneficiaries with more
social risk factors and that are more medically complex.
The recent legislation corrected some flaws of the program but there is more opportunity to improve.

Here is the policy option for your discussion today. The Commission's feedback will shape the development of potential Chair's draft recommendations that would be presented at the March meeting. First, eliminate the current SNF VBP. Second, establish a SNF Value Incentive Program that would meet the design elements we have previously discussed. Third, finalize development and begin to report patient experience measures. The first two portions of this option would be directed to the Congress with a third to the Secretary of Health and Human Services.

I will now turn it back to Michael and look forward to the discussion.

DR. CHERNEW: Great. We're going to jump into Round 1 in a second. I just want to clarify, for those that are listening. Unlike the telehealth discussion we had yesterday, where we discussed policy options that weren't envisioning moving to recommendations and a vote, this is actually the step that precedes draft recommendations and then we'll proceed on a vote. The vote
will probably be -- the schedule now is in the April meeting. We'll have draft recommendations in March. So to give you some idea, that's the direction we're going. This is not the first time we have seen the SNF VBP discussed, but that's sort of the track where we're going, so comments, observations, if people are comfortable with that track are super important.

So with that we should start with clarifying questions.

MS. KELLEY: Okay. Larry, I have you first.

DR. CASALINO: Thanks, Dana. Nice presentation, as always, guys. Could you show the slide again, the first modeling slide in the incentives that would be paid out, by peer group? Yeah, that one. So am I reading this correctly, to say that in the MedPAC recommended model the payment adjustments, or the incentive payments, let's call them, would be very small? Is that right, or is that a bad interpretation?

MS. TABOR: Yes. In our modelings they would be small. I will say these are average net payments so there is still a range. We use the 5 percent withhold in the modeling so it could go up to 5 percent, or it could go
higher than 5 percent but not lose -- the penalty couldn't
be more than 5 percent.

DR. MATHEWS: Can I ask for a clarification on
your answer to Larry's question? So on the right-hand side
of Slide 14 here, what this is showing is not necessarily
that the payment adjustments themselves would be small,
because with a 5 percent withhold they could be plus or
minus 5 percent. What this slide is showing is that the
amount or the magnitude of the withhold does not vary
systematically, under our construct, as a function of the
share of full dual eligibles the way it does under the
current SNF VBP, where the larger your share of full dual eligibles, the larger your negative adjustments.

Ledia, is any of that correct? I'm keeping my
fingers crossed that it is.

MS. TABOR: That is all correct.

DR. CASALINO: So I think I'm not understanding
that. So if we look at the red bar on the SNF VIP
modeling, which is about 0.2, what exactly does that 0.2
state? What is that?

MS. TABOR: That is the average net payment
adjustment for the providers in that peer group.
DR. CASALINO: So is that 0.2 percent or 2 percent?

MS. TABOR: 0.2 percent of payment.

DR. CASALINO: So, Jim, I must not be understanding still what you said. So that looks to me like a very small incentive, but I must be interpreting it incorrectly.

DR. MATHEWS: Let me make another run at the explanation here. This is when you array the percent adjustments by peer group category, and what this is showing is that in contrast to the current system, where the higher your share of duals the more disadvantaged you are, that here the SES of your population, at least as measured by full duals as a proxy, isn't going to systematically influence your performance. However, if you took SNFs performance and just arrayed it on an ordinal basis, best to worst, you would have a very different-looking histogram here. Again, Ledia, is that correct?

DR. CASALINO: Okay, I think I understand now. So I did understand, at first, looking at these slides, that this shows that you won't be penalized anymore for having lots of dual eligible patients, so that I get. But
the 0.2 there is the average incentive payout that we're modeling for SNFs in that peer group. Individual SNFs can earn much more or much less.

DR. MATHEWS: That is exactly right.

MS. TABOR: And I would refer to -- this is an average, and I would refer to Table 11 in the paper. That shows the range within each peer group, that you could earn up to a 15 percent reward or a 5 percent penalty.

DR. CASALINO: Yeah, I should have gotten that point from the paper. Okay, thank you.

MS. KELLEY: Okay, I have Jon Perlin next.

DR. PERLIN: Good morning, and thanks, Ledia and Carol, as always, for an excellent report.

I assume the answer to this is yes because of the nature of the metrics that are being introduced into this new value-based payment program. But it always strikes me that as we address one more circumscribed policy issue, are we setting the trail toward our ultimate destination? I was wondering if you could comment on how this builds forward to our current concept of unified PAC PPS. Thanks.

DR. CARTER: It is okay if I start? Yeah, so we think this is a really good building block because it would
create a model that a broader program, that spans the four
settings, could emulate, and it would give at least this
sector some experience under that model.

We purposely selected these measures because they
are uniform across the four settings, so they would be
ready to use across the four settings. But the whole
approach of peer grouping and risk adjustment -- the risk
adjustment is uniform, but I think it was yesterday it was
mentioned that we now have a mandated report on PAC VBP,
and we'll be looking at how this could be rolled out across
the four settings in that.

DR. PERLIN: Maybe just a brief follow-up. Maybe
a paragraph of context to that trajectory, how the pieces
come together, would really clue in the industry. Thank
you so much.

MS. KELLEY: So that's all I have for Round 1
clarifying questions. Should we move to Round 2, Mike?

DR. CHERNEW: Absolutely. I guess if someone has
a Round 1 question you now must build it into your Round 2
question. So I happen to know that David, you're up first,
but I'm turning it back to you, Dana, to call on David.

MS. KELLEY: Go ahead, David.
DR. GRABOWSKI: Great. Thanks, Mike, and thanks, Dana. And first, Carole and Ledia, great work. I'm really excited about the way this chapter and this set of recommendations is shaping up.

First, I was pleased to see that the Congress addressed the SNF VBP with some legislative changes. I do believe this is a step in the right direction. However, the program is better but still not well, and that's why I think the SNF VIP is an opportunity to really fix the full sort of set of problems that you've identified with the SNF VBP.

As the program currently stands, even with the legislative changes, I still don't believe it's equitable or effective at directing payments to the highest-performing facilities. Though SNF VIP would be much more equitable, obviously by accounting for social risk factors, per Larry's comments and questions just a few minutes ago, while also expanding the measure set here to better approximate quality.

So let me list out what see are the real sort of positives of the program and then highlight a few concerns. Things I really like here, I have always been troubled by
the reliance on just a single measure, the readmissions measures, so expanding the set of measures is really important. I like that we're using a higher minimum state threshold for greater reliability. You mentioned the elimination of the "cliff" effects. I think that's really important. The peer grouping by duals is a great step. The improvement in the risk adjustment is also incredibly important.

And then finally, I don't know why we have had this holdback and not paid out all the dollars in this program. The idea that this was a budget saving program never made any sense to me. So I'm really pleased about all of those elements.

Let me now tick off just a few kind of concerns, and I know these are already on your radar screen, Ledia and Carol, but at least I will talk a little bit about them. The first, and you didn't raise this during the presentation or I missed it, but in the chapter you talked about incorporating a satisfaction measure, and that came up, obviously, during our last discussion.

You did reach out to CMS. I didn't find the agency's response very compelling on this issue. Their
response was this is hard and yes, I agree with that, but I really think this is an important part of the program, that we have these three claims-based measures right now. How do we get a measure of satisfaction? And I think really pushing them on development of such a measure, that would really kind of round out the measure set here.

Second comment or concern was really about how best to maximize the number of participants in the program. This minimum state threshold is really important towards improving reliability. You mentioned, in the chapter, and you touched on it during your presentation, this tradeoff between kind of a higher minimum state threshold in the most recent year versus kind of using multiple years of data, and maybe weighting the more recent year with kind of an integrator amount.

I like using multiple years with weighting in the most recent year in order to increase the number of participants in the program. I feel like with a minimum state threshold we might lose some smaller SNFs. And so if there's a way to kind of maximize the number of participants, I realize then we're using data from two or three years back and that's suboptimal, but maybe by
weighting the most recent year a little bit more we could get around that issue to some degree.

There was a text box in the chapter around kind of how do we sort of match the information that is being provided in this program to quality reporting. One of my other kind of policy hats, in addition to MedPAC, is I serve on the CMS technical expert panel for the Nursing Home Compare website. That's the CMS nursing home report card where they produce a lot of quality information. These measures we're discussing today are totally different than the measures that are presented on that website, and I can say as just a broader comment, MedPAC's philosophy around quality reporting is very different than CMS's, based on my experience. Just two very different views where if you were to go on Nursing Home Compare there's 30-plus measures and lots of details, whereas MedPAC prefers a smaller set.

And I'm just wondering a couple of things there. I love the idea that was raised of trying to better align the information that's being used. I think that will be more straightforward for consumers but also for providers in terms of producing the information and actually
responding to these measures.

The one kind of final element that's really emphasized in the CMS Nursing Home Compare website is staffing. That's not something we've taken on here. I realize it's very different than your typical MedPAC measure but the staffing data that's now used in nursing homes has improved a lot with the Payroll Based Journal data. I don't know that I'm advocating we include it but only kind of think about this alignment. It's a really important measure to a lot of consumers. It's a really important measure in the nursing home space. I realize this blurs the kind of post-acute and long-stay populations, but it's really important to think about how we're thinking about quality on that side versus this program.

So just to sum it up, I'm really excited about where we're going, Carol and Ledia, with this, and some ideas that maybe to further improve our recommendations. I'll stop there and say thanks.

MS. KELLEY: Okay. Marge, you're next.

MS. MARJORIE GINSBURG: Well, notwithstanding David's comments about additional work we have ahead within
this, what I wanted to comment on was the fact that how
much we reinforce the idea that this is urgent. And, in
fact, it said on page 1 the Commission concluded in October
that the SNF VBP should be immediately eliminated. That
sense of urgency is written throughout this, so my comment
is, do we really have to wait until June if we can actually
ever work it all out that we're all happy? The idea that
this is a mandated report, which means we don't really have
to wait to include it in the policy report in June, and
would it not have, in fact, perhaps more impact, get more
attention, raise more flags if we sent it out separately?
So my recommendation is let's not wait until
June. At least let's consider this. Let's clean it up and
maybe send it out in April. But to send it out like in the
June report. Thank you.

DR. CHERNEW: So, yeah, let me jump in on that.
A few things. We'll see how the rest of this discussion
goes, and again, this is not our first discussion on this
point. But unfortunately, the process by which we get to
actual recommendations, which involves a vote, and we need
to stick to that process. What we don't, and that's
certainly clear in telemedicine, is in our engagements with
the Hill and what happens, all the directions we're going
can inform those discussions and they inform any comment
letters we may make.

But I think in this particular case, because
we're going to have to get the draft recommendation, and
because we're going to have to get to a vote, and because
we will do that by June, our ability to do anything much
before June I think is really severely limited. I was
going to say a little more about that but I'm going to
defer to you before I do. Jim?

DR. MATHEWS: Yes. So we do indeed, as Mike
said, have a process, and we have a two-times rule when it
comes to formal recommendations -- here's the draft and
here's the one you're going to vote on. I also agree that
just by virtue of having these discussions in public and
the technical assistance that we provide the Congress
between meetings, we are sending a clear signal of where we
think the SNF VIP work should go, and that is not missed by
any of the intended audience.

And then lastly, from a production point of view,
even putting together our March and June reports along with
everything else that we do is just exquisitely, tightly
wired. And if my production manager is watching these proceedings she is no doubt on the floor of her den having a heart attack right now. So we'll call an ambulance. We'll make sure she's okay. But we've got to be cognizant of just the logistics as well.

So the message is being heard.

DR. CHERNEW: So the last thing I'll say is even though we are in a transition of administrations and the change in the leadership of CMMI and all the things related to that, I actually think that there's not a lot of pressure to come out with this a lot sooner, particularly now. I think telehealth is one where it's really been a staff-at-night issue trying to figure out how to deal with the timing because of the pace with which telehealth stuff has been going and the complexity of that issue.

In this particular case, I actually think our timing will probably be okay given the timing that I perceive and what CMS would be able to do, particularly since they have moved a little bit in this direction, and I'm not going to quantify how much. They have moved somewhat in this direction anyway, so I don't think we are missing a big vote. In fact, I think we should be happy --
I think David expressed that we were -- that, in fact, some of the concerns that were raised have been moving into the broader policy discussion. So that's where we are.

MS. KELLEY: Okay. I have Jonathan Jaffery with a comment.

DR. JAFFERY: Great, thank you, and I won't belabor it. Of course, it's always hard to follow David talking about some of these things. This is really -- I echo really his comments, and thanks, Carol, Ledia, and others. I think it's wonderful to see a chapter that not only gives some concrete things about advancing specific policies here, but as you laid out in the beginning, it really lays the foundation for some of our broader work around post-acute care.

The only thing I would -- I'm fully in support of all these pieces for all the reasons David mentioned and that you brought out. The only thing I want to emphasize even I guess a little bit more that maybe we can -- when we talk about the peer grouping, it sort of ties in some of the conversation we had yesterday that we recognize that this is where we are now and it's really helpful for us, but it's not -- we recognize that it's not sufficient, that
it doesn't capture everything. And, again, as I think David said in the past, for example, Medicaid eligibility varies by state. And so some of those shortcomings, just acknowledging them and saying that -- recognizing that we've got more work to do there and look forward to that.

Thank you.

MS. KELLEY: Brian.

DR. DeBUSK: First of all, Carol, Ledia, thank you. Just absolutely fantastic work. I'm really, really impressed with what you've done here with the VBP, particularly the methodological consistency. Really, really nice to see, you know, some of the same principles that we're seeing in the hospital VIP and the MA-VIP and all those other areas, very nice to see those uniformly applied and to see these same things appearing again and again.

I want to echo David's and Jonathan's comments as well. I think your treatment using peer groups for dealing with socioeconomic inequity or adjustments is outstanding. So really great work, and I hope we continue to pursue this.

MS. KELLEY: Dana.
DR. SAFRAN: Thank you. I'll just pile on. I really just so appreciate how this work has continued to evolve and take shape over the last couple of months. I think it's really important and valuable. I love the parsimony but breadth at the same time of the new measure set, and so I really appreciate everything about it.

I in particular would just call out that I really am glad that you've incorporated the work around reliability calculations and that we will propose even though past CMS policy has suggested that they might not incorporate the idea of waiting across three years. I'm really glad that you're proposing that and incorporating the important information about reliability, because without stable, reliable information, you know, we're just kidding ourselves if we think we're rewarding performance based on, you know, small, noisy pieces of data.

I love that you're removing cliffs and improving risk adjustment. I would just make two small comments about the risk adjustment. One is I think we all understand duals to be a quite inadequate indicator of social risk, and so I dealing with really encourage that we -- even as we use that in the beginning, continue to
explore how to make it better. And, in particular, I really favor exploration of incorporating data from census bloc group because I in my own work have found that gives very rich information that's a quite good proxy for individuals and much broader than what dual status can tell us.

My final thing -- actually, final quick two things. One is, as I previously highlighted -- and I apologize if I missed it in the chapter. I just couldn't quite tell whether the current approach that you're suggesting for peer grouping holds different groups accountable for different levels of performance or not. And I should have asked this in Round 1, so I apologize. But as you've heard me say before, I think it's a really important principle for us to vary the reward for providers who care for a more disadvantaged population but not the performance standard. So we would want to see the same level of performance rewarded regardless of the difficulty of your population, but your reward is higher. So I just didn't see that level of detail in the chapter, and I apologize if I missed it, but I just wanted to understand if that is, in fact, how it works from your perspective.
The last point is that, you know, I think COVID has really shown us the extreme vulnerability of this population, and I do wonder whether there are measures of safety that we can ultimately incorporate here. Even as I say that, you know, I debated with myself that perhaps the first two measures related to hospitalizations and then safe discharge or successful discharge to the community might be kind of ultimate outcome measures of safety. But I just wanted to make that point about whether there's any indicators of definitely that we could incorporate.

Thank you.

DR. CHERNEW: So, Carol and Ledia, let me try and address Dana's question about holding folks to different standards. The phrasing of exactly what's meant being held to different standards is a little complex, but I believe we're doing what you would want us to do, so let me describe that. And then I'll let -- I'm going to do a Jim thing and say, once I'm done with the comment, I'm going to ask Carol if I got it right.

But the gist here is the score for any organization is based on the exact same scale. If you're a 41, you're a 41; if you're a 92, you're a 92; if you're an
88, you're an 88. The score is computed exactly the same. What is changing in each peer group is how robust you get rewarded for that score. That's what the adjustment is doing. So, effectively, we are changing that relationship, and as the slide that Larry was talking about earlier shows, in the current model you can get penalized if you are serving more disadvantaged populations, so we end up penalizing those types of organizations in that peer group collectively. There's obviously variation within each peer group, but, collectively, those that are serving more disadvantaged populations are penalized in the current model. I believe I have that right. And what our model does is it sort of adjusts on average, but within each peer group, you still get rewarded if you do better.

So your score is what your score is, and it's comparable across all the peer groups. The payment changes. In each case if you do better, you do get paid more, so there's always a benefit to doing better. But as the chart that Larry was asking about before, I think, demonstrates, there's no longer a systemic skewness against organizations that are serving more disadvantaged people, and that's accomplished not by changing what we hold them
to. It's accomplished by changing the penalty levels or how we construct the penalties, some version of that.

Carol, do you want to set me straight? Ledia, do you want to set me straight?

DR. CASALINO: So, Michael, can I just confirm that I understand? And Carol and Ledia. So if you get a 41 in Group 2, it's a 41; if you get a 41 in Group 20, it's a 41. But the average scores in Group 20 are going to be lower and, therefore, you're being compared to your other peers in that group, and so the 41 will get you a bigger positive payment or a smaller penalty than it would in a higher SES peer group. That's part of the --

DR. CHERNEW: Yeah, I believe the answer's yes, and if this were Zoom, I'd give you a little thumbs up. But that is -- you said that -- in fact, if this is getting recorded or something, maybe we'll just write that in there, because what you said was --

DR. CASALINO: Yeah, I mean, it's -- yeah, it's a simple concept, but it's hard to -- simple but brilliant, but it's hard to word it non-ambiguously, and so hopefully that helps. But I guess my --

DR. CHERNEW: Well, you just worded it non-
ambiguously, I think. A 41's a 41.

DR. CASALINO: Desperation made me --

DR. CHERNEW: Yeah, okay, but a 41's a 41. It's just the amount you get for a 41 depends on where you are relative to your peer group.

DR. CASALINO: Right. But now I guess the question I have is: Who will see who got a 41 and who got a 75? Because we're not -- these results are not going to be publicly reported, correct? This is not Nursing Home Compare or whatever the new name for it is.

DR. CHERNEW: Yeah, I'm going to defer that question to Carol. So my focus, Larry, has been on the payment amount. The publication of the numbers I'm going to defer to Ledia and Carol.

DR. CASALINO: And, again, I think the idea is we don't want to risk-adjust this because we don't want to obscure the absolute performance. But we don't want to penalize people. We'll pay in the way we just discussed, but ideally people -- everybody would still be able to see who got a 41 and who got a 90. But is there any mechanism for that as we -- as the proposal is now?

MS. TABOR: I think we consider payment different
than what we would do for public reporting because there's
a science to both, and we really just focused on the
payment side. My hope would be that, you know, results
would be publicly reported, but kind of how to best do that
is a separate question. We did try to kind of cull that
out in a text box in the chapter, but we can, you know,
kind of add more to it if you all would like.

DR. CHERNEW: But the key point is, Larry, at
least in my opinion, we would report your score. We could
report your score. We could report your score relative to
your peer group, but the point is we would report your --
the key point is we would report your score. We would
never do a subtraction and say you're plus three relative
to your peer group. You would get your score like 41, so
that would be -- so people would understand that's what
your score was, and they would have to interpret that in
the context of the peer group. I think that's what you're
advocating for.

DR. CASALINO: Well, I think I'm just not clear
about the reporting mechanism. If there's already a CMS
nursing home reporting mechanism, how does the 41 get
reported?
DR. SAFRAN: If I could, I'll just say that I'm not sure -- and I'm happy to take it offline because I don't want to bog us down here. But I'm actually not sure, based on what Michael has said, that we're accomplishing what I hope we're accomplishing, because if what we're saying is that for certain Medicare beneficiaries who are more socially at risk, their providers will get rewarded for lower performance, then I think we need to think hard about that, because what I was hoping we were accomplishing is good performance is good performance regardless of what population you're serving, and poor performance is poor performance. But if you're achieving good performance with a harder population, you're getting a bigger reward for that.

So if you tell me that's what we're accomplishing, that's fantastic. But if we're saying that actually a 41 will get rewarded in some peer groups but not in others because in others that's low performance but in - - you know, then I would say that means we're holding folks to a different standard based on the population, and I'd be concerned with that.

DR. CHERNEW: Dana, we will go back. We did an
exchange after the last time we discussed this about the math, and we'll go back and revisit exactly where the exchange is. I thought we had gotten to a place where we sort of understood where we were, but we're not going to now work through how the exact math works. So then you'll see the way it works. There's certain things that have to happen mathematically in this context, whether you count it at -- it is the case, for example, that if you get a 41 and you do it with a more disadvantaged population, in the SNF model we're talking about, the SNF VIP, you would get a higher payment for achieving that 41 than you would if you did that with fewer disadvantaged people. I think that's -- and, again, Carol, I think what I said was right, but I believe, Dana, that is also a correct interpretation of the words that you said, which is good performance/good performance, you just get paid more for that if you're serving a harder population. And I think that mathematically leads to the property that I said. But, again, I don't know if we're going to be able to sort through all of the exact math here on the call, so we will make sure to clarify that as we move through to the draft recommendation to make sure we understand your concern and
really how to translate that into the actual mash.

   DR. SAFRAN: That's great, thanks. I just want
to make sure that we don't have to face out to the Medicare
population and say we will reward low performance for some
beneficiaries and not for others -- but we won't reward low
performance for others. That's just -- the optics on that
and just the policy on that would be poor.

   DR. CASALINO: If I may, though, Dana, I think
that is what this amounts to, and what -- I think that is
what this amounts to, for better or for worse. If that's
correct, that is one reason that it is important, I think,
to publish the scores so that people can see what the
absolute performance is. But I don't know how that would
work since CMS already has a public reporting program in
place.

   DR. CHERNEW: The challenge, I think -- and,
again, we will go through this -- is if you go back to the
slide that Larry pulled out, the question is how people
feel -- pointed out, it was the one that had the red bar.
Larry was talking about the red bar on the left-most one.
So in the current model, it pushes money -- because
currently SNFs that have a lot of dual-eligible
beneficiaries, in this case the red, on average perform worse, in the current model they get penalized. And when you look at the SNF VIP we're proposing, they don't get penalized, and the reason is not because their scores are any different. The scores are exactly the same as the scores in the other peer groups. It's just we don't take the money away from those organizations the same way we do in the existing current SNF VBP. And we can debate the merits of the optics of that separately, but I think, Carol and Ledia, I think I phrased that right, but if we do, I think it's consistent very much with what Larry said and, frankly, I personally advocate that because I don't want to take money away from the peer groups that are serving highly disadvantaged patients. I also don't want to make it seem like they're performing well. So what we've done I think is how I phrased it before, which is pretty much what Larry summarized, which is your score is your score, but how that gets translated into dollars depends on where you are in the peer grouping. And, again, we can go through exactly what the math looks like, but if you want to avoid taking money away from the SNFs that are serving disadvantaged populations, you're going to end up having
some version of the problem you raise, I think.

MS. KELLEY: Jonathan, did you have something on this.

DR. JAFFERY: Yeah, please, just I'll try to be brief. This has been actually a really important discussion, I think, and I want to thank Dana for pushing us on this.

I guess, you know, I've always viewed trying to adjust things based on social risk factors and what—not as a means to try and get additional resources to providers who are taking care of a more disadvantaged population, recognizing that there may be things that they need to do to invest in that care. And I guess as we -- I hadn't thought about it as much as I have in the last couple minutes, but I guess for me, what I'm starting to think about is that maybe we're doing it at the back end instead of the front end here, and that's creating some of this problem, that we're trying to say we're going to give people more payment if -- you know, associated with quality and outcomes that then gets inherently linked to some differentials in what the expectations are, as opposed to trying to somehow adjust that on the front end and actually
provide more resources via payments based on whether or not you're caring for a population that is on average more -- has higher social risk factors.

So I don't have -- I think that's starting to open up a whole can of worms now, so I don't mean to bog us down on that, but it does become a fundamentally different approach, and so maybe it's worth us thinking about that more at future discussions.

DR. CASALINO: May I comment again, or is there someone else in the queue?

MS. KELLEY: I have David in the queue, but I think he may have had a point on a different topic. So go ahead, Larry.

DR. CASALINO: Well, I'll just say I think, you know, the point Dana's raising is one that is important and, you know, people have been debating for some years now, and there obviously is no perfect solution. But I do think if there's no published reporting of the 41, then a SNF in a high dual-eligible group could just say, okay, I'm getting paid for these 41's, I can just kind of go on as I am, really. This is Dana's concern about apparently rewarding poor performance -- well, apparently rewarding
lower scores because the population is low SES, and they
need to give some motivation to keep improving your score
even if you're in a low SES peer group.

So one way to do that is to pay for improvement
as well as absolute score, but another way to put at least
some pressure on a provider organization, whether it's a
SNF or whatever else, to keep improving and not be
satisfied with a low score but good incentive because
they're in a high SES peer group, is to publish the scores
so that everybody can see that there's a 41 or two stars or
whatever.

So there's really two -- there's three tools, I
think, to try to motivate. One is the incentive payment;
one is the published reporting of the absolute score; a
third would be to pay for improvement. But, you know, that
can be quite complicated.

DR. SAFRAN: I'll just comment that, Larry, I
think the model here already does pay for improvement and
absolute performance. That's the beauty of getting rid of
"cliffs" is that for every increment of improvement,
there's more reward. So that's a model that I incorporate
into my work at Blue Cross that we found very motivating to
providers because you're rewarding both performance and improvement by having a continuum across which there is increasing reward.

I'm just looking for that continuum to be the same, regardless of what population you're serving, so that we say, like, here's the beginning of good performance, here's exceptional performance, and whoever you serve, you get rewarded for that. But you get rewarded more at every point on the continuum if you have a higher degree of difficulty based on who you're serving.

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

DR. NAVATHE: Yes. Just really quickly, I think, Dana, that was a nice description. That being said, I think any time we decide to reward more based on the population, I think we end up in this challenging situation of potentially end up sort of setting different standards concept.

That begin said, I fully support the idea of incorporating a piece on transparency here around the absolute performance, as, Larry, I think you started to push us toward, which I think is great.
The other part that I think that's important to remember is because the allocation is done within peer group, the incentive to improve certainly exists for every organization because if you don't improve and your peers improve, then staying stable means that your bonus goes down. That competition around quality itself is also, I think, fundamentally important.

We have to strike a balance between ensuring that we're recognizing the challenges that some SNFs may have in socially disadvantages areas versus others. I don't think that the peer group being by structure is absolutely problematic in that domain because of the incentives to improve, regardless. I think, again, the transparency part is a really good addition.

MS. KELLEY: Brian?

DR. DeBUSK: I just wanted to comment on the discussion about the peer grouping and rewards and penalties. I think it's important to separate out the measure of performance and making that data -- Amol, you touched on that as well -- making that data publicly available; for example, knowing where someone scores in the discharge-to-community rate on the relative scale. I think
making that -- publishing that in absolute terms and making that information available is different than categorizing these providers into different peer groups and handing out rewards and penalties, because, again, a discharge-to-community rate for Peer Group 1 which has the lowest share of fully eligible duals, the average discharge-to-community rate in Peer Group 1 might make you a 95th percent performer in Peer Group 20.

So I think we need to untangle the issues of absolute performance, which should be transparent, which should be published, versus how we hand out rewards and penalties, which then can be compartmentalized by peer group, just to ensure that we aren't penalizing the lower socioeconomic groups simply because they are lower SES.

Thank you.

DR. CHERNEW: So I'm not sure how many people want to jump in on this more. I think we might want to bring this part of the discussion to a close.

Dana, I think I understand what you're saying.

The challenge in many ways is to get the math of what you're saying right. To some extent -- and, again, I've been sitting here pondering if I should use these words in
a public meeting -- this is a little bit about an intercept
versus a slope, and we could discuss exactly what you mean
there. But the point is if you give a different value,
whether you shift the intercept or the slope, when you get
to a point, there will be different rewards for people
based on the population that they serve.

           You can't not have that happen. There is no way
it will not happen. You might think there's some level of
performance below which no one should get anything, that if
you move down the performance gradient, it shouldn't matter
what your score is -- I'm sorry. If you move down the
performance gradient, it shouldn't matter what your SES is.
You shouldn't get rewarded, that you to have and look and
see where that is, but the fact of the matter is if you
plot out the actual performance and how it relates to the
SES amount, if you don't adjust the payment by SES, you end
up pooling a lot of the money away from the organizations
that serve low SES people, and that's what I think is
fundamentally problematic.

           You could solve that problem by shifting a slope.
You could solve it by shifting an intercept. We can look
how that plays out in the math, and I think you can go
offline to see where that goes. But there is going to be some point in which -- maybe I shouldn't have picked 41, my example. If you get a 92 and you have a very advantaged population, should that organization get the same amount of money as an organization of 92 in a disadvantaged population? And then you can move down the 92 to say, okay, well, what about 82? What about 70? And I can work that back, and at some point, those are going to have to stay separate, or our methodology has a particular functional form we can discuss. And we will work through the math, I think, offline. But this is really, I think, about that principle.

I don't know. I can --

DR. SAFRAN: Absolutely, I agree. I think we all agree that we want a picture that looks more like the right-hand side of the slide that's up where we are not disadvantaging SNFs that take care of disadvantaged populations, but I'm also looking to be sure we're not disadvantaging the populations themselves by settling for and rewarding low performance, because my own experience says that if you set the performance bar the same, regardless of the population served, those who serve lower
SES populations will rise to the challenge to deliver better care.

DR. CHERNEW: Yes.

DR. SAFRAN: And that's what I hope to accomplish.

DR. CHERNEW: Yes. So maybe there's a discussion about level versus change, and I think, Amol, you may have said something like this. But I will try to iterate this point.

My view is in order to prevent people from settling for low performance, what you need to do is set the price for better performance high, and so there's nowhere in the existing SNF VIP that anyone gets to rest on their laurels and say, "Oh, it's not worth it for us to do better." Everyone, no matter what they serve, no matter what -- this is set up that no matter what peer group they're in, there is an incentive to do better for those individuals.

So if the question is what is the incentive for you to improve, that -- in fact, I think the way it might work -- and I'd have to look. It might actually be higher. It's complicated for me to know exactly what the slope is
across the different groups, but the point remains no one
gets to say, "Oh, I did fine. I can now stop." There's
always a benefit for getting better in the way this is set
up. So everyone has an incentive to get better across the
board. There's never a point where we say, "Oh, you hit
41, but given your SES profile, that's fine." That's not
the way this works.

You're always better if you're at 41 to get to
42, as you're always better if you're an 81 to get to 82.
It's just the amount that you get increases. It's harder
to get if you have a different SES profile. That's
basically the way that this works.

So we've tried to maintain exactly that.

Basically, we're trying to get a picture that looks like
the right-hand side of this as opposed to the left-hand
side but do it in a way that gives every organization
incentive to move to better performance, and I think the
current formulary does that.

Carol? Ledia?

MS. KELLEY: Jon Perlin.

DR. PERLIN: I was actually going to weigh in,

but I'll share what I was thinking, which is I remember
facing this problem in managing the VA system. This is a little bit off the direct path here. But this is fundamentally a utility of process measures.

I realize there are limitations categorically with certain process measures, as there are with outcome measures, but those few that have to be tightly linked with outcome are measures that we can use across different risk populations, so just to think, as we're thinking about our evolution here, as there will be certain metrics that don't back us into a corner of unintended consequences. Thanks.

MS. KELLEY: Okay. I have no one left in the queue on this particular issue -- oh, I'm sorry. Wait. Pat. I do have Pat. Go right ahead, Pat.

MS. WANG: Thank you.

Just really quickly, this has been a really important conversation. I just wanted to weigh in that I think what we're looking at is sort of we're judging sort of fairness to institutions based on distribution of the award, but I think underlying this -- and I really appreciate Dana kind of raising it. This is my personal view. In the absence of really good risk adjustment of the measures themselves, there is no purity to these quality
metrics.

I view these approaches as an attempt, you know, to use the tools that we have, to recognize that these quality measures are not absolute.

Successful discharge to the community, if we deem that 41 is bad and that 82 is good, and a facility that has a high proportion of disadvantaged folks can only score a 50, that is not necessarily a reflection of what's good. If they were to score 91, it would -- housing is great, that social supports for that individual are great, that there is -- you know, that the person lives maybe in an elevator building with a doorman as opposed to stairs. You can tell I live in an urban area. I just want to say I don't -- and I'm not a quality expert. So I'll be the first person to say that.

Some of the quality metrics to me are a little bit -- they're not pure. It's not sort of like a mathematical certainty that successful discharge to the community is so absolute that we can't -- I view these as sort of back-door ways of pulling together the tools that we have to recognize that the measures themselves are not perfect. So I don't view this so much as giving a break to
the institution as a recognition of the situation that is real for people, that starts and extends way beyond what happens inside of a facility.

I am all for rewarding improvement and better performance and setting a high bar out there, but I just wanted to offer that perspective. I don't see this as sort of we're trying to be nice to these facilities. I think that it is more recognition that the measures don't capture the reality of a lot of beneficiaries. Thanks.

MS. KELLEY: Anyone else on this before I move to David on a different topic or a different issue in this topic?

[No response.]

MS. KELLEY: Okay. David?

DR. GRABOWSKI: Great. Thanks, Dana, and I can't help myself, but now I've got to weigh in on this as well. So I'll do it really quickly.

Larry raised a great point about transparency. We've had a real lack of transparency, I think, with the SNF VBP. If you want to lean who the winners or losers are, you don't find that on Nursing Home Compare. You go on the CMS website, and you download a flat file. And you
find the facility, and it's totally hidden somewhere on Medicare.gov.

Larry, I love the idea of bringing these results out and putting them on Nursing Home Compare, but as I said earlier, Nursing Home Compare is built around a five-star system with survey deficiencies, staffing, minimum dataset-based measures, claims-based measures. We have a measure here that's based totally on claims. It's just focused on post-acute. So it's a very different measure, and just harmonizing what we do or what CMS is doing on the payment side with what they're doing on the quality reporting side, there is a little bit of a -- not even a -- there's a lot of disconnect across the two.

So I love the idea of transparency, but it strikes me that it's easier said than done, just given the different systems. That will be great, and I think Carol and Ledia took some of this on in the chapter. Carol and Ledia, maybe you want to talk about transparency as being one of the goals of this program of getting these -- to get the 41 or the 96 or whatever. That's public information, and folks can see that as part of their report. That's a really nice idea.
But as Carol and Ledia know well, that's totally separate from what's currently reported with the -- you get one to five stars, Larry, and that's a totally different system.

I promised another comment. We spent a lot of time on part of Dana's comment, but she also had this, I think, really interesting point about are there safety-based measures that might be included. The one that we often point to, Dana, as you know well, are falls, and that's been this kind of great measure.

But, Carol and Ledia, talk a little bit about falls. Unfortunately, the minimum dataset, once again, is facility-reported. There's been some great academic work showing that if you compare sort of falls from the MDS versus claims-based measures of falls, they don't match very well. I think just a simple claims-based measure may not be frequent enough, but I do think, Carol, Ledia, I like where Dana is going with that, thinking about are there claims-based adverse events that in terms of safety that we could potentially leverage.

Maybe it's just a quick question. We haven't really explored this. Is it a small number issue? There
just aren't enough of those kind of claims from a given facility that it's really meaningful, but it is intriguing. Thanks.

DR. CARTER: Yeah. Ledia and I talked about safe measures yesterday, anticipating this question, and that was the one we came up with and then sort of talked amongst ourselves about the MDS versus claims-based measures the problems within, so everything you just laid out. So that's the dilemma.

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

[No response.]

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

DR. CHERNEW: Yeah. You couldn't hear me talk about how exhausted I've become.

So this is the policy option session. We will come up with a recommendation when we go forward. We will be very cognitive of this discussion. We will try and do it in language that don't involve intercepts and slopes, but the point remains I do think there's a mathematical problem that has to be solved, which will give you a point in the distribution where your SES population will influence how much you get paid. By definition, that will
create different payments for groups serving -- you can't
mathematically make that not create different groups. So I
don't want to relitigate that.

Actually, I should have just stuck with thank you
for the very rich discussion. We have heard it all, and we
will revisit it, and I do appreciate -- I think the word
that someone may have used was "conundrum." I do
appreciate the conundrum, and we will try and find a way
out. But we're going to do so in a way that makes sure, in
my opinion, that we don't direct resources away from
organizations that are serving some of the most
disadvantaged individuals, without signaling that it's okay
that their performance isn't very good. That's the core of
the conundrum, and that's what we would like to do, and
obviously, transparency is a part of that.

But for now, we're going to move on to another
topic which is vaccines. This is something we've been
working on a long time before the current vaccine activity,
which is obviously crucially important, but I think, Nancy,
are you starting this off?

MS. RAY: I am starting. Thank you.

The audience can download a PDF of the slides on
Today we are going to continue our discussion from the September meeting about Medicare coverage and payment for vaccines. Many other people beside the three of us listed here have contributed this work, including Rachel Schmidt, Shinobu Suzuki, and Bhavya Sukhavasi.

During today's session, I will first summarize Medicare's quality efforts to measure vaccination rates across providers and plans. This is in response to Commissioners' requests in September for such information.

Next, Kim will discuss two policy options on vaccine coverage and payment based on your discussions at the September meeting. The first relates to moving all appropriate preventive vaccines under Part B, similar to the Commission's 2007 recommendation. The second option is in response to your request for alternatives to improve Medicare's payment method for Part B vaccines.

It would be helpful to get your feedback on the policy options and whether you would like us to work with the Chair to develop them into draft recommendations.

In response to Commissioners' request, we found that use of vaccine-related measures for public reporting...
on medicare.gov and in the providers' quality reporting programs varies across fee-for-service providers. For example, for hospitals paid for under the inpatient prospective payment system, cancer-exempt PPS hospitals, long-term care hospitals, inpatient rehabilitation facilities, measures assessing influenza vaccination of healthcare personnel are used in each setting's quality reporting program and are publicly available on medicare.gov. By contrast, no measures are used for the other provider types listed on the slide -- ASCs, dialysis facilities as of payment year 2022, hospice providers, and SNFs. Some clinician specialties have the option to be scored on vaccination measures. Otherwise, vaccination rates are not scored in any of the value-based payment programs for fee-for-service providers as of payment year 2022.

ACOs are currently scored on flu vaccination rates of their beneficiaries, but beginning in payment year 2022, ACOs will be scored on a smaller measure set which does not include any vaccine measure. Flu vaccination of beneficiaries is publicly reported and scored in quality bonus program for MA plans.
Now Kim will take you through the two policy options for your consideration.

MS. NEUMAN: Good morning. So first we'll talk about the policy option related to Medicare coverage of vaccine. Medicare coverage of vaccines and their administration is split between Part B and Part D. Part B covers preventive vaccines that are specifically named in statute, that is flu, pneumococcal, and for beneficiaries at medium or high-risk hepatitis B. The CARES Act added Part B coverage of COVID-19 vaccines in their administration.

In limited circumstances, Part B also covers certain other vaccines when used in response to an injury or direct exposure, such as rabies or tetanus vaccines. Part D covers all commercially available vaccines not covered by Part B. Shingles accounts for the vast majority of Part D vaccine doses.

When Part B or Part D cover the vaccine, they also cover the administration.

A few differences between Part B and D coverage of vaccines. Part B covered preventive vaccines are not subject to cost-sharing whereas Part D plans are permitted
to charge cost-sharing for vaccines, and those 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 of administration, but hospitals, skilled nursing facilities, home health agencies, and other providers also bill Part B for vaccines. Part D vaccines are mostly administered in pharmacies, but systems referred to as clearinghouses have been developed so physicians can generally bill Part D for vaccines.

In June 2007, the Commission recommended that all Medicare vaccine coverage be moved to Part B. Some of the rationale for that recommendation stemmed from concerns that physicians would have difficulty billing Part D plans for vaccines 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 of all preventive vaccines 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 B and D. Also, coverage of vaccines under Part B without cost-sharing would ensure that cost-sharing is not a barrier to vaccine access for beneficiaries.

For these reasons, the Commission could consider a policy option to cover all appropriate preventive vaccines under Part B instead of Part D without cost-sharing. The language in this policy option is similar to the Commission's 2007 recommendation, except that it specifically states that there would be no cost-sharing for preventive vaccines under Part B in the future, whereas the previous recommendation had been silent on cost-sharing. Adding this language on cost-sharing would ensure that there is no cost-sharing for vaccines moved from Part D to Part B and for new preventive vaccines developed and covered under Part B in the future.

Next, we will turn to how Medicare pays for
vaccines. At the September meeting, we discussed how Part B's payment approach for preventive vaccines was inefficient, and Commissioners asked for additional analysis about how Part B payment rates compare to other pricing benchmarks and asked for alternative payment approaches that could be considered.

So first, some background on how Medicare pays for vaccines. Part B preventive vaccines are paid 95 percent of average wholesale price. AWP is akin to a sticker price does not necessarily reflect market prices. In limited circumstances, Part B covers a small number of vaccines in response to an injury or direct exposure, like a rabies shot after an animal bite. The payment rate in that situation is the same as for other drugs and biologicals, 106 percent of the average sales price. Part D pays for vaccines based on a plan-negotiated rate with pharmacies. Part D plans may also negotiate rebates with manufacturers, although we don't have data to know whether that occurs.

This next slide compares Medicare's payment rates for vaccines under Part B and D to wholesale acquisition costs. These payment rates are for the vaccine itself and
do not reflect the separate payment made for administration. Note that some of the data in this chart, in particular the middle column, has been revised from what's in your paper.

In the first column on the left, we compared Medicare's payment rate of 95 percent of AWP for flu, pneumococcal, and hepatitis B vaccines to WAC. As expected, 95 percent of AWP substantially exceeds WAC. For example, for the flu vaccine, 95 percent of AWP is about 17 percent greater than WAC for the median product.

In the last column on the right, we compare Part D's vaccine payment rates for ingredient cost to WAC. As you see, the median Part D payment rate is typically a couple percentage points above WAC.

A few of the vaccines covered by Part D are also covered in limited circumstances by Part B at a rate of 106 percent of ASP. And we can see in the middle column of the chart, that Medicare's payment at 106 percent of ASP is substantially below WAC for the products we have data.

So Commissioners asked us to think about alternatives to payment at 95 percent of AWP. One option would be to pay based on WAC, for example, 103 percent of
WAC, similar to the rate Part B pays for new drugs and biologics that lack ASP data. WAC is the price set by the manufacturer and it reflects the price at which the manufacturer sells to the wholesaler, and it does not reflect discounts or rebates to the extent they are available. But WAC is lower than AWP, and paying based on WAC would moderately reduce payment rates.

Another option would be to pay based on the average sales price. ASP is a market-based price, and reflects the manufacturers average sales price to most purchasers, net of rebates and discounts with some exceptions. As we saw in the prior chart, for those vaccines where we have data, ASP appears to be substantially below WAC. So an argument could be made to pay based ASP because it would reflect actual market prices rather than an undiscounted wholesale price.

For a few reasons, it could be helpful to have more data before considering an ASP-based payment amount. We do not know what ASP is for the current Part B covered vaccines that are paid 95 percent of AWP and how it much using ASP as the basis for payment would change the Medicare payment rates. Because ASP is an average, we do
not know how much vaccines acquisition prices vary across purchasers such as physicians. Understanding that price variation could help inform whether 106 percent of ASP or an alternate add-on to ASP is appropriate.

With vaccines, there is also uncertainty about how the two-quarter lag in ASP would affect Medicare's payments. So for example, that could be an issue given the seasonality of the influenza vaccine.

Given all this, an option that could be considered is to modify Medicare's payment rate for Part B covered preventive vaccines from 95 percent of AWP to 103 percent of WAC, and require vaccine manufacturers to report ASP data to CMS for analysis. The intent of this option would be to move away from inefficient AWP-based payment while ensuring beneficiary access to vaccines.

As an initial step, this option would base payment on WAC, which better approximates acquisition costs than AWP. This would moderately reduce payment rates, but to a level that should be accessible to providers.

Concurrently, this policy would require manufacturers to report ASP data for vaccines to CMS, so that the agency could study how payment rates would be
different if ASP were used as a basis of payment. As part of this assessment, the Secretary could, potentially through the Office of Inspector General, gather data on immunizers’ acquisition costs for vaccines to study how prices vary across purchasers. The collection of ASP data by CMS and acquisition cost data by the Secretary could build the knowledge base to consider and potentially develop a payment rate that better reflects market prices in the future.

So this brings us to the end of our presentation. We would be glad to answer any questions and look forward to your discussion. It would be helpful to get your feedback on the policy options and whether you would like us, working with the Chair, to develop them into draft recommendations.

So now we will turn it back to Mike.

DR. CHERNEW: I'm muted but I'm good. We had some discussion so I'm going to turn it to you, Dana Kelley, to manage any comments that people may have asked to make.

MS. KELLEY: I think Pat has a Round 1 question.

MS. WANG: Thank you. Can you guys comment -- I
just wasn't clear. There's the cost of the vaccine and
then there's the cost of administration. Is there any
implication to how the proposal to shift everything to Part
B, is there any implication for the site of vaccine
administration, whatever the distribution right now is,
pharmacy versus physician office, et cetera, as well as the
cost of administration? I know that the paper talked about
the desired kind of look at the cost of administration, but
aside from the cost of the vaccine itself, do you think
that there are implications for moving vaccines to Part B?
And I guess tucked in there -- this is sort of an
ancillary question, I guess -- is are there implications
for 340B, if everything goes to Part B and ordering of the
drugs or what have you is perhaps more reliant on 340B? I
just wonder if there is some other threads of implications
running behind the transfer.

I can't hear you, Nancy.

MS. RAY: So I guess I'll take the first part of
the question. In terms of implications for the site of
care, I think that's something that we'd like to consider a
little bit more. But, you know, right now I wouldn't
expect that there would be. But I think we would like to
think about that a little bit more and get back to you on that.

Kim?

MS. NEUMAN: I think we also should get back to you on the 340B question as well, to confirm that these products are not subject to 340B discounts. Let us double-check that point and we'll get back to you.

MS. WANG: Okay. Thank you very much. Where I'm going with this, I just want to understand if there are implications for the cost of administration, because in a pharmacy there really aren't, but in physician's office, to the extent that it's accompanied by an E&M visit or whatever, there just might be implications. Thank you.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Thanks, Kim and Nancy, for a very thoughtful chapter. You know, since the last time we discussed this I think all of us have been thinking about vaccines a whole lot more, and I certainly have been. I guess it's led me to the question on this slide that's up right now, 13, cover all appropriate preventive vaccines. What constitutes, as we think forward, an appropriate preventive vaccine? I know when we're contemplating the
context of that previously we were really thinking about infectious disease. And I remember we had some discussion about those things that span from infectious to, you know, what we consider oncology or cancer, like HPV vaccine.

But as we think forward and project the changes in technology, there may be anti-cancer vaccines, immunological approaches. And, in fact, some of them may not only be generalized, like the HPV vaccine, but, in fact, could be tailor-made for a specific individual, based on their genetic makeup.

And I just wondered whether we've contemplated were we to limit our concept of vaccine, which I realize this part is Part B, which I strongly endorse, with some circumscription of things that are likely coming down the pike that perhaps we're not ready to deal with yet.

Thanks.

MS. NEUMAN: So that does raise a number of complicated issues. I think that we have some discussion in the paper that talks about the definition of an appropriate preventive vaccine as being a key piece of this policy, and one of the things that we point to is potentially using a group like ACIP and their
recommendations on what vaccines are recommended for adults as a way to potentially define appropriate preventive vaccines. But we could think more about that and other alternatives.

The other thing I would note is that the definition of vaccine, as you say, is complicated, and there are some vaccines that prevent conditions, you know, like flu and pneumococcal. There are also uses of vaccines as treatments. There are certain cancers that are treated with a vaccine once you already have the condition. Currently Medicare treats those kinds of products as treatments to cure an illness or injury, and as such they're subject to the normal payment provisions for Part B drugs and biologics.

DR. CHERNEW: I think that was useful. In fact, in general, the one thing I realize is no matter what you do, we run into semantic problems. So I appreciate that comment, and of course, I also very much appreciate the challenge and the focus CMS faced because they run into the same semantic issue that they have to deal with.

I think as new things get developed and sort of get in the gray area, there will have to be decisions, and
we will have to make comments on those as they arrive. So I think now we're trying to get the system to work better for where we are now, and we will approach things that might stretch the gray area when the things that stretch the gray area arise. That's my take on this. Others may disagree.

MS. KELLEY: Larry?

DR. CASALINO: Thanks, Dana.

Could you show us Slide 9, please?

In terms of the payment rate or how Medicare pays -- this makes my eyes cross, but looking at the note there, some providers such as hospitals, SNFs are paid reasonable cost. So hospitals and SNFs are not a trivial part of the health system.

So I guess two related questions. What does reasonable cost mean? Two, how, if at all, does the policy option you suggest in terms of how Medicare pays for vaccines -- does out policy action interact with this reasonable cost thing for hospitals and SNFs or not, and if not should we have something to say about this reasonable cost way of paying hospitals and SNFs and home health agencies and rural health clinics?
MS. NEUMAN: So reasonable cost for vaccines is adjudicated at cost report settlement. We have not to date looked at what Medicare is paying on the cost reports for vaccines, but we're hoping we'll be able to come back to you with some information on that at a future session.

As the policy option is currently structured, it's focused on 95 percent of AWP, but we could consider whether it should be expanded.

DR. CASALINO: As you were talking, I realized I want to ask you a very basic question. Is the vaccine cost for a hospital or a SNF built into the prospective payment and not paid separately?

MS. NEUMAN: It is paid separately, and it's still adjudicated later.

DR. CASALINO: Okay. So it is reasonable to think that at some point, we might want to have a policy option for how these providers in this footnote are paid. I mean, hospitals and SNFs are not small, right, as part of -- or home health agencies as part of the health care system.

MS. NEUMAN: Right. As part of the whole health care system, they are not small.
You can see on page 10 of the paper, we break out the locations of vaccinations, and you can see that of those settings, hospital is the biggest of the ones paid reasonable cost. But it's a smallish, a much smaller share of vaccines than it is of other kinds of services.

DR. CASALINO: Thanks.

MS. KELLEY: Okay. I have no more Round 1 questions, unless someone wants to raise their hand now. So we'll go to Bruce on Round 2.

MR. PYENSON: Thank you. I want to compliment Nancy and Kim on just terrific work here, and the policy options that are discussed seem pretty much on target. I did want to have a comment for future consideration that we're getting into public health issues -- flu vaccine, COVID vaccine -- public health issues where the acute care system in the physician fee schedule are perhaps not the best way to meet the needs of Medicare beneficiaries.

We obviously have to move ahead with what we have in the structure we have, but I think as we look at the public health aspects of vaccinations as well as perhaps
public health aspects of other kinds of services, to think broadly about what's the best way that Medicare beneficiaries can get these services, there's all sorts of challenges, I think, for the beneficiaries and, frankly, for physicians in considering these are part of physician services.

But thank you. My compliments on this material. I think it's really very, very well done.

MS. KELLEY: That's all I have for Round 2, Mike.

DR. CHERNEW: I don't have a lot more to add, to be completely honest with you. I think this is a tremendous body of work.

So Amol has something to add, I see. So I will continue with my thank-you after Amol adds what will surely start with his thank-you. Go ahead, Amol.


I just wanted to point out that you guys do make the point in the paper itself that the Affordable Care Act created a no cost-sharing policy for commercial health plans, yet in Medicare, we don't have that situation. And
I just wanted to highlight that asymmetry, which we should hopefully all find very disconcerting and uncomfortable given that Medicare is always state government programs.

So as you guys have, you've laid out policy options that addresses that. I think that's very important that any policy option we pursue going forward has this parity, if you will, between the requirements of the Affordable Care Act for commercial plans and what we might pursue as a Medicare policy option.

DR. CHERNEW: Amol, thank you. That's certainly reasonable.

Jon Perlin. I'm sorry, Dana. People are raising their hands. So go ahead, Jon.

DR. PERLIN: Yeah. Just very quickly, first off, you made the point that this is a public health issue at one level, but, you know, Mike's very -- and VA is such a wonderful sort of test bed, its, you know, bias toward older high concentrations of chronic illness. The implementation of pneumococcal vaccination in VA -- and this is correlative, not causal, we actually published, actually decreased the rates of hospitalization.

So in thinking from a purely Medicare beneficiary
stewardship perspective, while there is a beneficial public health aspect, there's also a beneficial return for particular populations. In some instances, that return is actually faster than others, in fact, in VA. Moving the pneumococcal vaccination rate from about 24 percent up to above 90 percent saved the taxpayers about $60 million annually, so appreciate those distinctions. Thanks.

DR. CHERNEW: Paul?

DR. PAUL GINSBURG: Yeah. Thanks.

I'm glad Amol brought up the issue about Medicare seemingly being forgotten about when the Affordable Care Act required no cost sharing for vaccinations for both employer-based plans and individual plans, and I definitely support the first option.

On the second one, this probably should have been a Round 1, but I think it's a good idea to move from 95 percent of AWP to 103 percent of WAC. But what's the argument for not going to 106 percent of ASP, which we do for all other physician-administered cost?

MS. NEUMAN: So we talk about in the paper that there being some uncertainty about what the payment rates would look like at using ASP and as well as not knowing the
variation around ASP for vaccines and whether 106 percent
would be the right add-on or some other add-on would be
appropriate.

And then there's something related to vaccines
that's a little bit different from other products in the
sense that -- the flu vaccine is a really good example.
It's a vaccine that has seasonality to it, and the ASP
payment rates, the way they're set up, it's based on a two-
quarter lag.

So in the fall of the year, the ASP payment rate
would be based on the prices from two quarters prior, and
so there's some uncertainty of how that lag might affect
the rates. And so there could be benefit for additional
study to look at that, get the data, and make a
determination.

DR. PAUL GINSBURG: Yeah. So actually to use ASP
might actually require changes in the way the data are
collected, which may be more burdensome than just not
pursuing the ASP and relying on WAC.

MS. NEUMAN: Yeah. I think we don't know at this
point. We don't know whether the ASP would be just fine or
whether these unique things to vaccines should be factored
1 in, in some way.

2 DR. PAUL GINSBURG: Yeah.

3 DR. CHERNEW: I would just as an aside, actually it gets into what Dana was saying. We were having our discussion about Part D earlier today. I still worry in general with payment policies that are a percentage of anything that someone set because I'm worried that that basic formula is inflationary. This adds all this data component to it, but again, this is a broader -- right now, I think -- let me see if I can characterize this.

4 First of all, thank you all for your comments.

5 Second of all, I think the sort of main goal here, at least for me, is to think about how to make sure that we can get people access to vaccines in an efficient manner. I personally think this moves us in the right direction, and I hear some consensus around that, at least broadly. We'll come back with actual recommendations.

6 There are some issues around pricing, for example, that dovetail with other discussions we've had about pharmaceutical pricing over time and how that works, and I think those are the ones you're raising, Paul. And I agree with that, and I do think there's some unique data
issues here.

But, anyway, I guess I'm pausing for a second to see if anyone else wants to add. Kim or Nancy, do you want to add anything else to this discussion? Do you think you have what you need?

[No response.]

DR. CHERNEW: Jim?

DR. MATHEWS: I think we're good on vaccines.

DR. CHERNEW: I think we're good for the entire January session. So let me call our a particularly hearty thanks to all of the staff that did a lot of work, and I said at the beginning of the meeting -- and I will close in a moment -- particularly all the work they did over the holiday season. It really is remarkable to see your dedication and restores some of my faith in public service, so a hearty thank you.

To the audience that has joined us, remember this is a somewhat begrudging virtual meeting, and we would all like to see each other and you in person. And hopefully, we will be able to do that again. Notice how I dovetailed that into the whole vaccine session?

Anyway, we hope to be able to do that again, but
in the interim, please feel free to reach out to us on the website or other means. Reach out to the staff to give your comments on our work. It is important that we do our work in public, and we really do value that feedback that we get.

So for many of these sessions, including vaccines, but the others, we are going to be returning to them in March. We draft recommendations after we debrief from this whole discussion.

So I appreciate everybody's time. I hope that we have what is a good long weekend. I think we all need a long weekend to reflect on where we'll collectively end up in this country, and we will do that. So, again, have a terrific weekend, everybody, and thank you again for all your contributions and for participating in the meeting.

MS. KELLEY: Thanks, everybody.

[Whereupon, at 12:44 p.m., the meeting was concluded.]