MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

VIA GO-TO-WEBINAR

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DR. CHERNEW: Well, first of all, welcome to the public, assuming that you can see me and the tremendous members of the MedPAC Commission. I'm Michael Chernew. I am the new Chair of MedPAC, so I'd like to start by saying how honored I am and excited to be both Chair and to have such a tremendous group of people to work with.

As you can tell, we're not in the Reagan Building in D.C., so we all have to make sacrifices. So to the audience, I'll start by saying thank you for your patience about how we make all of this work.

We're going to do our best to replicate an in-person meeting and remain socially distant. We will see how that goes. This is the first time I've worn a tie in about five months. I want to give a particular thanks to the Commissioners and all the work they've done and all of the patience they've had as we've gone through this process, and an even heartier thanks to the staff that under really difficult circumstances has done an enormous amount of work.

So as in the public meetings in person, the way
this is going to work is we're going to start with a staff presentation. Then we will have Commissioner comments and interactions.

This first chapter is obviously on an incredibly important topic, the coronavirus, and so I would simply lead in by acknowledging the incredible hardships and work that different people have done. An enormous amount of the burden of COVID has fallen on Medicare beneficiaries, which are our focus. And I think as we go through this meeting, we can't forget the importance of the real group of people we serve, which is the Medicare beneficiaries. And I'd be remiss if I didn't call out an incredible appreciation to providers across the country for all the work they have done in hospitals and nursing homes and home health agencies across the board, and the physicians, obviously, in all of the areas that we touch. There has been incredible dedication and really people putting themselves at risk to provide care to people who need it, and I think it's worth starting this meeting with some acknowledgment of all of the work that they've done and all the populations that have been really seriously affected by COVID.
Sometimes you'll see our presentations are a bit dry, which is fine. We are a congressional agency. But understand that I know that all of the Commissioners, myself included, are really understanding of the challenges faced by the program and the beneficiaries, and these are really extraordinary times.

Hopefully we'll all be again in person, but for now thank you for joining us, and I'm going to turn this over to Jeff Stensland and some other staff to go through some information that we've compiled on the coronavirus pandemic. So, Jeff, I'm turning it over to you.

DR. STENSLAND: Well, before I start, I want to let the audience know that they can download a PDF version of the slides by clicking on the handout button, which is in the control panel on the upper-right-hand corner of the screen.

This session is a status report on the effect of the coronavirus on beneficiaries and providers. It is a preliminary analysis using available data and is not a deep dive into all of the ramifications of the pandemic. We will continue to monitor data as it comes available.

Now, we are the Medicare Payment Advisory
Commission, so we will primarily focus on payment issues and provider finances on the upcoming slides. But by focusing on the financial side of the equation, that should not minimize our respect for the human toll the pandemic has had on patients and health care workers across the nation.

In addition to the tragic effects on Medicare beneficiaries, the pandemic has affected provider finances. Today we will discuss the effect on Medicare beneficiaries and then discuss the aggregate effects on the finances of three sectors: hospitals, post-acute care providers, and clinicians. We report aggregate effects on provider finances. However, individual provider experiences will vary. In addition, we are limited to available data, and the comprehensiveness of the data varies by sector.

The effect of the coronavirus pandemic on beneficiaries has been stark.

Studies estimate that 80 percent of the deaths from COVID-19 in the United States have been in the 65 and older population. In addition, over 40 percent of the deaths have been among residents of nursing homes and assisted living facilities. The pandemic is a Medicare
issue.

The other major effect has been on access to care. Earlier in the epidemic, some providers were closed and elective procedures were cancelled. Telemedicine substituted for some in-person visits, as you will hear in detail tomorrow. However, even when providers were available, some beneficiaries were reluctant to seek in-person care.

The ultimate effect of these changes in access and patient outcomes is unknown. We will keep you updated as the literature develops.

Both the delayed and forgone care will have effects on provider finances, and we'll discuss those next.

I will start by talking about hospitals. As you know, hospitals' all-payer volume declined dramatically in April. Based on reports from hospital systems, we roughly estimate that hospital volume declined by about 40 percent in April for the average hospital. By May, hospitals reported a partial rebound in volume, with some hospitals still reporting volumes 10 to 20 percent below the prior year. In addition to public sources, we have been tracking Medicare claims data for certain services such as hip
replacements. As you can see from the bottom row, Medicare hip replacement volume declined dramatically, but then rebounded largely by June of 2020.

By the end of March, it was clear that hospitals would face clinical challenges and material declines in revenue. In response, the Congress enacted on March 27th $127 billion of grants through the CARES Act to hospitals and other health care providers. Importantly, these grants are designed to replace lost revenue. They are not limited to helping hospitals facing losses. Because hospitals can offset lost revenue with declines in costs, or at least partially, the CARES Act created the potential for hospitals with significant cost reductions to see profits increase after factoring in CARES grants. Whether a hospital experienced losses or profits in the second quarter of 2020 will in part be determined by how far they adjusted their costs as patient volume declined. We'll illustrate this over the next couple slides.

The declines in volume caused hospitals to lose money in April. The AHA estimated that COVID caused hospitals' April profits to decline by almost $51 billion. This number has been widely circulated in the press.
Throughout the summer we have been updating our estimates as data becomes available and now estimate that hospital profits would have declined by between $20 to $30 billion in April if Congress had not provided grant funds. We present a range of possible effects because there is uncertainty as to how much providers reduced their costs in response to their lower volume. Our estimate is about half the AHA estimate, and it reflects our finding that revenue losses were slightly smaller than the AHA assumed, and there were some cost reductions at some hospitals. The details of our methodology are in your mailing materials.

Another difference is the AHA assumed April-level losses would also continue in May and June, bringing their total loss estimate to $150 billion for the quarter. In contrast with the AHA, we do not believe the April-level losses can be extrapolated to May and June due to the rebound in volume we discussed in our prior slide.

In aggregate, we estimate that enacted grant funds and payment changes will in total direct almost $92 billion to hospitals. However, grant funds vary by hospital because only certain hospitals receive the special rural, hot spot, and safety net grants. On average, the
grants would cover about three to five months of April-level losses. However, given that volume has partially rebounded since April, the $92 billion of grant funds alone should cover more than four months of most hospitals' COVID losses. Now, that $92 billion can roughly be divided into three buckets. It appears that about half that amount has been received and booked by hospitals as income in the second quarter. About a quarter of that $92 billion was received by hospitals, but has not yet been booked on their income statement. And there's about a quarter of the money that the federal government still has not distributed. It's been enacted but not sent out to providers.

Now, in this slide, I present the average effects of COVID losses and grants across hospitals, but there's substantial variation, as we're going to see on the next slide.

We do not have complete data for how hospitals performed financially in the second quarter of 2020. However, we do have data from a sample of hospital systems. Here we present data on three large nonprofit systems and four large for-profit systems. The seven systems we present here represent about 10 percent of all acute care...
Let's start by looking at this first row. It represents three large nonprofit systems. In aggregate, their 2020 second quarter patient revenue (which excludes grant funds) was about $1.5 billion lower than in 2019. This was a 17 percent decline in revenue. In aggregate, their expenses declined by $13 million. The "$65 million" on the slide is a typo. But that only offset 1 percent of their lost revenue. However, they booked $782 million dollars in COVID grants in the second quarter, and this offset 50 percent of their lost revenue. In the end, operating income of these three systems declined in aggregate by about $621 million compared to 2019. After the CARES Act grants were accounted for, operating profit margins in the three systems ranged from negative 13 percent for the quarter to positive 5 percent.

Next, look at the second line. Here we aggregated data from the four largest publicly traded systems. They had a $3.5 billion reduction in patient care revenue in the second quarter of 2020 relative to the prior year, and that was a 15 percent decline in revenue. This is similar to the nonprofit sample. However, what differs
from the nonprofit sample is that the for-profit systems
all substantially reduced their expenses in the second
quarter. In aggregate, they reduced expenses by $2.3
billion, and this offset 65 percent of their lost revenue.
In addition, they booked grants equal to 56 percent of the
lost revenue. Because the combination of expense
reductions and grants offset more than 100 percent of the
lost revenue, all four systems saw an increase in profits
relative to the prior year in 2020. In aggregate, their
operating profits increased by $634 million. The ending
operating profit margins varied among the systems from a
low of 1 percent to a high of 14 percent. I should also
note that these systems all still have some remaining grant
funds available for the third quarter.

As you can see, the big difference in the two
groups of hospitals was not in the reduction of revenue or
in the federal grants. The big difference was in how much
they reduced costs in response to the decline in revenue.
Due to this variability in cost reductions across the
systems and incompleteness of data at this point, there's
still some uncertainty as to the hospital industry's
overall financial condition in that second quarter.

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Now, Kathryn will discuss the effect of the pandemic on nursing homes.

MS. LINEHAN: Hi. Can you hear me okay?

[Heads nod.]

MS. LINEHAN: Okay. I'm going to review what we know about volume, cost, and revenue for post-acute care settings during the pandemic period. Much of the information about volume and financial effects on post-acute care providers comes from publicly traded companies' SEC filings and investor calls.

The impacts of the coronavirus pandemic on volume have varied by setting. The recovery of PAC volume will depend, in part, on recovering hospital volume and will likely vary by market and provider type.

Home health agencies and inpatient rehabilitation facilities experienced volume declines during the first quarter of 2020 in the 20 to 30 percent range, largely due to the cancellation of elective surgeries. Publicly traded home health agencies and IRFs reported that volume began to slowly recover in April and had reached at least 95 percent of pre-pandemic levels by late June.

Nursing facility volume declined an estimated 10
percent from January through May 2020 according to data analyzed by the Wall Street Journal. This reduction was the result of fewer hospital referrals, moveouts, and deaths. Evidence suggests volume has not bounced back, with data from the National Investment Center for Senior Housing showing continued though less dramatic declines through the second quarter. Some volume in nursing homes may not return or may be slower to return than in other sectors if beneficiaries opt to avoid this setting.

Turning to long-term care hospitals, the largest publicly traded LTCH company reported a less than 1 percent increase in admissions, so basically flat, and a more than 5 percent increase in patient days for the first half of 2020 compared to the same period in 2019. Occupancy rates for this company were up in 2020 and have been steady through June.

Some of the volume effects shown on the previous slide were likely related to temporary policy changes that affected Medicare payments for LTCHs and SNFs.

For LTCHs, CMS waived the site-neutral policies and the required share of stays meeting LTCH criteria. As a result, all LTCH stays are being paid the higher LTCH
rates for the duration of the public health emergency.  

For SNFs, a temporary waiver of the three-day prior hospitalization requirement provides Medicare coverage of SNF services for beneficiaries affected by the emergency. In addition, certain beneficiaries who exhausted their SNF benefits may renew SNF coverage without a 60-day period of non-inpatient status normally required. Publicly traded companies reported these policies had a material and positive impact on their payer mixes.

Post-acute care providers have faced increased costs and have also received additional revenue in the form of federal payments, grants, and loans.

In terms of costs, SNFs and LTCHs have incurred higher staffing costs as a result of overtime, the use of agency staff, heroes pay, and the need to conduct many tasks one-on-one. Home health agencies reported overall lower staffing costs for the period because their visit and episode volumes declined.

Post-acute care providers have incurred higher costs for personal protective equipment, testing, and cleaning. Some SNFs and LTCHs incurred additional costs to establish isolation units. Nursing homes have continued to
report a shortage of PPE and testing. The overall magnitude of PPE, supply, and staffing cost impacts have been difficult to quantify. Some industry estimates may be anecdotal or the costs cited may be temporary, and the extent to which reported costs are generalizable and how they vary geographically or over time are still unclear.

Now turning to revenues, PAC providers benefited from two waves of CARES Act disbursement (that together equal about 2 percent of total net patient revenue), the elimination of the sequester, and pre-payment loans. Some providers opted to use the Paycheck Protection Program and payroll tax deferral.

Nursing homes also received some targeted funding, including $200 million for infection control and CARES Act targeted funding of $4.9 billion. In late July, HHS announced another $5 billion of the Provider Relief Fund authorized by the CARES Act to nursing homes. The distribution of about half of the funds will be "performance-based." In addition, 24 states also increased their Medicaid payment rates for nursing homes.

Similar to what we did in hospitals, we estimated
nursing homes' profit losses and compared those losses to enacted federal relief, but in the case of nursing homes we used some -- we used available but, in some cases, scant data on volume and cost effects due to the pandemic. The data sources and our assumptions, including how our assumptions about costs vary from higher industry estimates, are detailed in your mailing materials.

Taking into account volume reductions, the impact of policy changes on payer mix and cost increases for supplies, personal protective equipment, testing (for staff and patients), and labor, we estimate profit losses of a little less than $2 billion per month starting in March. And we estimate that enacted federal support (not counting loans) has offset profit losses for about eight and a half months.

I want to note again that this estimate compares aggregate losses to aggregate federal support and acknowledge the variation in the impact of COVID-19 on nursing homes as different parts of the country have experienced outbreaks since March and nursing home cases have in some places increased again in August. Evidence from two large nursing home providers illustrates the
uneven and uncertain effects of the coronavirus pandemic on nursing home providers' finances -- with one unsure it will last the year and another returning all federal funds.

Sam is now going to tell you about physicians and other health professionals.

MR. BICKEL-BARLOW: Similar to other sectors, clinicians saw large reductions in the volume of services provided, starting in March, as many beneficiaries avoided potential exposure to the virus at the doctor's office. However, over the next few months, clinicians' volumes steadily recovered, in many cases returning to pre-pandemic levels by June. Clinicians have received significant federal grants, loans, and payment increases in response to the pandemic, which have helped to offset a majority of the revenue lost from March to May.

Office visits from Medicare beneficiaries declined rapidly during the first few weeks of the pandemic, but over the next few months they steadily recovered to pre-pandemic levels.

This chart shows the change in Medicare office visits from mid-February to mid-July. All office visits (shown by the red line) declined rapidly in March. At its
nadir, weekly visit volume was at 2.4 million -- about half its usual volume.

If we set aside telehealth visits and just look at in-person visits (shown by the green line), we see even steeper declines.

Telehealth visits, which account for the difference between these two lines, partially offset the decline in in-person visits. Telehealth visits increased rapidly from early March through mid-April, but have declined somewhat since then.

Medicare beneficiaries were not the only ones avoiding the doctor's office. This chart uses Phreesia's all-payer data to track the impact of the coronavirus pandemic on outpatient visits at ambulatory care practices. It shows that different types of payers saw strikingly similar utilization trends, with visits declining in March before steadily recovering over the next few months.

Though the general trend in volume of visits among different payers is similar, clinicians saw a relatively larger drop in their volume among Medicare patients. But visits among Medicare beneficiaries also rebounded more quickly than patients covered by other
Corresponding with the fall in patient volume, clinicians also experienced a fall in their revenue. However, the fall in revenue was not as large as the fall in utilization.

According to FAIR Health analysis of their multi-payer claims database, estimated clinician revenue -- shown in red in the chart above -- declined, but to a lesser degree than clinician utilization -- shown in yellow. FAIR Health theorized that this may be because less expensive procedures declined, while more expensive procedures -- especially those that were emergent or urgent -- continued to occur.

FAIR Health's analysis also shows a significant recovery in volume and revenue in May, consistent with other sources.

Based on FAIR Health's revenue estimates, we estimate that revenue for physicians and other health professionals from March through May was approximately $45 to $55 billion lower than it would have been in the absence of the coronavirus pandemic.

To help offset some of those losses, Congress and
CMS have advanced billions of dollars in grants, loans, and payment increases during the public health emergency to clinicians through a number of programs and policies.

We estimate nearly $5 billion has gone directly to clinicians through the Provider Relief Fund. We also estimate that about $26 billion of Paycheck Protection Program funds went directly to clinician offices. The loans do not need to be paid back if at least 60 percent of the loan was used for payroll costs.

In addition, Congress suspended the 2 percent sequestration payment reduction for the remainder of the year, which should result in an additional $1 billion reaching clinicians.

It is also worth mentioning that through changes to telehealth payment policy, clinicians have been temporarily able to bill for a variety of additional telehealth services, including audio-only visits, and payment rates for these services have been temporarily increased to rates for in-person visits.

Our presentation this morning has focused on the utilization, cost, and provider revenue effects of the coronavirus pandemic. We want to conclude by again
acknowledging that the pandemic has imposed costs and had
tragic effects on Medicare beneficiaries and health care
workers.

Though the currently available data we presented
has limitations, particularly in some sectors, we have
found that the aggregate level of federal subsidies and
policy changes have allowed providers to weather the
financial impacts of the coronavirus pandemic. However,
the experience of individual providers may vary
considerably.

We will continue to monitor the impact of the
coronavirus pandemic on beneficiaries and providers to
inform payment update recommendations. We ask you to
provide any suggestions about tone, content, or anything we
should know as we continue to follow this evolving
situation.

Now I'll turn it over to Mike.

DR. CHERNEW: Great. Thanks, Sam, and to the
other presenters.

Because of the time and because this is largely
an informational session as opposed to something that's
going to have particular recommendations associated with
it, we're going to skip Round 1 and really just go to Round 2 questions. So, Pat, I'd asked if you had some reflections or thoughts on this, and so maybe I'll turn to you first, followed by Jaewon.

MS. WANG: Okay.

MS. KELLEY: Before we get started, can I just remind people to please keep your mics off unless you're speaking. Thank you.

MS. WANG: I'm happy to kick off the comments.

So I think it was a great chapter and again, you know, as usual would commend the staff for all of the work done here. My overall comment, I guess, has to do with whether it is possible, as you continue to do this work, to focus in more on Medicare impacts. As was stated at the outset, this is really a Medicare -- you know, COVID hit the Medicare population so deeply, and so while we're viewing the overarching picture of where the money from the CARES Act went, I'm hoping that particularly to inform payment update and other discussions going forward we can focus in a little bit more on where the Medicare money went.

So the first comment is just it's amazing how quickly Medicare responded to send money into the system.
The release of the sequester, the 20 percent inpatient COVID bump, you know, telehealth payment, SNF relaxation, LTCH payment, you know, across the board I think it should be noted how quickly and fully the Medicare program responded to try to get money in.

I think the next question, though, is where did the money go, I mean, especially certainly if you're talking about a COVID inpatient bump, you know, by definition it went to hospitals treating COVID patients. But the rest of it I think was just overall payment policy, so it would be helpful, I think, to understand in aggregate how much money went out the door and the correlation, if we can, on an ongoing basis to understand its correlation to places that actually have a lot of COVID burden.

There were a couple of slides in there about lost hospital revenues and the reductions comparison in expense reduction between not-for-profit and for-profit systems, which are just staggering to me. And I have a feeling that other people will comment on those. But, again, sort of on Slide 6, the estimates of reduced operating profit obviously is a combination of lost revenue and increased cost. I think it would be helpful to understand more about
the Medicare picture here. A lot more Medicare money went
into the system, so was the revenue loss -- whether it's
the AHA estimate or the MedPAC estimate, what was the
composition of the revenue loss Medicare versus non-
Medicare? And if it's even possible to parse the expense
increases or reductions, same story.

I would love to see more information on the
impact on beneficiaries regarding sort of where -- within
the intense impact on the Medicare population within the
Medicare population on communities of color, on low-income
communities, on communities with other characteristics. I
think that a very big story that COVID has exposed is just
how vulnerable folks in those categories were to really
being at the top of the pyramid, the first to get hit by
this, devastating. I think that we have an obligation in
the Medicare program to understand more about that because
it should inform our thinking about social determinants of
health, social disparities, and so forth.

You know, and I guess that the -- just two quick
comments. So from a Medicare Advantage perspective, the
notable thing is all of these impacts are a little
different if folks are in value-based payment arrangements.
And I know that this is a priority for the Commission, but, for example, primary care physicians who were in capitated arrangements saw no change in their revenue. So sort of the information on the impact on physicians looks a little different if you're talking about providers in value-based arrangements, similarly for those in value-based arrangements where certain expenses went down, especially on the commercial payer side. The benefits of those surpluses might well have gone back to the delivery system by virtue of contracts, and so I think that we have to keep our focus on the impact and the importance of value-based payment to keep money in the health care system.

A final quick comment. The things that have emerged from COVID and which are evident in this presentation about changes in utilization, et cetera, SNF utilization, for example, I'm hoping that when we get to the payment update portion of our work this year that we can develop some sort of framework of understanding what is the future of the different sectors and the utilization of the sectors, because if folks are not really -- if we think people are not really going to return to certain types of institutional settings, how should we be thinking about
that in a payment update? How should we be thinking about
the alternative types of care that they might seek for
their needs and where changes in utilization might occur as
a result of COVID?

Thanks.

DR. CHERNEW: Thanks, Pat. And now we have 10
minutes left, and there are a lot of faces on my screen.

So we're going to have to be pretty concise in our
speaking. So we're going to go to Jaewon, and then we'll
start working through the queue. Jaewon.

DR. RYU: Sure. Thanks, Mike. First of all, a
big shout-out to the folks who put together the chapter.

It's a really complex area, very nuanced, and worse yet,
it's quickly evolving. So I thought it was just a great
job of amassing a lot of information.

At the same time, I think the question Pat raised
is exactly the right one. It begs the question of where
did these funds go and did it match up well with what the
impact was and the dynamics at play.

I think to answer that question, it would be
helpful to have maybe one deeper layer, one more step to
try to get into that a little bit more. And I have a
couple areas in particular where I think it might be beneficial to dig into.

One is around the timing of the hot spot areas, when COVID kind of made its way through, and how that matches up geographically with the footprint of, you know, the seven systems that you had evaluated -- the four for-profit publicly traded and then the three that were not-for-profit. And you could probably even include more into that not-for-profit mix because as those financials start coming out more publicly, I think there's an opportunity to incorporate more of that picture into evaluating did they have essentially a differential experience, which I believe they may have based on that geographic footprint.

Number two is payer mix, and I think you make a reference to the payer mix susceptibility on page 14 of the materials in the chapter. But I think it's also helpful to look at both pre-COVID and post-COVID, those same systems that you looked at, what was the payer mix? Because we all know that preparedness and the cost associated with that is very different for populations that are more vulnerable. And so to the extent that the for-profit systems you looked at have an underlying different payer mix and a different
patient population, I think their ability to quickly adapt from a cost structure or cost reduction standpoint is fundamentally different than folks who are really grappling with populations that are vulnerable, that have greater needs, and trying to manage through the pandemic in light of that.

Number three, I had a question around the intensity of services. There's a lot of focus on the volume. I think it would be helpful to understand intensity, because even as we start seeing a recovery, I think the persistence of that recovery is a big question mark. And there's a belief out there that maybe a lot of this is just working through a pent-up backlog versus how much of the demand will actually stick. And intensity will also shed some additional light on that.

And then, lastly, I think getting back to the not-for-profits space -- and I think this is exactly the slide -- even within the not-for-profits there probably is further segmentation between, you know, whether it's academic medical centers and other nonprofits; but as audited financials come out, I think we continue to see in the media coverage of big nonprofit systems who have had a
significantly different experience than what's been shown
in the for-profit space. And I think the cost or the
ability to reduce cost is one driver of that, and I think
you lay that out really well. But I suspect there are
others that it would be helpful to try to dig into.

Thanks.

DR. CHERNEW: Great. Thanks, Jaewon. Terrific
comments.

Dana is keeping the queue. I think there's about
seven or eight people. We have about seven or eight
minutes. So let's try and be efficient, and I look forward
to all your comments. So, Dana, I'm going to turn it over
to you to call out the order that you have people in.


DR. PERLIN: Okay. Can you hear me?

MS. KELLEY: Yes.

DR. PERLIN: Okay. I just have comments from the
perspective of a system that's now treated over 60,000
COVID-positive inpatients, done over a million tests,
treated over 120,000 outpatients. Let me first start by
saying, as, you know, a larger investor-owned system, it's
pretty clear there's maldistribution of dollars, and I
I think it's also important to contextualize that this is a pretty scary time. There was a period before the CARES dollars started rolling where no one was quite sure where things were going.

You know, many of the cost-cutting measures are simply not sustainable. In our organization, the volumes were so reduced, we kept 130,000 staff paid despite the fact they were not working at the hospitals, and essentially mothballing those assets for that period of time is obviously not sustainable.

I think it's also important to recognize, perhaps especially for Medicare beneficiaries, that not all of the forgone care was low-value care. We saw decrements in presentations for acute coronary syndrome, stroke, complications of diabetes. We had reports of emergency medical responders really arriving to patients in extreme circumstances, increased rates of mortality there. So these are very difficult issues.

This issue about geographic variation is
particularly acute, and I think that is the big challenge of this chapter. It reminds me of my favorite Lincoln quote: "The man with his hair on fire and his feet in ice water is on average comfortable." Well, there is no average here, and in our own organization there was a point with the resurgence of COVID where we suspended all elective procedures in the State of Florida for a period of time. And I think that's the lens with which we have to re-approach what comes next in terms of this pandemic and any future preparation.

I think one other thing that's not mentioned is that by virtue of that geographic variability, the situational variability of the institutions themselves.

There's a mention about, you know, some mechanisms for relaxation of accelerated repayment, because coming out of this, many facilities will be very financially damaged and unstable. I think in terms of assuring adequacy of access, that's one of the issues that should be addressed.

So putting it all together, I think, you know, these were extraordinary emergency measures. To some degree, they may have missed the target, but we have the opportunity now to use a scalpel and not a sword going
MS. KELLEY: Okay. Brian, you're next.

DR. DeBUSK: Thanks to the staff for a fantastic chapter. I want to comment. Chart 7 of the presentation, it is really remarkable the difference in the for-profit and not-for-profit either ability or willingness, or some combination of the two, to shed costs. And as we advance this chapter, I really hope we can dig into the nature of how those cost savings occurred. I would love to understand more about how or what drove those reductions.

The other thing I'd love to see is how providers who relied more on global payments fared. I think Pat alluded to this. I think payer mix, but equally important with payer mix, the amount of transactional revenue that they had versus the amount of, say, global payments or capitated payments, I suspect those folks fared much better during the PHE.

The other comment I want to make just on Chart 13, and it was in the reading material as well, the speed that telehealth medicine ramped up, I mean, we went dramatic increases in things like three weeks. My one
recommendation there would be the next time we're as a Commission discussing a phase-in period, I think it might help us to remind ourselves that providers can respond with three weeks when pressed. So I think ten years versus three weeks, we might be able to split the difference.

Then my final comment -- and, again, Pat touched on this -- I really commend CMS on getting that money out quickly, you know, very effective in what they did. I do hope that we'll spend some developing a reconciliation process to make sure that the money went to the right places and that it was targeted. The money's out there now. I do hope we get a chance to go looking for it and make sure that it all landed in the correct place. And then, furthermore, I think this is a great opportunity for us as a Commission to help develop a plan for how funds could be distributed in the future. I think there's an opportunity here to be more prospective should a public health emergency like this occur again.

Thank you.

MS. KELLEY: Okay. Amol?

DR. NAVATHE: Thanks for a great chapter. I'm going to try to be really brief here, picking up on a
couple of comments.

So I totally agree with the idea that aggregates can be misleading sometimes and aggregates can hide. So I would support not only looking at this from a geographic variation perspective but variation across multiple dimensions. And we have some evidence from my own research group and others that the way that COVID relief payments actually ended up working out didn't necessarily go prioritized with need per se, and so I think looking at geographic variation, looking at variation based on COVID impact, variation based on public health responses, for example, community needs, community-served populations, as Pat said, looking at the Medicare side versus all-payer, I think these sorts of dimensions may really help us get a slightly more nuanced view of what's happening in communities that really had need were impacted.

Thanks.

MS. KELLEY: Karen.

DR. DeSALVO: Thank you, Dana, and thanks again to the staff. I just want to put a pin in the potential value of us looking at providers who were supported by global payments and for beneficiaries to understand whether
that was a stabilizing factor and also a factor in people
continuing to have access to care for chronic conditions or
preventive care.

What I wanted to also ask about was whether there
was an opportunity to understand the impact on primary care
practices since there's been quite a lot of concern in the
primary care community about the potential closure of
primary care practices because of the lack of revenue and
the difficulties in shifting practice model as quickly as
some of the larger organizations did, so really thinking
more about independent primary care practices. I know it's
a small part of Medicare, but it's a really important part
of access to care.

Thanks.

MS. KELLEY: Okay. Bruce?

MR. PYENSON: Thank you, and my compliments to
the staff. I wanted to amplify the point that Brian made
about phase-ins. I think one of the lessons of this
incredible shock to the system is the resilience of many
sectors of the health system. This shock was many times
the magnitude of the changes in reimbursement that we
typically talk about, perhaps orders of magnitude worse.
And to think about the responsiveness of many sectors of the system to that and how they were able to respond is in contrast to the phase-in that we typically build into relatively minor changes by comparison.

Later in this session we're going to see one of the examples of that in the laboratory reimbursement and how there had been a long phase-in of relatively small changes relative to what we've been through. So let's keep that lesson in mind when we think about changes that are needed and whether a phase-in -- how fast the phase-in should be.

Thank you.

MS. KELLEY: David.

DR. GRABOWSKI: Thanks, Dana, and thanks to the staff for a great chapter. So we know that COVID had been particularly devastating for post-acute care settings. I would love to see us continue to unpack the importance of the relief funds versus the importance of some of the waiver changes that also occurred, such as the changes in the LTCHs with site-neutral payment and with skilled nursing facilities the relaxation of the three-day rule.

The chapter introduced this great term, "skilling
in place" for SNFs, where they could actually deliver post-
acute care without a three-day stay, just convert over a
long-stay nursing home resident to skilled status. And
they also don't need to have that 60-day window in between
episodes. So, conceivably, you could have 200-day SNF
episodes back to back. How much is this occurring? Has
this been important? I think we're going to get a great
window into sort of the responsiveness once again of the
post-acute care sector. And I've had a lot of folks over
the years tell me we don't need the three-day rule. I'll
be really curious to see how much this was utilized and how
it was utilized by the different post-acute care providers.
So I'll stop there. Thanks.

MS. KELLEY: Okay. Larry.

DR. CASALINO: There it goes. One thing that was
really striking to me was that net revenues after the funds
that were pushed in by the government for hospitals and a
lot of long-term care or post-acute facilities looked
pretty good, at least in the time period studied, and much,
much, much less money was shoveled out to physicians whose
revenues probably don't look so good. And I can easily
understand how that could have occurred, probably for some
good reasons and some bad reasons. But the difference is striking. Some hospitals are going to be better off, whereas just about all physician practices are going to be worse off. This may lead to some of them closing, as Karen suggested, for primary care. But it's also, I think, very possibly going to lead to a further acceleration of the trend for hospitals and health insurance companies and private equity firms to acquire physician practices, which, having gone through what they just went through, may be quite happy to be acquired, get a little shelter from the next storm. And this will cost Medicare money. There's pretty good data to show what happens when physician practices are acquired by hospitals, for example. Private equity firms, we don't know yet. But I think the failure to support physician practices as well as other health care providers I think is going to lead to further huge demographic change in the health care system that probably will cost Medicare money in the short and long run.

MS. KELLEY: And last, we have Sue.

MS. THOMPSON: Thank you, Dana, and thank you to the staff for this very good chapter. I wanted to make a comment about your notation of low-value care, and I think
we're in a very unique time when we saw such a dramatic reduction in utilization, whether it was elective procedures, whether it was preventative care, whether it was some of the low-value procedures that at MedPAC we have spent time talking about, you know, whether or not we should continue to even fund. I just think there's a real interesting opportunity in this time to study what that impact might have been, whether it really was unneeded, or perhaps if we're going to see the severity of conditions, as has been well described by my previous peers, and I wanted to just make a notation in this transcript of that opportunity.

That would conclude my remarks. Thank you.

MS. KELLEY: Okay, Mike.

DR. CHERNEW: Great. So you've probably noticed we're about seven minutes behind. We're going to jump right into the context chapter with Rachel and Molly. It looks like we can do that pretty quickly. So I will not take much more time except to say depending on how long this goes, we may again, because this is largely an informational chapter, combine Rounds 1 and 2 to help us catch up on some of the time. But, with that, Rachel and
Molly, why don't you take it away?

MS. BURTON: Thanks. Good morning.

Before I begin, I want to point out for the audience that a PDF version of these slides can be downloaded from the "Handout" section of the webinar's control panel.

In the last presentation, we talked about the coronavirus pandemic -- THE contextual factor to be aware of in the short term.

In this presentation, we'll shift to the long term -- focusing on Medicare's financial situation today and what it could look like in the future if spending trends continue.

I'll note that data sources used in this presentation to project future-year trends generally do not yet incorporate the effects of the coronavirus pandemic, so some adjustments to these projections will eventually be made.

This presentation is intended to be contextual information for Commissioners to consider as they weigh payment policy changes this cycle.

This information will also be included in our
March report to the Congress, to accompany our annual payment update recommendations.

In this presentation, I'll describe overall trends in health care spending and then focus in on trends in Medicare spending.

I'll then explain how this spending trajectory strains Medicare's three main funding sources and talk about what's driving Medicare's spending growth.

For decades, health care spending has grown as a share of the U.S.' GDP.

Total health care spending now consumes twice the share of our country's GDP as it did 45 years ago, rising from 7.9 percent of GDP in 1975 to 18 percent in 2020.

Private health insurance spending has more than tripled over this period, and so has Medicare spending.

When we look at spending per enrollee in more recent years, we find faster growth in spending per privately insured individual, which has grown 24 percent from 2014 to 2018.

In contrast, Medicare spending per beneficiary has only grown 10 percent over this same period.

Increasing prices paid by private insurers have
been largely responsible for this faster spending growth -- which occurred at a time of relatively flat growth in health care utilization for the privately insured.

That being said, Medicare spending is nevertheless increasing and is projected to nearly double in the next ten years -- rising from $782 billion in 2019 to $1.5 trillion by 2029.

Medicare constituted 14-1/2 percent of federal spending in 2019 and is expected to grow to 17-1/2 percent by 2029. Spending on the Medicare program alone is already equivalent to 3.9 percent of the country's GDP.

Medicare is primarily financed through three revenue sources: the Medicare payroll tax, shown in blue; other general tax revenue, shown in orange; and premiums paid by beneficiaries, shown in red.

I'll talk about each of these one at a time, starting with the Medicare payroll tax. This is a tax that is collected from workers and their employers and deposited into Medicare's Hospital Insurance Trust Fund, which pays for Part A services.

Over time, the number of workers in the U.S. has not grown as fast as the number of Medicare beneficiaries.
As this graph shows, there were four-and-a-half workers per beneficiary around the time of the program's inception, but that ratio has now fallen to just three workers per beneficiary.

In the next ten years, this will decline further, to just two-and-a-half workers per beneficiary. As a result of this declining ratio, the Medicare trust fund that relies on workers' payroll taxes was previously projected to become insolvent by 2026. However, just yesterday CBO announced that it's now expecting the trust fund to become insolvent two years sooner, in 2024.

I should note that Medicare already spends more on Part A services than it collects through the trust fund. The only reason the trust fund hasn't already been declared insolvent is it carries forward a surplus each year, leftover from years when trust fund revenues exceeded Part A spending. In recent years, this surplus has been dwindling, and within the next few years, the surplus will be depleted -- meaning the trust fund will be operating at a deficit, unable to fully cover its obligations each year. At that point, payments to providers would be reduced to levels that could be covered by incoming revenues.
However, lawmakers have never let this happen. To keep the trust fund solvent over the next 25 years, the Medicare Trustees estimate that either the payroll tax would need to be increased immediately from its current rate of 2.9 percent to 3.7 percent, or Part A spending would need to be reduced by 17 percent, which is equivalent to nearly $1,000 per beneficiary per year.

The next funding source I'll talk about is general tax revenues, which help pay for Part B and Part D services.

Since the federal government spends more than it collects each year, Medicare's general revenue transfers are partially funded through federal borrowing -- which pushes the country's debt up.

To unpack what I just said, this graph shows spending on Medicare and other federal programs layered on top of each other.

The top red line shows the total amount of federal spending for all programs as a share of the country's GDP. The green line, below it, shows the amount of revenues the country collects to pay for this spending.

The key takeaway from this graph is that Medicare...
spending, shown in dark red on the bottom, makes up a substantial share of federal spending. So as Medicare spending grows, it pushes the amount we need to borrow up. By 2038, which is shown with the vertical white line in the middle of this graph, spending on Medicare, other health programs, Social Security, and net interest will equal total federal revenues.

This now brings us to Medicare's third main source of funding, which is beneficiary premiums.

In original fee-for-service Medicare, there are no premiums for Part A hospital coverage, but the annual cost of premiums for Part B is $1,735 in 2020, and premiums for Part D coverage average another $372.

Beneficiaries also face cost sharing, not shown in the prior graph. Cost sharing in original Medicare averaged $415 for Part A services in 2018, $1,513 for Part B services, and $432 for Part D drugs.

Taken together, beneficiary spending on premiums and cost sharing consumed 24 percent of the average Social Security benefit in 2020, which is up from 14 percent in 2000.

The Medicare Trustees estimate that in another 20
years, premiums and cost sharing will consume 31 percent of
the average Social Security benefit.

So now that we've established that Medicare
spending is increasing at an unsustainable rate, it's worth
asking: What are the factors driving Medicare spending
growth?

One way to try to answer this question is to
split the program into its main parts and look at spending
per beneficiary over the last ten years.

When we do that, we find that the type of
spending that has grown the fastest is actually Medicare
Advantage, which now costs about a thousand dollars more
than original Medicare per beneficiary.

We also find that Medicare Advantage spending per
beneficiary has been accelerating since 2014. The
relatively faster growth in Medicare Advantage spending per
beneficiary may reflect three things.

First, there's been an increasing share of
enrollees in MA plans receiving higher payments due to
their quality bonus status.

Second, plans have been reporting more diagnoses
-- leading to faster risk score growth for MA enrollees
than for beneficiaries in original Medicare.

And, third, there's been MA enrollment growth in areas of the country with relatively high MA payments, such as counties where benchmarks are set at 115 percent of original Medicare's spending levels.

Another way to decompose Medicare spending is by looking at how much of the average annual expected growth in spending is driven by enrollment growth and how much is driven by growth in spending per beneficiary.

The Medicare Trustees and CBO project that over the next ten years, growing Medicare enrollment will account for only two percentage points of Medicare's percent average annual expected growth rate. This is shown in the green portion of the bars in this figure.

The larger driver of Medicare's spending growth is spending per beneficiary, (shown in red), which will account for four to five percentage points of the program's average annual expected growth rates.

Spending per beneficiary captures both increases in the quantity of health care services used and increases in the prices Medicare pays for these services.

As the largest payer in the country, Medicare
unilaterally sets the prices it pays, which has enabled the
program to restrain price growth in a way that private
insurers have struggled to do.

To try to restrain the quantity of services used, Medicare primarily uses alternative payment models, which I'll talk about next.

Alternative payment models, or APMs, are usually voluntary payment approaches that give providers an incentive to practice more efficiently.

APMs are usually layered on top of original Medicare's existing fee-for-service payment systems and give providers incentives to more closely manage and coordinate their Medicare beneficiaries' care in order to keep them healthy and reduce the need for costly hospital admissions.

The most prominent types of APMs are accountable care organizations, bundled payment models, and advanced primary care models.

In ACOs, CMS offers groups of providers bonuses if they can keep their beneficiaries' spending below a target, while maintaining care quality over a one-year period.
Bundled payment models differ from ACOs in that they cover a shorter period of time associated with a particular episode of care, such as a hip replacement. Advanced primary care models typically offer primary care providers supplemental monthly payments per beneficiary to expand the breadth and depth of services they deliver and also offer bonuses based on performance on quality measures. We will be talking more about APMs throughout the upcoming meeting cycle.

With that, I welcome your questions and your guidance on finalizing the chapter for inclusion in the March report.

DR. CHERNEW: Great. Thank you both so much. That is really interesting. It is a sobering presentation to be sure.

Before we go to the comments, I do, given the sobering nature of this, want to make one comment for the broad public audience, and that is, it is obvious to anybody that the fiscal situation in Medicare is an enormous concern. It was a concern before COVID. It is certainly a concern after COVID.

That said, it's important to understand that our
criteria, MedPAC's criteria, when we make our update recommendations, include things like access to care, quality, things like that. We do not have nor are we driven by a specific budget target. I sometimes say in private, I guess now in public, we are MedPAC not IPAC. That being said, it is central to our work to promote efficient payment, and you will see, I think, through the coming presentations today and future meetings that we are very dedicated to finding payment models and other program modifications to promote efficient delivery of care, and what you should take away in part from this presentation is given the financial situation that we are in, there is a never more important time or more salience that we be successful in promoting efficiency, which is a bit different than just saving money.

So, with that, I'm going to turn this over to Amol, I think, for some initial comments, then Karen, and then we're going to go through the queue. Amol.

DR. NAVATHE: Great. Thanks, Mike.

So thank you to the staff for the comprehensive work here. I think obviously there's a lot of work that goes into setting the context for the Medicare program,
broadly speaking. I think you guys, as usual, have done an excellent job of collating a lot of evidence and making it digestible and in its early short format.

Rachel brought up the fact that the trust fund depletion is only accelerating in the context of COVID and, of course, is even more striking and sobering in a broadly sobering environment.

With that as a backdrop, I had a couple of recommendations or thoughts to consider in the future about this chapter as we evolve it. So one point is I think to some extent changes in comments, I think we can maybe do a little bit better in terms of how we're articulating the impact or the sort of real trajectory, if you will, of prices. There's a number of places where we talk about prices in a relative fashion, percent over time, for example. In a couple of places in the chapter, we also make note of the absolute difference may be quite small even though the percentage growth is very different. And so I think in those cases it might actually be helpful to also articulate the absolute differences, maybe even, for example, in the chart with a second axis or a paired chart next to it, just to give that context. I think relative
and absolute is something that we want to be mindful of. 

Similarly, I think we want to be mindful of 
changes in prices that we might call nominal versus real 
changes in prices, or net of inflation, net of other sort 
of comparative changes that are happening around prices. 

A couple other points. I think I really liked 
the new Table 1-1, which I think didn't make it into the 
Power Point slides, for everyone who's basically giving a 
reflection of what would have to happen for the payroll tax 
increase basically to offset the trajectory here or at 
least in part of the spending. I think these types of 
facts, if I could encourage us to do even more of it, sort 
of what impact do we have to have on spending in different 
parts of the program to actually offset this trajectory. 

To me, it makes it very real. When I see something like 
there has to be a 17 percent decrease in Part A spending to 
increase solvency for 25 years, that's really striking. I 
think that makes it very concrete, makes it relatable, to 
some extent makes the context much more palpable in some 
sense. 

A third point is I think we all frequently think 
about the aging population as a potential challenge for
solvency of the trust fund in the Medicare program
generally speaking. I think it might be nice for us to
also differentiate fairly explicitly or crisply the
difference between changes in enrollment, which are
obviously an important factor, with an aging population
within the group that is already enrolled. And I think
there's a little bit of discussion of this, but you also
provide I think important facts and figures around more
elderly Medicare beneficiaries utilize at a higher rate and
are more costly than younger Medicare beneficiaries. I
think that needs to also come out in terms of its impact on
the Medicare program as well as the population eventually
ages but with increasing costs down the road.

The last point I'll make is about the discussion
of consolidation, specifically consolidation as sort of
logic -- consolidation leads to higher commercial prices,
which then eventually will put pressure on the Medicare
program to raise prices because of quasi-indirect effects,
though, in terms of hospitals and/or physician groups,
providers deciding not to accept Medicare anymore. And I
wondered if there is any empirical evidence about that. I
think that seems like a multi-step process. I don't
dispute the fact that consolidation has its ill effects. I think we should think carefully and hopefully back it up with evidence if we can in terms of how it's actually going to impact the Medicare program going forward.

So, overall, thank you for a fantastic chapter, and hopefully my suggestions are helpful as well.

DR. CHERNEW: Amol, thank you. And for the Commissioners, you may have noticed, given the nature of this chapter and the time, we're going to combine Rounds 1 and 2. So I encourage you all to get into the queue, and I'm now going to turn it over to Karen.

DR. DeSALVO: Great. Thank you. It was a really nice job on the chapter, and I'm recognizing also that the staff was trying to do some condensing of what can get to be a very weighty topic, which is, frankly, quite important, as Michael has shared. We have an obligation around fiduciary responsibility to the Medicare program, and so I think there's some tradeoffs about what we want to highlight that impact the beneficiary and some of the challenges for the cost. I have probably done four big areas that I just wanted to lift up and get some suggestions/questions in the chapter.
I'll say first that I really did like the layout, and I loved the way that the staff listed out the recommendations in chronological order of what we have previously thought would make a difference in changing the trajectory of spending for the Medicare program while also improving access and outcomes.

I didn't see in the chapter and I think it might be helpful if there's some way to estimate what we think that the implementation of all those recommendations, what impact that would have on truly bending the spending curve and just get some sort of an accountability or maybe even just a subset, because I suspect it's significant and it might be helpful to quantify that in addition to seeing qualitative recommendations and having to make the report out.

The second area is just, again, respecting that we're trying to keep this as brief as possible, I didn't notice in the chapter that you highlighted even in a sentence what is the driver behind the rising cost. Amol was, I think, alluding to this a minute ago. I think a part of it is the demographics of the population, more beneficiaries and older beneficiaries with more medical
conditions. It's embedded, but I think just being crisp and clear that this is multifactorial and also just has to do with the fact that we have a larger population to serve that has perhaps more needs, which just drives the impetus that we have to be a lot more thoughtful about prevention and upstream services to help prevent the onset and progression of chronic disease, so something to clarify the importance of changing demographics.

I think related to that is just a better reflection of the act that there has been work not only on recommendations by the Commission but by the delivery system, writ large, and by the administrations, plural, to try to address cost and drive value. Again, I think it's in there, but it's not as clear that there have been -- there's been work to try to drive down costs, and it's just not really gotten us to where we need to go.

The third area is I -- and I feel pretty strongly about this. I think we'd be remiss if we did not call out something around racial and ethnic disparities for the Medicare population, not only in COVID but generally. I think we know that there are differences in health burden and in health outcomes, and we don't need, I think, a
detailed accounting of that, but I think we need to acknowledge that the program is different based upon the color of your skin or your geography, and find a way to weave in that important -- that we're seeing this through that lens and have that as a consideration.

I know that you referenced the reports, for example, from CMS about COVID and disparities, but I didn't see much lifted into the chapter, and I don't think it needs a lot of attention. I mean, I'd like it to have, but at least some acknowledgment that was more clear in the chapter.

And I think the last thing has to do with a figure that you have in there, and you had it on Slide 16 about MA, and I just wanted to make sure I understood the treatment of that data. It seemed -- thank you. It seemed like maybe it -- I couldn't tell from the legend, but I don't think it's age adjusted, and I suspect given that you have in other parts of the chapters that you've shared that older Medicare beneficiaries have higher costs, and I think we know that Medicare beneficiaries that are older are more likely to be covered in Medicare Advantage, at least I think that's still the case. So just thinking about how
we're comparing the spending and making sure that we're
thinking through whether we're actually making a reasonable
comparator if we're risk-adjusting for some of the
important characteristics that might vary according to
original Medicare and Medicare Advantage populations.

I'll stop there.

MS. KELLEY: Okay. Jonathan Jaffery?

DR. JAFFERY: Thank you, Dana. And thanks,
echoing others' comments, this is always a great chapter to
sort of look at early in the year, and then I think this
year's chapter has been fantastic and, as others have said,
"sobering" is certainly a word that comes to mind.

I just have two comments. One is at one point in
the chapter you talk about restraining price growth not
being enough, but the quantity of health care services also
has to be reduced. And I wonder if there's something that
can be said about not just the quantity but the mix of
services. Often, we focus on things like, you know, we do
too many MRIs, which is probably true, but there's also a
mix of services, and it sort of gets to that efficient
delivery of care that maybe there's some way to think about
wording that.
And then my other comment also is a little bit about the efficient delivery of care. So, you know, as Amol pointed out, it's really great to see that table where it lays out some of the ways that we can get to solvency for periods of time that maybe are a little more tangible than thinking about, you know, percent of GDP and how that would translate into action.

But I wonder if, you know, when we talk about decreasing costs by $1,000 per beneficiary per year, I wonder if there's something in there that we should think about focusing on that's a little bit different that might inform how we strategize around tactics and not -- by "we," I mean not only the Commission but CMS and CMMI and others -- about promoting that efficient delivery of care that Mike talked about as our big charge for us.

So thinking about ACOs in particular, you know, a lot of what our policies seem to talk about is focusing programs so that all different groups and ACO providers can bring down their costs. And to me, that starts to imply that we're trying to shift everybody's costs down, and that's one way to think about bringing down the average. But another way is to say, well, there's a certain
efficient level of care, and there's some providers that are much more costly on average, even adjusted for risk and age and other things. And I wonder if there's a way to model out what is that efficient level of care that we would want to bring groups down to that would get us to the same outcome of solvency and the same outcome in terms of an average decrease cost of care that's $1,000 per beneficiary per year or lower, if that makes sense.

I know we've talked about that a little bit before, that, you know, how sustainable is it for us to look at the higher-performing ACOs and ask them to constantly bring down their average cost versus trying to understand what an expected efficient target should be overall. And maybe there's something where we should be focusing on those real high spenders.

So I'll stop there. Thank you.

MS. KELLEY: Okay. Sue, you're next.

MS. THOMPSON: Thank you, Dana, also thank you to the staff for this sobering chapter.

Like Karen, I, too, wondered -- as I looked at all the recommendations made by MedPAC that appeared on page 29 through 38 of this reading, these recommendations,
you know, they restrain growth, we need to outline the
challenges, but I wondered, you know, what's the dollar
amount? What would we save Medicare? What's the impact of
these recommendations? And it did cause me to reflect,
because I wonder, you know, are we bending the curve? Are
we moving to help? Are we making a difference for Medicare
beneficiaries and the state of health care in this country?

Today I'm in my sixth and final year as a MedPAC
Commissioner. It's my sixth September of reading the
context chapter, and, you know, while it's grounding for
the year, this year it's particularly sobering.

Upon reading this chapter, you know, the status
of the trust fund and the fact it's in much more dire
condition other than when I started, basically it's on life
support. This very well written and factual narrative
seems to disguise a call to action that is necessary to
protect Medicare solvency and health care for this country.

I found myself reflecting on the ghosts of
Commissioners past as I thought about this September
meeting and this very chapter. I remember last year -- and
I pulled up some of the transcripts. Warner Thomas said,
"I feel like I have failed as a Commissioner because I
don't think that we have taken bold enough steps to move this curve. We're talking about millions of people that are counting on us to make the right changes."

Two years previous, Dr. Rita Redberg said, "So we clearly have our work cut out for us. We're at a crisis stage. This is not going to be here for us. This certainly won't be here for future generations. We have an opportunity to improve it, but we really need to be bold."

In that same year, Dr. Craig Samitt, with great emotion, said: "This is the sixth time I've seen this, and it hasn't really changed. And so if it truly were a burning platform, I think the platform has already burned down. I think now would be the time for us to take action. I don't know to what degree we have fully underscored the imperative in this chapter, but certainly heading out of MedPAC this year, I feel a greater sense of urgency to solve this problem than when I started."

So with the ghosts of Commissioners past, I, too, am committed more than ever to the work of this Commission and join in the choir of past Commissioners to encourage all of us to be brave and bold and earnest in this work.

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

DR. MATHEWS: Yes. Just to address quickly the question that Karen and Sue raised about quantification of the financial impacts of MedPAC's recommendations over time relative to the magnitude of Medicare's funding problem. This is a great question to raise, and as you guys are aware, when we do make recommendations, we do work with CBO to in rough terms quantify the financial impacts of each of our recommendations. And I use the word "rough" because this is very different than the way CBO scores a piece of legislation where they are looking at specific parameters and they are taking into account interactive effects, that sort of thing. They are giving us, you know, broad what we refer to as "buckets" of financial impacts. And, you know, we publish those alongside of each of our recommendations that we make, and, you know, for internal purposes, we do keep track of, in general, how much those recommendations would save.

But we do not, you know, update the dollar effects of those recommendations over time, so we might have made a recommendation in 2007, 2012, that had a certain impact, and we leave it lie. So, you know,
carrying that impact forward to the present day would be an exercise that we simply do not have enough precision to devote to.

So it is a good question. We do pay attention to this, but trying to quantify the magnitude of our unimplemented recommendations against the current financial challenges would be a difficult proposition.

DR. CHERNEW: Thanks, Jim.

MS. KELLEY: Mike.

DR. CHERNEW: Yeah, I also wanted to give a quick reaction to Susan's comment. I was on the Commission for six years before, Susan. I'm not sure I heard as impassioned a speech in the entire six years. Maybe in this group it will be a monthly occurrence, but thank you.

What I wanted to say in response to that is first I agree and, whenever possible, I do think it's incumbent upon us to be bold. That said, there are certain challenges, for example, tax policy and how we should deal with taxes as the number of workers per beneficiary shrinks or broad program changes related to things like age eligibility and stuff are probably going to be outside at least where I particularly would like to go and limit
ourselves to, unfortunately, a somewhat narrower set of
policy options related to efficiencies and payments. So
that includes anything we can do in payment to encourage
efficient delivery of care. There's a bunch of those
things, as you know, and anything we can do in payment to
reduce overpayment of services, again, I think you know
there will be a bunch of those types of things. So that
gets to sort of the P and the Q of things.

I say this now, this is my first meeting for the
Commissioners, we'll probably avoid other important policy
questions related to the fiscal solvency of Medicare
related to, for example, tax policy and other broad things.

So that's just a little Chernew
contextualization. Hopefully we'll get through this, we'll
be able to have a Round 3, and we can engage on points like
that. But I do want to get through the rest of the
commenters. Again, Sue, thank you so much for the passion
and the eloquence of your comment.

So, Dana, who's next?

MS. KELLEY: Brian.

DR. DeBUSK: Again, great chapter, very sobering
chapter. This is the fourth time -- fifth time I've seen
it, and, yes, it is sobering every time.

What I want to do is mention I was really glad to see pages 9 through 12 of the reading materials where they looked at the spread between commercial rates and Medicare rates. And I do want to echo Amol's comment about closely following the effects of consolidation. You know, I think consolidation is at best a mixed bag. I think there's some benefits, but there are clearly some detriments, and I do think they may very well raise rates.

But, again, I'd really like to see us emphasize the growing spread, for example, in hospital rates between Medicare and commercial payers, because I see that it's almost like an earthquake fault line. You know, there's stress that's building in this crack, and I have to think at some point it will be beneficial. You know, you won't be competing against the marginal benefit of a Medicare payment. What you'll be competing against is the opportunity cost of taking on another commercial payment. And, again, I see this almost like a fault line, and when this fault -- when the earthquake happens, you know, I don't know that we're going to be able to go back with a 5 percent or a 10 percent payment update and simply fix the
problem. I think as the spread grows; I think the magnitude of the shift that could occur could be quite dramatic. So I think we do need to look for any early signs that there's a shift in not just hospitals but providers in general disproportionately pursuing commercial rates or de-emphasizing or abandoning Medicare beneficiaries.

Again, I do see this as a potential threat to Medicare in the upcoming years, especially as the spreads grow.

The second thing I want to point out, on page 25 of the reading materials, this is always a very sobering chapter, but I always find myself asking, you know, what's the insight? What can we get from this? Page 25 of the reading materials, it really stood out to me the differences in the spending per capita for some of these conditions like diabetes, ischemic heart disease. What really stands out is not just the difference in spending -- I mean, there are 60 and 100 percent increases in spending -- but the prevalence rates. You know, you're looking at prevalence rates of, you know, 57 to 27 percent, which were on the table in the reading material. And it makes me
think about what's actionable. And, you know, Jon, to
build on some of your comments about ACOs, do we need to
maybe place more emphasis on condition-specific population
health management? Should we be encouraging more special
needs plans, for example, in the MA world? Do we need more
diabetes SNPs? Do we need CHS SNPs?

When we did population health, you know,
arguably, MedPAC is a co-inventor of ACOs. When we look
back at that, could we have placed too much emphasis on
geography and perhaps not enough emphasis on condition? Do
we need to capture a very specific geography, you know, all
the way from the 65-year-old triathlete all the way to the,
you know, 92-year-old with six comorbidities? Should our
next round of APMs -- I know, for example, we do this in
ESRD. But should our next round of APMs focus on
population health, but should they be focusing on maybe
condition-specific populations? And is that a way to sort
of split the difference between a broad population health
solution versus, say, episode-specific bundles in lower
joint replacement? Is the solution to start focusing more
on these conditions that are called out on page 25?

Those are my comments. Thank you.

DR. PERLIN: I don't believe I'm in the queue, actually.

MS. KELLEY: Oh, I'm sorry. All right then. Betty.

DR. RAMBUR: Well, thank you, and thanks to the staff for a fabulous report.

So this is my first September, and I would say although I've been aware of these issues, this was very sobering to me. And I personally consider this an issue of intergenerational injustice. As a baby boomer, I think we have a responsibility to leave a better world behind. And I would have to say I agree with Sue that we need to be, I think, much more aggressive. And I won't repeat some of the great comments people had about ways we might do that. But as a clinician who has been in the trenches, I actually see that part of that aggression will probably need to be more mandatory alternative payment models, because I do believe practices do change, and I see many, many things that could be done differently to better use nurse practitioners and nurses and having people really think differently about care, not just medical care.
So to the extent that we can create circumstances that really create value, inform practice throughout the disciplines and across the continuum, I think we will have come -- at least taken some steps toward creating a more equitable circumstance by generation.

Thank you.

MS. KELLEY: Marge.

[No response.]

MS. KELLEY: Marge, we can't hear you. Just a moment. Let me check your microphone. Can you try now, Marge?

MS. MARJORIE GINSBURG: Okay.

MS. KELLEY: Yes, thank you.

MS. MARJORIE GINSBURG: Great chapter. Very discouraging. I have lots of comments, but I'm going to try to bring them down to just two general comments.

I'm very focused on the impact of the high costs on particularly low-income beneficiaries. And I read a lot of mixed messages in here. For example, original Medicare uses beneficiary cost sharing to deter overuse of services. And then as it turns out, only 11 percent of people who are on OM do not have a Medigap plan.
But on the one hand, we don't really want people to have a Medigap plan and actually -- so that was a recommendation early on that we charge more to discourage people as a way of trying to temper what people expect and what people are willing to pay for. And then, on the other hand, we are very unhappy because people are paying so much.

So there's a lot of the inconsistency here about the role that we should play in trying to do two things which are contradictory: discourage people from getting services that they probably don't need, and yet make health care affordable for everyone. So a lot of areas, and I'm happy offline to point out particular ones that I see inconsistency in this messaging.

And the other comment I will make is that have we ever at the end, the summary of all the recommendations is so interesting and so enlightening. At this point it feels like we're faced with such a gigantic problem. Have we ever thought about prioritizing our recommendations, making it really clear to Congress these are the ones, this is the order in which we need to move for you, Congress needs to move forward to get a handle on Medicare costs? And my own
personal belief is we've got to go after MA plans. I just
think it's sinful that we are paying so much more for MA
than we are for original Medicare, and I'm an MA supporter.
But I'm not supporting how much we're paying.

So thank you.

MS. KELLEY: Bruce?

MR. PYENSON: Thank you very much. A terrific
chapter. I wanted to point out a couple of optimistic
things, things that point to success and I think a
direction forward.

The reading material shows that Medicare has done
a much better job than other payers and the commercial
payers on controlling spending and controlling largely
through fees, despite ignoring many of MedPAC's
recommendations. I think that's a very important issue
because overall we're seeing health care siphon the
resources for things that are much more important to
people's health than health care, such as education,
housing, infrastructure, and other aspects, other
resources.

I think this is very relevant because although
we're not into tax policy, Part A is funded by payroll tax.
And to the extent that workers are paying a lot for their benefits, that puts pressure on funding Medicare.

In the past, this chapter has made very interesting comparisons to other countries, and I think that's very valuable information because it puts a path forward and the comparisons have been not just spending but also outcomes and quality. Over the decades, I've been an advocate for efficiency, better efficiency in utilization and prevention. But today I'm seeing those being used as excuses to blame physicians for inefficiency or to blame patients for chronic conditions. I just want to put in a warning that that's not something we should fall into. My view, which is part of the success of Medicare, is that we're just -- we're mostly paying too much. That's not to say we shouldn't strive for efficiency, strive for wellness and prevention. But the issue is the price, and I think we can afford to be bold in recognizing that and pushing that ahead.

Thank you.

MS. KELLEY: Dana Safran.

[Pause.]

DR. SAFRAN: Ah, there we go. Can you hear me?
MS. KELLEY: Yes.

DR. SAFRAN: Yes, okay, great. Just seconding that, the many complimentary comments about the chapter and the sense of how sobering this is, as I enter sort of the back nine of my Medicare Payment Advisory Commission service in year four.

I think I'll focus my remarks on really two things. One, just to amplify, I agree with other Commissioners that I really like the section toward the end of the chapter. I don't remember this from past years where you inventory the challenges that have been faced and the solutions.

Oh, goodness. I have someone at my door and no one else home to answer it. And I am expecting -- so can you come back to me later in the queue? I'm so sorry.

MS. KELLEY: Of course.

DR. SAFRAN: Thank you.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: This has really been a great chapter and a great conversation. I'm really glad that Sue raised the point about being bold because how else can you come away from this chapter without a concern about not
being bold enough. And, you know, I think we need to come up with recommendations that are administratively feasible and politically feasible, but I think we can be a lot bolder than we often have been.

I think Mike's comment about efficiency is very wise, and there really are two aspects of paying efficiently. While one aspect is that we don't want to pay more than we need to to get the quality and access that we seek, but perhaps even a bigger aspect of it is that we need to pay in an efficient way, which means, you know, fostering alternative payments, not overpaying for Medicare Advantage but shaping it so that it can play a role in providing care efficiently. So I think that we should follow that as our guide and also be bold in what we come up with.

I think when we look at the Medicare spending trends per enrollee, you know, they look pretty good. Part of it is that we're not paying the increasingly high prices of private insurance. But another reason they look good is that we've had a ten-year period of our Medicare population getting younger as baby boom people age into it. We have another ten years to go on that, but then it turns a lot
bleaker. So this just adds to the urgency that the chapter sets out of really grappling with Medicare's problems as soon as possible.

MS. KELLEY: Okay, Dana, do you want to go ahead now?

DR. SAFRAN: Sure. Thanks. So sorry.

Okay. Just picking up from where I was leaving off, I do really like the piece at the end of the chapter where you inventory what the challenges are and what our recommendations have been to date.

I was struck, I guess, by the fact that, you know, the cost per beneficiary spending is so outpacing as a driver of overall spending, the increases in enrollment, and the knowledge that with respect to spending per beneficiary, we know that it's really the utilization much more than the price increases that are dragging that.

There were a number of places in the inventory of challenges where you made reference to a kind of lack of mechanisms to address appropriateness, and so I'll just focus a couple of comments there. One is -- and others have highlighted this, too, but I think our recent and at this point many-year emphasis on growing value-based care
is really one critical lever for addressing the lack of
ability to continue to eat away at inappropriate care and
wasteful care. But I think we continue to understand that
we need greater adoption and we also need stronger value-
based care programs. I know I've emphasized multiple times
the importance of creating some models that really start to
get fundamentally at hospital payment and not only at
physician payment.

Another thing that I'd like to see us address is
the issue around data infrastructure to help us get a
better evidence base around appropriateness, and two
thoughts occur there. One is, you know, leveraging the
recent ONC regs around making clinical data more
accessible. How do we leverage EMR data in order to start
to build out the connection between claims and clinical
data to really understand process/outcome links and get
that evidence base on appropriateness?

In addition, it does strike me that this year of
COVID does provide a kind of natural experiment. We
understand -- we just talked for much of the morning about
changes in utilization. And I do wonder whether we could
use claims data to begin to understand what are the places
where forgone care resulted in harm and what are the places where forgone care did not result in harm and maybe even prevented harm and how can that enlighten us around a greater evidence base on appropriateness.

And then finally on that topic, you know, we've talked in past year, and I think it bears repeating here, that we lack the mechanisms up front, particularly in the drug space but elsewhere, to identify the cost-effectiveness of new innovations in health care, which will continue to be a driver in upward spending, and to know which of those new innovations are actually providing incremental health benefits and what should that imply in terms of the pricing, their inclusion as a covered benefit and at what price. And so addressing that very important gap in how the program is allowed to run I think is a critical thing that we have to think about, particularly with the oncoming tidal wave of specialty drugs and gene therapy, et cetera.

The last comment I'll make, something that Marge started to touch on, is Medicare Advantage. You know, the demonstration of the faster growth in Medicare Advantage spending and the higher spending in Medicare Advantage,
even though we know from quite a lot of literature that the population tends to be less sick, is something that we really just can't afford to continue to ignore.

I do want to make one small point, which is I wonder about adding in the chapter a line on that visual that would show us the combined original Medicare and Part D spending. Since, in general, those are addressing the same beneficiaries, I think it would be helpful as a comparator to Medicare Advantage. I don't think it will change what we see in that line, but I do think that would be a useful thing to show.

That's my remarks. Thank you.

MS. KELLEY: Jaewon.

DR. RYU: Thanks, Dana. I have two comments. One is -- and I think Jonathan and Betty and some others touched on it a little bit already -- around APMs. I also enjoyed pages 29 through 38 that had the inventorying of all the recommendations, but it did seem a little odd to me that we don't explicitly call out APMs and augmenting or growing or accelerating the development, the movement into those models. And I don't know if that's because it's never risen to a formal recommendation that
we've made, but it seems to be an area that does deserve
some explicit mention in the chapter as, you know, either
formal or informal -- I'll put it in quotes --
recommendation.

The second point I had was getting back to
Brian's comments around -- and I like his term of the
"fault lines," -- the differential between the payment of
Medicare versus commercial. It would be helpful if there
was some way to gauge how close or how far are we from
those fault lines. Are the fault lines already there? Is
it getting near a point or is there some threshold where
the differential becomes so great that we can anticipate
that there would be implications on access?

Every year when we do the payment adequacy work,
I think thus far we've seen that access is sound. It's at
a level that we feel comfortable with in the program. But
then you look at programs like Medicaid, and we see that
the differential there has clearly become great enough
where there are implications and effects on access.

Somewhere in between I think is where Brian's
fault lines may appear, and I think it would be helpful to
understand how close or how far do we believe we are to
those fault lines.

MS. KELLEY: Okay, Larry.

DR. CASALINO: Okay. So, you know, I think -- I just want to make a broad point. Pretty much all the Commissioners one way or another, our careers have been very much about trying to make medical care more efficient, both reduce the cost and improve the quality, and we're excited about that. That's what we do. That's what the Commission focuses on, and that's all good. And we're talking about being bolder even in our recommendations for making medical care more efficient.

But I wonder if we do have a duty to let policymakers, and the general public for that matter, know, give them a sense of what's realistic, and is our enthusiasm for increasing efficiency kind of blinding us to the situation we're actually facing? Are we basically sticking our heads in the sand?

So how much -- this gets back in a broad way, I think, to what Karen initially said and then others supported. It would be nice to get a sense of, over time, what the cost savings could be from the recommendations that the Commission has made and makes.
There's a big difference between reducing Part A spending by 17 percent, never mind also reducing Part B spending, and with the kind of savings we're seeing from the alternative payment models that we have now, big difference between 17 percent Part A reduction and, you know, half a percent ACO savings, for example.

So I think despite the fact that increasing -- you know, making medical care better is what we all care about, I wonder if it falls within the Commission's purview to try to make it a bit more clear how much can we expect from that, and if there's a big gap between what we think we can expect even with bold recommendations accepted by Congress and savings for making Medicare more efficient and what needs to happen to make Medicare financially sustainable, then that obviously does have implications for tax policy and for benefits, which we're not going to address, but policymakers should know about.

I myself often feel uneasy about this. I'm very excited about this program or that program, but I think if we're not very sober about what we can expect these programs to do and we just go on year after year this way, while the financial picture looks like this, maybe we need
to think in broader terms.

MS. KELLEY: Okay, Pat.

MS. WANG: Thank you, Dana. Just two quick comments.

One is -- and Dana Safran touched on it before -- I hope that we can keep the focus on the cost of drugs. Inside of this there's a text box in the paper that talks about a share of prescription and I think Part B spending of total spending increasing from 20 percent at one point to 23 percent. I would add to that the cost of drugs as an inpatient -- a cost input for things like inpatient care. You know, we sort of discussed it before when we've talked about the payment updates. I don't know if it's possible to kind of try to tease that out a little bit. I don't want to lose sight of the trend increase in the cost of drugs as one of the drivers. I realize that some of that is Part B, some of that is Part D, and we're talking about Part A trust fund here. But there is an interaction there, so I don't want to lose sight of that because I think it's worrisome.

And the second thing is just a general comment about the important discussion that is going on here as
concerns APMs. Brian's suggesting maybe we should have more chronic care SNPs, things like that. I think that, you know, we are by definition the Medicare Payment Advisory Commission, but the fact of the matter is that the issues that we're talking about here don't just start at age 65, right? The folks who are becoming dual eligible have been part of Medicaid plans for their lives, and they are entering the Medicare program with conditions that perhaps with different approaches could have been prevented from becoming a very serious chronic condition. Somebody who was on the verge of, you know, getting into serious trouble with kidney disease maybe doesn't enter the program with ESRD or become ESRD requiring. And so, you know, we're Medicare, so I'm not suggesting that we expand our focus -- we can't -- by legislative mandate. But I do want to just raise it as the issue because these things really do interact. The fault lines of commercial and all of the rest, this is a moving target here. Even before COVID, the commercial population was shrinking because people are aging into Medicare. And so, you know, providers are scrambling to sort of -- they have a sudden drop in revenue. It used to be commercial, now it's Medicare, it's
lower. And that contributes to the dynamic, I think, of pushing commercial prices higher to try to compensate from that and so forth.

During COVID, so many people lost commercial insurance because they became unemployed. They're now Medicaid. They're now Medicaid. So it's in the states that are fortunate enough to have a safety net big enough to have caught them, so that is a -- that doesn't even make it onto the chart in terms of the payment level, it's so far below Medicare.

I just raise this because I think there is a broader context. It's Medicare's problem to deal with the accumulation of all these issues when somebody turns 65. But we do exist in a much bigger world, and I think we have to keep sight of that.

For the elderly Medicare -- [audio difficulty] -- FIDE SNP, there's that huge interaction again with Medicaid. There -- [audio difficulty].

MS. KELLEY: We seem --

MS. WANG: -- different spending package. The only sort of specific thing I wonder about for our work is whether there is -- we can have that perspective when we
talk about ACOs, because a lot of the APMs are bundles for
the unit or for the specific condition that is being
treated. The ACOs and Medicare Advantage are population
health-based, and for ACOs I just don't know whether
there's more curiosity that we can have about ACOs and what
they're doing to promote wellness of their community so
that when people become Medicare-eligible, perhaps they are
in better shape than otherwise. It's just a thought. I
don't know if there's any way to incorporate that.

Thanks.

MS. KELLEY: And the last person on my list here
is David.

DR. GRABOWSKI: Great, thanks. And it's
fortuitous I'm going after Pat because I think a lot of my
comments really align well with that last point she made.
I was just going to make the point, so I'll make it very
quickly -- I don't think I can say it more eloquently than
Pat -- that Medicare doesn't pay in a vacuum, and many of
our beneficiaries don't receive services in a vacuum. So I
think this is really important in going back to Mike's
original charge about we need to encourage greater value.
I'm thinking of the discussions we had with the payment
updates every year. Hospitals -- obviously Medicare pays alongside commercial. We're the less generous payer there. We have to think about those issues in terms of a mixed payer model. The opposite issue, obviously the skilled nursing facilities where we're the more generous payer, how do we think about encouraging greater value when you have Medicare existing alongside these other payers.

And then I'm really glad Pat raised the duals, so I'll just piggyback on that comment. All of our dual-eligible beneficiaries also receive services through Medicaid. Oftentimes they're long-term care services. We've spent some time on this Commission obviously worrying about how to better coordinate those services. Pat mentioned the model like the FIDE SNPs. How do we actually measure value in that program? We know we spend a lot on services for those duals, but how are we making certain we're getting good value in return?

So I just think I'll stop here only to say that value is a really complicated issue here when you're thinking about Medicare not just paying in a vacuum but also a lot of our beneficiaries receiving services from other payers as well.
Thanks.

DR. CHERNEW: Great, David. And, Dana, that means, I think, there's no one left in the queue.

MS. KELLEY: That is correct.

DR. CHERNEW: So let me just make a closing comment before we head off to lunch. To the public, I want to remind them or at least let them know that many of the things discussed here by the Commission are going to be high on our agenda, particularly things like APMs and APM design and Medicare Advantage. We'll be spending a lot of time this year on those topics. We always spend our time on the fee-for-service prices. That is part of our core mission. And I think it's important to understand that we will only be successful if the delivery system can find ways to deliver care with less -- less costly. So the cost of producing care is in many ways the core problem that we face.

I will lastly say we've done a lot of things on drugs in the past. We're going to let some of that sit for now. We will surely turn back to that at some point. But the broader issue that I think we face -- [audio difficulty] -- prices. So we're going to spend our time on
some of these big-picture issues, and if you follow us over
the course of the year, and I encourage you to do that,
we're going to spend a lot of our time on the nooks and
crannies and inefficiencies in the system, ranging from
coding to a whole bunch of other things where we might be
more efficient to try and find ways to help Congress
maintain the sustainability of the program, and we will do
as much as we can in that regard.

So, again, I want to thank all the Commissioners
for their comments. We, I think, are now going to now go
to lunch. I wish we could go to lunch together. We're
going to come back, and if I've got this right, Dana, we're
going to be joining a different webinar, or at least
relogging on this again at 1 o'clock so we can take up the
first sort of real substantive thing, which is important
and fits in the theme of this, the skilled nursing facility
value-based purchasing program. So we will start there at
1 o'clock. Everybody, take a good stretch. I miss seeing
you all, and we'll see you all back at 1:00.

Did I miss anything, Dana or Jim?

MS. KELLEY: No. I think that sounds right. Go
ahead, Jim.
DR. MATHEWS: All good.

DR. CHERNEW: Okay. Thanks, everybody. Eat healthy. Do calisthenics.

[Whereupon, at 12:17 p.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]
AFTERNOON SESSION

[1:05 p.m.]

DR. CHERNEW: Hello, everybody. Welcome back. I hope you had a great lunch. I'm sure it wasn't as good as what the Reagan Building usually provides, but here we all are. Welcome back to the public.

We have three, I think, really interesting sessions coming up. I'm not going to take a lot of time because I want to reserve that for the discussion, but the first one is going to be led by Carol and then Sam about the skilled nursing facility value-based purchasing program. This is part of a mandated congressional report, and our hope is to see if in that report we can get some recommendations to help guide CMS and where they should go next.

So, with that, I'm going to turn it over to Carol.

DR. CARTER: Okay. Good afternoon.

Before I get started, I want to note that the audience that they can download a PDF version of these slides in the handout section of the control panel on the right-hand of the screen.
A value-based purchasing program creates incentives for providers to furnish efficient, high-quality care. Payments are tied to performance measures, with payments increased for providers with better performance and lowered for providers with worse performance.

CMS is increasingly tying Medicare's payments to value. As required by the Protecting Access to Medicare Act of 2014, or PAMA, CMS implemented a VBP for skilled nursing facilities that affects payments beginning on October 1, 2018.

PAMA also required MedPAC to evaluate the VBP program. The statute requires us 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 in 2021, and we plan to include it as a chapter in the June report. To meet this due date, we'll be working on the following timetable. Today we'll review the current program design and its results for the first two years of the program.
We should have third-year results later this year, and we can add those to our analyses. Today we will also identify the shortcomings of the current design.

Next month, we will outline an alternative design and assess its potential impacts, and compare its impacts with those of the current design. Depending on that discussion, the Commission may consider replacing the SNF VBP with an alternative design.

In January, we will consider an alternative design for the VBP as when it was a policy option.

In March and April, we'll review the draft and final reports, and based on your discussions, the report may include recommendations.

So let's start with an overview of any VBP design, and there are four key elements. First are the measures that are used to gauge performance. Then there's a volume minimum, and that's a threshold that helps ensure that the measure results are reliable. Providers with volume below the minimum are held harmless from the program, and their payments are neither increased nor decreased.
Scoring translates a provider's performance into a payment adjustment. For providers with sufficient volume, their performance during a performance period is compared to other providers or to some performance scale and then scored. This score is then converted to a payment adjustment that is specific to each provider. This adjustment is then applied to each payment during the year.

Finally, there is a method to finance the program. Often the financing is done with an amount withheld from each payment. These withholds create a pool of dollars that is then distributed back to providers.

Now to the specifics of the SNF VBP. PAMA requires that the program use one measure -- all-cause hospital readmission rate. This measure counts any unplanned readmission within 30 days of discharge from the hospital.

The statute requires that this all-cause measure be replaced with a potentially preventable measure as soon as practicable. This fall, CMS plans to submit the potentially preventable measure to the National Quality Forum for endorsement, and then CMS will assess the timing of a transition after the NQF has completed its review.
CMS has stated that it does not have the authority to add measures to the program. In terms of scoring, the statute requires that each SNF performance be gauged for improvement and achievement, and the incentive payment must be based on the higher of the two.

The improvement score awards points if a SNF's readmission rate during the performance period is lower than its rate was during a baseline period, and more points are awarded for larger improvement.

The achievement score awards points based on how much better a facility's performance is relative to a threshold.

The baseline and performance periods are one year in duration.

To convert a SNF's performance into an incentive payment, CMS uses an S-shaped exchange function to translate the total performance score into a multiplier that is applied to each payment, and the law requires that payments must be lowered for providers with the lowest 40 percent of rankings.

Regarding a minimum volume, the VBP assesses
penalties and rewards for providers with at least 25 stays in a year. SNFs with fewer stays are held harmless by the program.

In terms of financing, the statute requires that the program is financed by a 2 percent reduction to payments. The statute also requires that aggregate incentive payouts be between 50 and 70 percent of the total pool of dollars collected, with the program retaining the remainder as savings. CMS opted to pay out 60 percent of the withheld amounts, with the program retaining 40 percent as savings.

And now Sam will go over the results of the first two years of the program.

MR. BICKEL-BARLOW: In each of the first two payment years of the program, 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.

Many SNFs earned back essentially none of the 2 percent amount withheld, 21 percent of SNFs in fiscal year 2019, and 39 percent of SNFs in 2020.

A small share of SNFs received the maximum increase. In 2019, 3 percent of SNFs earned the maximum,
which was 1.6 percent. In 2020, fewer SNFs earned the maximum, which was 3.1 percent.

This chart shows the distribution of adjustments to payments in each of the first two years of the program. In 2020, the distribution was more spread out, with a higher share of SNFs receiving the minimum payment adjustment and a higher share receiving a larger maximum payment adjustment than in 2019.

We also looked at the consistency in individual SNF performance across years. Many SNFs that received a large reduction in payments in 2019 also received a large reduction in payments in 2020. Except for these SNFs, there was little consistency in performance across years. Compared with 2019, in 2020 more SNFs received a lower payment adjustment than received a higher payment adjustment. The lack of consistency in performance across years could indicate that the minimum count is too low.

Our mandate requires that we look at performance of SNFs by social risk factors. We used the share of patients that are fully dual eligible for Medicaid as a proxy for social risk. We found that adjustments to payments were related to shares of fully dual-eligible
1 beneficiaries.

2 Providers with the largest reductions to
3 payments, in yellow, had higher shares of dual-eligible
4 beneficiaries compared with providers with the largest
5 increases in payments, the green bars.

6 In fiscal year 2019, 46 percent of beneficiaries
7 in the worst performing SNFs were fully dual eligible
8 compared to only 33 percent in the best performing SNFs.
9
10 In multivariate regression work, we found that
11 incentive payments increased for providers with higher
12 volume, higher occupancy rates, and for hospital-based
13 providers. Hospital-based providers typically have lower
14 readmission rates than freestanding facilities.

15 Incentive payments decreased for providers who
16 treated patients with higher risk scores and higher shares
17 of fully dual-eligible beneficiaries.
18
19 Across the two years, we did not find a
20 consistently statistically significant effect of staffing
21 levels or ownership.

22 DR. CARTER: Before turning to the shortcomings
23 of the design, I want to review the Commission's principles
24 for quality measurement because they help us identify the
The Commission's principles state that quality should be gauged using a small set of outcomes, patient experience, and value or resource use measures that are not burdensome to report.

A provider's performance should be scored against absolute performance standards that are known in advance.

The scoring should convert performance to payment using a continuous scale that avoids cliffs in penalties or rewards.

Finally, as necessary, the value-based payment should take into account differences in providers' populations, including social risk factors through peer grouping and not by adjusting the performance scores.

In identifying the shortcomings of the VBP, I'll note where the current design features do not meet these principles.

The mandate requires us to make recommendations as appropriate, and the first step in doing that is to identify any shortcomings in the current design.

A key shortcoming is that the program only uses one measure to gauge performance, and yet we know quality
is multidimensional. Further, the Commission stated that value-based programs should gauge outcomes, patient experience, and resource use.

We also have issues with the measure itself, which are discussed in the paper. Most notably, it does not hold providers accountable for all readmissions that occur on their watch; that is, during the entire beneficiary stay.

A second shortcoming of the design is the minimum count. It is too low. It does not meet a commonly used standard of good reliability. CMS reported that the measure is at the low end of moderate reliability, which may not differentiate performances especially for small providers.

Another shortcoming is that the scoring does not encourage all providers to improve. SNFs in the bottom 40 percent of rankings must have their payments lowered, and the scoring includes thresholds that create scoring cliffs. The design also does not account for social risk factors of the patients treated by a provider, and yet we found that providers with high shares of fully dual-eligible beneficiaries were more likely to receive
penalties than rewards. Facilities with poorer performance may lack the resources needed to improve.

Last, the 2 percent withhold may be too small to motivate providers to improve.

In October, we will outline an alternative design that corrects these shortcomings. We will estimate the impacts of the alternative design and compare these to the impacts of the current design. Based on your discussion, we will then outline policy options for replacing the SNF VBP with an alternative design.

Today we'd like to hear your reactions to the results of the program and the shortcomings we've identified.

And now we'll turn back the mic.

DR. CHERNEW: Great. That was terrific. Thank you for all the material.

I have asked Dana Safran -- actually, I take that back. Dana Kelley. We're going to start with Round 1.

How is our Round 1 queue looking?

MS. KELLEY: I have Jaewon, and also, Paul, did you want to be in Round 1 or Round 2?

DR. PAUL GINSBURG: Round 2, please.
MS. KELLEY: Okay. Then I just have Jaewon.

DR. CHERNEW: Thanks, Dana. A fantasy Round 1.

DR. RYU: I just had a quick question. I'm not sure I'm understanding the risk adjustment commentary correctly on page 19. It sounds like the higher the risk score, the less likely that the entity would receive the positive adjustment, but it also says that we think the risk adjustment model is complete. Do we have other working hypotheses on what we think is going on, then? Is it that there's other correlations at play that's driving that? I would just love to hear a little bit of thought on that aspect.

DR. CARTER: We think the risk adjustment is pretty good. So it's possible and -- but, of course, no risk adjustment is perfect. So it's possible that there are, I'm sure, other dimensions of care that probably, at least I don't see a way to gathering, using easily and readily available administrative data.

It's just, I guess, I think I'm thinking these providers actually perform more poorly. So it's not in the risk adjustment. It's actually in the performance.

David, I think you have an article that came to
the same conclusion; is that right?

DR. GRABOWSKI: Yeah. We used a slightly different readmissions measure, Carol, where we used kind of a longer lookback period. So we got around the small sort of numbers problem. We used a three-year lookback versus the one.

And then we also risk-adjusted for those social factors, like the percent of duals, which this program doesn't. And that was going to be my response to Jaewon. Maybe there's some correlation with the acuity and the social risk factors that they're not accounting for here.

MS. KELLEY: Pat, did you want to be in Round 1 also?

MS. WANG: Thank you.

It's just a question about the readmission measures. You mentioned that CMS has created a potentially preventable readmission measure. How is this different from the current HEDIS specifications around potentially preventable? Can you comment on whether there are characteristics about nursing home readmissions that need to have different components or measure differently? Is this a different readmission measure than is used in other
settings that are the NCQA definitions?

MS. TABOR: I can take this, Carol.

The measures are conceptually the same, looking at the readmissions within a certain time period, all using 30 days, so hospitalization is 30 days after discharge. I will say the risk adjustment models are different, and some of the definitions of how you calculate the numerators and nominators are different, and you've got the problem -- you know, we kind of see across programs, that in different sectors, the measures, again, are kind of conceptually the same, trying to move providers into reducing readmissions, but how it's populated, there are differences.

MS. WANG: Is this one homegrown by CMS?

MS. TABOR: They work with the contractors to develop this one, yes.

MS. WANG: Thank you.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Oh, sure.

MS. KELLEY: Oh, wait. I'm sorry, Paul. Can I interrupt you for one second? I'm sorry. I've missed one Round 1 question.

Larry?
DR. CASALINO: The question on page 24, you have a nice discussion of the readmission measure, what it probably -- evaluation and what it doesn't, and then some discussion of alternatives. But in the end -- the discussion was interesting, but in the end, I wasn't really clear about the alternatives and then particularly the last sentence, "The Commission supports a separate measure."

So just in the work for the next meeting where you talk about alternative designs, can you tell us a little bit more about what a readmissions measure or measures you're considering?

DR. CARTER: Well, let me just say one thing about the current measure, and then we can give you a sneak peek at the measure that we're proposing for next time.

This measure, because it includes 30 days from discharge from the hospital, depending on the length of the stay of the SNF stay, it's going to scoop into that measure, days when the patient has been discharged and either is in home health or home or maybe been in another PAC setting and days during the stay. So it's actually conflating two very different sets of kind of responsibilities, the SNF and what they're responsible for
during the stay and a good transition to the next post-
acute care or home. And it's kind of mixing both of those.

I think CMS did that because it was by statute
could only use one measure, and I think it was concerned
that if it only looked at readmissions during the stay,
that it would encourage SNFs to discharge a patient if they
thought they were going to be readmitted, and then they
wouldn't have a measure to capture the readmissions after
discharge.

So one of the things that we've always said you
need a measure that's for the stay and one after the stay
because they capture pretty different things about the care
process. So the measure that we're thinking about, we have
a couple of measures, and they will correct both of those.

DR. CASALINO: Carol, you don't want to say right
now what those are?

DR. CARTER: Well, we actually last year
presented them. One is a hospitalization measure. So it
includes hospitalizations, readmissions, and observation
stays, and then a second measure is safe discharge home.
And that is a measure of when the beneficiary went home,
were they readmitted, or did they die in the first 30 days.
And so it sort of deals with both of those pieces of the process of care.

DR. CASALINO: Thank you.

DR. CARTER: You're welcome.

MS. KELLEY: Wayne, did you have a question?

[No response.]

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

DR. RILEY: Okay. Let me see. Hello.

MS. KELLEY: There you go. Yes.

DR. RILEY: Thank you.

Good afternoon, Mr. Chairman and fellow Commissioners. Delighted to be a part of this great group. The erudition is just amazing.

A question, in terms of -- was there any geographic variation in the average increase in rate of readmissions? I'm curious. Did you see any regional differences?

DR. CARTER: Yes. And there's a little bit in the paper that talks about the variation by state. This is similar to the variations you see in all kinds of measures in health resources. Yes, there is quite a bit of
variation.

MS. KELLEY: Okay. Dana, were you going to lead
off, or, Mike, did you want to speak? I think Dana was
going to lead off Round 2.

DR. SAFRAN: Okay, great. I'll be very brief.

Thank you, Dana.

Can you hear me? Okay. I'll be very brief.

I think this is a very well-done chapter. I
think you do an excellent job of highlighting the
weaknesses in this program, which in my estimation are
considerable.

I would put it this way. Not only is there just
one measure which really is a severe limitation for any
program that attempts to do performance-based payment for a
category of Medicare provider, but that measure, it
appears, is so noisy due to small sample sizes that we're
effectively not really measuring anything real about these
institutions and we're moving money around. So it's very
concerning to me.

I think the staff knows very well that there's an
excellent and well-accepted methodology in the field for
computing the minimum sample sizes needed for reliability.
Back when I was at Blue Cross, I had that number for this measure, and I don't remember it. But it was more than 100. It may have been 200. It's certainly not 25. So the fact that we see institutions year over year balancing from one category to the next tells us what we need to know about the reliability and stability of this information.

So I think that this has to be -- it has to be addressed, or the program perhaps has to be paused until we have sufficient sample. You do a nice job in the chapter of exploring some options, you know, multiple years of data. We've talked before about how that's problematic, especially for low performers who then have an anchor that they're dragging around year by year as they try to show a better performance.

We could consider an all-payer version of this measure. I think that's an option to consider, to see if we could get closer to the sample sizes required.

And then the two other points, I guess, I would make are, number one, that we make a little bit about the concern around duals, and if, in fact, that is not noise also, then I agree it's concerning. But I am fearful that
what we're seeing with respect to the duals finding here
could also be noise. So I'd ask us to consider that. But
for sure, we'd want this program to use the same approach
to social risk factor stratification that we recommended in
others.

Then, finally, there's some commentary in the
chapter about questioning whether 2 percent is adequate.
There's some citations from folks in the industry saying 2
percent is, in fact, a number that's not at large and not
large enough to overcome the cost that would be required to
make improvements. That surprised me just because I think
the margins for SNFs are quite small, and so 2 percent in
that context, it seemed to be quite significant. So I just
had a question about that.

The last comment I'll make is I'd be more than
happy -- I think David probably has the best breed of any
of us because of his expertise in long-term care space for
thinking about what other measures might be possible. For
sure, we'd want some patient experience, though that's
complex for this population, and we don't want to have to
rely on proxies. We'd want outcome measures more than
process, but if it's useful to the staff to have a session
of thinking about what the options are so we can make some affirmative recommendations about other measures, I'd be very glad to be part of that.

Thanks.

MS. KELLEY: Okay. David, I think you're next.

DR. GRABOWSKI: Great. Thanks, Dana.

My comments line up really well with Dana Safran's. I'll just say at a high level, the SNF VBP is just a terrible policy.

In the spirit of full disclosure, I was part of the team that evaluated the nursing home value-based purchasing demonstration, or the NHVBP, which was the predecessor or the demo with which this current program is built on. We had a lot of ideas for CMS. Unfortunately, they fixed some of them but created other problems and didn't end up fixing other parts of the program, and so we're left with really a flawed program. It's never a good sign when the MedPAC staff can't even fit all the shortcomings on one slide. Carol actually had to go into a second slide there.

And I think the two most damning shortcomings or the two most important in my mind -- Dana did a great job
of focusing in on this first one, that readmissions as currently constructed are really poor measure of quality. As Dana suggested, it's largely noise with very little signal there, and I also -- Dana was troubled by just the lack of consistency across the two program years in terms of which facilities received rewards and penalties.

The second, I think, most important shortcoming is just this idea that the measure, the program is regressive. It's really rewarding to have and penalties the have-nots. The program is taking dollars out of low-resource SNFs that nominally care for duals and giving them to facilities that care for fewer duals. This is obviously not the kind of program we want to have in place.

I would suggest that there's a number of potential fixes here. First, we want to fix the readmission measure. We want to account for social risk factors. We want to fix the minimum count threshold, as Dana was suggesting.

I really like where Carol was going with fixing readmissions during and after the stay. I think that's a really important issue.

I did want to quickly again mention that paper
that Carol raised. It's the Rahman and colleagues paper that's cited in the chapter.

We've validated a readmission measure. So I do think there is some validity to measure, but our measure that we looked at was very different in terms of sample size, in terms of incorporating the social risk factor.

I don't want to throw out readmissions as a measure. I think that there's something here, but I think we need to work on fixing the readmission measure.

Second, we need to fix the performance measure. Once again, there's no need to account for both overall improvement and performance. With proper risk adjustment, we can focus just on performance.

But for the Commissioners, we hate payment cliffs here in MedPAC. So we need to get rid of those cliffs and get a more continuous payment methodology that doesn't have those thresholds.

And then third -- and Dana did a nice job of highlighting this -- we need more measures. I do think, once again, readmissions is a good start when properly constructed, but the challenge is finding other claims-based measures. We often look towards mortality. That's
not a very good measure in the SNF context. There's not much in the way of patient experience measures.

I do think we want to think about other claims-based measures. I think we want to avoid MDS, minimum data set-based measures due to the self-reporting bias there, but I hope that we can think about additional measures that might go alongside the readmissions measure.

Final point -- and I had a similar reaction to Dana. One area where I would push Carol and the team is around the size of the withholding is 2 percent and whether that's too small, kind of the old pennies for performance problem. This reminds me of the old joke from Annie Hall where two older women are at a restaurant, and one of them says, "Boy, the food at this place is terrible." The other one says, "Yeah, I know, in such small portions."

I don't know why we want to make the SNF VBP portions bigger until we really fix the quality of the program. I think, Carol, I would be really reluctant to sort of put more dollars on the table here until we're certain we're just not paying based on noise.

I like what Dana suggested, pressing pause on this program until we fix it, because I really don't like
the idea that we're taking dollars out of low kind of -- I should say high-resource facilities that are carrying for a low share of duals and giving them to facilities that are basically caring for a more vulnerable population.

I hope we can fix this. I do have hope for it, but I think it's a really poorly constructed program as it currently stands.

Thank you.

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

DR. CHERNEW: Yeah. So I think the queue is building, and so I'm going to give people time to get in the queue. But I want to say, first of all, Dana and David, those were excellent comments and I'm completely on board with the direction both of you are going.

But I'd like to get a sense from the rest of the Commission is that there's a lot of flaws in this program, which I think Carol laid out, and Dana and David emphasized, I would lean toward the recommendation that this program should be paused until we could actually get the fixes in place. I worry sometimes that we spend a lot of time doing minor tweaks, and this is in some ways an anti-Robin Hood program. It robs from the ones we care
about and -- we care about everybody -- it robs from potentially the ones serving the poor and gives to the other places. I'm not completely sure that's true but I suspect that that's true, given the analysis.

And so I'm leaning towards, back to Sue's earlier comment, a bolder recommendation that this should just be stopped until it's fixed. And then a bunch of constructive comments about how to fix it, and I think Dana, your comments were very well taken. I agree. Your expertise on sample size and stuff is really important, and the number of measures matters. David, I agree with your points as well, how you said that.

But what I really need to think through as we go forward is where the rest of you all are on that level of approach. If you're a strong proponent of this proposal, now is the time to speak up. Or if you fit where David and Dana and, frankly, where I am, please say that. But that's kind of what I'm trying to get out of the remaining parts of the session, and anything else you want to say is obviously welcome.

So Dana Kelley, I'm turning it back over to you to manage the queue.
MS. KELLEY: Okay. It is now Paul's turn.

DR. PAUL GINSBURG: Thank you. This is really well done, and to me, who is not an expert in post-acute care, the big takeaway is could some value-based payment models can be sufficiently flawed that they're not doing us any good, and we need to really put as much work as possible into developing the models well.

I support pausing this, but with a strong plan to fix it and resume it. And one thing I was asking myself is that this is a mandatory program. It followed a demonstration. If we had continued as a demonstration, I'm not sure that we would've actually found out how flawed it was. And given the potential for fixing things, this has not limited my interest in pursuing these programs in mandatory designs.

One question that I was going to ask in Round 1 but decided it would be too sneaky in getting my big picture things in is, as far as the fixes that were recommended by staff or by Dana and/or David, how many of these would require legislation versus regulations by CMS? Because if some would require legislation, it just brought in some of the pitfalls of Congress writing legislation.
that's overly detailed and prescriptive about how to do value-based payments. I've long felt that the ACO program has suffered from some of the details in the 2010 legislation that established it.

I guess one other thought -- again, I think it's a question for others -- is when the legislation that we've been asked to look into was passed, to what extent did it reflect the best thinking at the time? And, you know, maybe that's just crying over spilled milk, but in a sense it's relevant to this notion of to what degree should Congress get into the details in value-based payments or give much broader directions and constraints to CMS to implement that, with the understanding that with experience these things will be changed as we learn more. Thanks.

Dr. Carter: So if I can just jump in, I'll address some of that. So a lot of the weaknesses of this program are in statute. The minimum count is not. But the single measure, the improvement and achievement, the scoring cliff, and the size of the withhold are all in statute. And so depending on -- it sounds like your discussion is leaning towards a recommendation, and it sounds like at least some of that is going to need to be
directed to the Congress.

MS. KELLEY: Okay. Amol?

DR. NAVATHE: Thank you. So first off, I wanted to say that I, you know, broadly speaking, support, in the context of SNFs and post-acute care, but secondly, support the recommendation from folks as far as stop the program based on the flaws inside the current program.

The second thing is I just wanted to offer what I thought was a clarification. So my understanding is, based on our own payment adequacy work, SNF payments are actually relatively high. SNF margins, as a consequence, are relatively high compared to other provider types. So we should take that into consideration when we think about how to design a program sort of separating, to some extent, what we want payment rates to be and how we want VBP to function, with respect to those 2 percent withholds and how that could work.

So in other words, we could suggest that rates are higher and the payment updates at those lower rates, and then have about a budget neutral type VBP program consistent with many of the Commission's principles.

One just really minor suggestion is I believe
Figure 1 in the paper had a histogram. I think virtually because of the 40 percent eclipse it might actually be nice to see that histogram in terms of percent of SNFs rather than number of SNFs. That's easier to tell, actually, where that cliff is impacting the distribution. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Well, I really got into the queue to ask a question, which I'll ask in a minute. But just responding to Mike's question about a pause, yeah, I would support a pause. We want the pause to be as short as possible, but of course, if a new program is going to require legislation it's hard to say how long the pause would be. So if we do wind up recommending that we would want to put some urgency, I think, into the recommendation that a new program be developed quickly.

And then just to point out that, again, I do support a pause but supporting a pause of an undetermined length we're essentially saying that the current program is worse than no program. And I think I agree with that, based on the staff's very lucid presentation. But just so we're all clear that that's what we're saying, it's worse than no program.
The question I wanted to ask, and this is for David and Dana and anybody else, is to the count, to the minimum necessary for readmissions measure, for example, to be reliable. What are the alternatives? Dana, you not big on multi-year. You mentioned multi-payer. A high count in a single year, just Medicare, is going to exclude a lot of homes, I guess, which might or might not be a bad thing. Do either of you, or anybody else, have any ideas about what to do with the count program, which is not unique to this program? Because we can criticize it but we should have a better alternative, in terms of the count/reliability.

DR. SAFRAN: Yeah, I don't have a great idea, you know, other than evaluating other measures where perhaps the required sample sizes could be smaller. But, you know, I'm not very knowledgeable about over the course of the year roughly how many different Medicare beneficiaries does a SNF typically have, and I imagine that's quite variable. There are larger ones and smaller ones. But having that information might help us think about, you know, are there going to be any measures that are going to meet the kinds of samples sizes that, let's say, 50 percent of SNFs or 60
percent of SNFs have over the course of a year.

One sort of wacky idea, but I'll just throw it out there, is the kind of grouping of SNFs, if there's some way that, you know, you want to have SNFs held jointly accountable, and they want to identify others with whom they want to partner so they have enough sample and then partner on performance improvement concepts, you know, that's one way to get to larger numbers. But I know it would be quite unconventional.

MS. KELLEY: Mike, did you want to go ahead?

DR. CHERNEW: I do, because I want to say, Larry, yes, I believe this program is worse than no program. I mean, I believe that very exclusively, based on my read of the chapters and the presentation and the comments by David and Dana, and I think we should not pursue value-based purchasing for the sake of doing it, that we can actually do more harm than good by taking -- I think this program probably, for example, exacerbates disparities. Why we would want to do that doesn't seem to make sense to me. You could convince me otherwise and I'm all ears, if someone wants to convince me otherwise, but my strong sense, given the chapters were not getting better quality
or making disparities worse.

Again, I could be proven wrong but I do believe that it's worse than nothing, and I think we should wait until we get something that's better than nothing before we do something. That's my personal view, just to respond to your comment.

So I think, Dana, you might want to go back into the queue.

MS. KELLEY: Brian?

DR. DeBUSK: Thank you. Thank you, Dana. Yeah, you know, the one thing when I was reading this chapter, what really stood out, with all the really quality work that we've done over the last year or two on developing that VBP template, like we used for the HVIP, like we used for the MA bid, it seems like this is something if we could go back to that same set of principles -- small set of core measures, use peer grouping, no tournament models. I mean, it seems like the template is really well-defined here, and I'd love to see us use this as an opportunity to standardize, yet again, the value-based purchasing program.

So, you know, Lydia and Carol, I was thinking, you know, that would be a solid week's work to get this
thing recast into the SNF model. Correct?

MS. TABOR: You're going to very excited for the October presentation.

DR. DeBUSK: All right. I was hoping that was in the works when I read the chapter, because I think the work that you guys have done building up to this is spectacular, and this is the perfect -- it makes to just pour it right into the template that you've already built. Thank you.

MS. KELLEY: Pat.

MS. WANG: I just want to respond to Michael's request for feedback on the question of pause or not, and I support pausing it. The analysis and the commentary here make it pretty clear to me that this is worse than no program at all, to answer Larry's question. I don't know how complicated or easy that is to achieve, to just sort of say time out. I don't know if CMS has any discretion over that or whether that it's congressional. But I just wanted to respond. Thank you.

MS. KELLEY: Dana, did you want to say something?

Okay. Then Jon Perlin.

DR. PERLIN: Thanks. Let me thank the staff for a very lucid presentation. I think the sentiment of the
group, I completely endorse. If we have a program that we
think is, marginal, at best, indifferent, that works
potentially worse than status quo, then just recommend it.
It also violates our expressed view on measures.
But I have two questions, really. One, it feels
a little bit like we're bidding against ourselves. I
thought the direction we were headed was related to this
concept of a unified post-acute prospective payment system,
or something that inherently builds in risk.
And second, related to that, I mean, a singular
measure can be so monodimensional and the measure that is
below a frequency event is inherently going to be
unreliable. And, you know, machinations to pick longer
times produce the predictive value in terms of trying to
make an assessment of whether that’s a good environment.
And that would seem combining the notion that
there may be an opportunity to unify some of our thinking
with the broader program nothing that we've been espousing,
that we also ought to be thinking about unified suite of
measures that really create, if you will, a balanced
scorecard, that look at cost, that look at outcomes, look
at measures of experience, and structure. And I'm not a
big fan of structure, but, you know, does that environment provide rehabilitative potential and certain skills? Does it provide infection control resources, and some of the things that have really been brought to light during COVID.

So those are my two points, one, you know, how do we align this with our thinking about an overall unified program, and two, across unified program, how do we think about a suite of measures that are more reliable? Thanks.

DR. CARTER: So just as a point of clarification, the measures that we're thinking about with an alternative design were developed across the four settings, so you could use those for other settings. We had explicitly in mind.

DR. PERLIN: Exactly my point. Thanks.

MS. KELLEY: That's all I have in the queue, Mike.

DR. CHERNEW: Great. So maybe we'll be way ahead of schedule and that will be amazing. We'll see if anyone else wants to add, although some of you haven't spoken and I may call you out just to get your sense of where you are in terms of a consensus or not. So I'm going to ramble for one second while you ponder your thinking.
I have a related question. Would it be possible -- this is almost a semantic question -- to create a composite measure? In other worse, these multiple measures create a composite measure from them, and then call that a single measure and claim that CMS is now meeting its single-measure criteria. In other words, if you built a composite measure and judged based on that composite measure, in some sense they're using a single measure. It just is a really multifaceted one.

I realize that's semantic, but it strikes me as a potential way out of this single-measure limitation that Dana mentioned.

The other thing that's nice about composite measures is you can deal with some of the sample size issues in composite measures in ways that are harder if you have a single measure, because you can bring in other pieces of information.

And lastly, I would add, no one mentioned this although it comes up in the chapter. There's this question about going back to get data from earlier years, and there's some hesitancy to do that. I share that hesitancy, in some ways, but I think in the grand scheme of evils,
going back and expanding sample size by looking at earlier
years is a lesser evil than some of the sample size
problems, again, that Dana was speaking about.

So again, I think there's a lot of creative
things that CMS could do maybe with or without legislation
that we could think about, and that we can take offline.
But the current approach, again, remains particularly
troubling to me.

So how have I done in terms of getting more
people in the queue, Dana?

MS. KELLEY: Not that well, to be honest.

DR. CHERNEW: Oh my gosh. So let's see. I'm
going to go around the top. Karen, I've been trying to
keep track here. Karen, I haven't heard your thoughts
about -- you don't have to say much. Are you with us,
against us, or uncertain? Are you pro or do you want to
share?

DR. DeSALVO: Most everything's been raised that
were my concerns. Let me just say, first of all, I think
David's comment that if it takes that many slides or that
much text to point out the flaws in the program, that there
are more that we could get into, then we think it's
problematic. It's a highly vulnerable population, and it's also sort of an area where we wouldn't want to exacerbate disparities, as you raised, Michael. And I think it's not only about disparities based upon income but other social factors that are sometimes harder to gauge. We all know clinically that sometimes people, you know, struggle to be home because they're alone and they have transportation or food security issues. There's a whole host of reasons why some of the things that may make sense in other environments won't here. So being able to adequate incorporate that thinking into the measures and the payment.

And I think the other point that was made is that having value-based care models for the sake of doing that, it isn't the goal. The goal is to really make sure that we're being responsible with Medicare dollars and serving the populations well.

So I'm excited to see what the team is going to come back to us with. I like the foreshadowing. And I really appreciate the attention to thinking through the responsibility that we have here to do right by the beneficiaries, especially those who are highly vulnerable.
1 So I'm with you.

2 DR. CHERNEW: Great. Karen, thank you. Again,

3 Dana, jump in if someone joins in, but I'm going to go

4 around my screen, which you can see my order.

5 MS. KELLEY: Mike, I do have Betty.

6 DR. CHERNEW: Betty, you're up.

7 DR. RAMBUR: Thank you, everybody. So I

8 certainly concur with the need for a pause. I do think the

9 idea of a composite measure is intriguing. I just wanted

10 to underscore what was said by David, I believe, about

11 mortality being a bad measure because of the potential for

12 measurement-driven behavior that creates measurement-driven

13 harm.

14 And I'm really sort of stuck on this notion or

15 this question. Is the potential for reward really not

16 large enough, or is it that it just seemed like too much of

17 a lift, like just can't get there? And I don't know how we

18 think about that.

19 So those are my thoughts. I'm definitely in

20 support of a pause.

21 MS. KELLEY: Dana.

22 DR. SAFRAN: Yeah. Just one very quick comment.
It occurred to me after giving my remarks that one of the things I recall with our global budget model at Blue Cross Mass was that hospitals started to have criteria by which they evaluated nursing homes to decide where were they going to send their volume, because they wanted to be sure they were good partners who weren't going to kill their budget.

And so I do wonder, as part of the work ahead, as we try to figure out what might some alternatives be, whether we want to do some interviews with hospital leaders about how they evaluate SNFs. That was just an idea to throw out there.

DR. CHERNEW: Great. Well, the next person around the screen that I see is Marge. You're up, Marge.

MS. MARJORIE GINSBURG: Okay. You can hear me?

DR. CHERNEW: I can hear you perfectly.

MS. MARJORIE GINSBURG: Thank you. So I concur with everyone else about the pause. I confess I am intrigued, Mike, with your statement about is there any way that we can consolidate the issues being addressed in a way that doesn't completely kill it.

So I guess my question is, is there any amount of
tweaking that could be done with the existing model that moves it from the no-go to yeah, it's keep it going and then do serious tweaking later? So we run the risk, if anybody pays attention to what we have to say, about killing it entirely, or is it easier, as I said, to try to make a few changes that make it just barely doable? Is that clear?

DR. MATHEWS: So this is Jim. I'm happy to try and take that question. So given the analysis that we've done over the last year or so, looking at the current VBP, you know, I think the message has punched through, given some of the commentary from the Commissioners thus far. We do believe that the current SNF VBP is not really salvageable in its present form, and given that some of the flaws are attributable to certain statutory constraints, that if you're going to change legislation it's probably better to just sweep away the current system and change it with something that is holistically better.

And as I'm listening to some of the commentary here, I can tell that maybe we've been a little bit too coy in alluding to what's coming in October, but our intention is to be able to present to you, in a holistic way, what
the better thing is. So if Blue Cross, loud and clear, paused, you know, this is worse than doing nothing, that is something we can accommodate when we come back and regroup after this meeting. But we will have something for you to react to that would be a wholesale replacement of the current SNF VBP.

MS. MARJORIE GINSBURG: Great. Okay. Thank you.

DR. CHERNEW: All right. Absent any other volunteers I'm going to call, if I can, on Wayne. I feel like I'm back in class.

DR. RILEY: Thank you, Chairman. No, I agree. This program should be paused and re-tinkered. I do agree with many of the comments, that I do worry about the health disparity dimension to this, knowing that, again, many seniors, African American seniors end up needing skilled nursing care at significantly higher rates, particularly, you know, in the southern part of the country, that we do need to pause it but try to get it reactivated in some better shape as soon as feasible, given the obvious constraints.

DR. CHERNEW: Thanks, Wayne. So that would put Jonathan up next on my screen.
DR. JAFFERY: Thanks, Mike. You meant me, right?

DR. CHERNEW: Yes. I meant you.

DR. JAFFERY: So thanks. Yes, I am supportive of the direction. I'm glad to hear the comments that we can expect in October to have something that's sort of moving in this direction. I agree with the comment that Brian had made also, that, you know, we've got a set of principles that we've been moving towards, and it's nice to try and align the various programs with that.

But just in general I guess I'm really glad to hear us having some emphasis in our conversation today about the idea that we really need to be promoting policies that reduce equities and not exacerbate them. So I am fully supportive of the conversation's direction today.

DR. CHERNEW: Great. Jonathan, thank you.

Bruce, you would be next on my list. If you've spoken, I apologize. My list-keeping isn't that great, but I do have a list.

MR. PYENSON: No need for apology, Mike.

DR. CHERNEW: I think, Susan, you're going to be after Bruce, and then we can be ready for the muting/unmuting part.
MR. PYENSON: Thank you, Mike. I was especially glad Jonathan Perlin asked the question, are we arguing against ourselves with respect to [inaudible - audio difficulties]. I was happy to hear Carol's answer that a unified approach is part of the solution. So I do support the pause.

DR. CHERNEW: Thanks. Sue.

MS. THOMPSON: Absolutely. I too support the pause, and I look forward to October.

DR. CHERNEW: Maybe I spoke too much. I asked everyone to be concise, but that's terrific. Thank you, Sue.

I think the last person for at least this round, although you spoke earlier, would be Jaewon. If I have missed anybody, again, my list-keeping isn't great, but I think you were the last -- you'd be the last one, Jaewon, to jump in on this. Dana Kelley, if I've missed anybody, please let me know, or anybody else. If I've missed you, again, I'm super sorry. I got chats in front of some of your faces.

MS. KELLEY: No, I don't have anyone in the queue. Oh, Jaewon.
DR. RYU: No, no. No worries. I concur as well.

I think everyone made great points. I think super compelling. I do agree that it seems like a little bit of an outlier or may be a lot of an outlier versus other VBP programs we've evaluated or discussed.

It did dawn me, and I like Dana Safran's comment around it would be interesting to see some of the feedback or ideas on whether it's from hospitals, or I thought even from nursing homes, SNFs that are out there. I just don't know how well appreciated some of these flaws are, or what is the perception of the operational folks who are on the front lines in that realm? And maybe David or others who are closer to this space know. But as I was listening to the discussion, I think that's one thing that kept coming up in my mind, is gee, do others feel this way too, and is there broad recognition that this is how the program's structured? You know, I just couldn't help but be curious.

DR. GRABOWSKI: I can quickly answer that, Mike. I don't think the industry is a huge fan of the program yet. As Carol mentioned, it's comparatively a small share of dollars. They end up taking an overall haircut on it, so I don't think they love it. They don't love the
measurement. But I don't know that it's been a huge area of focus. I don't know, Carol, if you would disagree with that. I would have expected more pushback, but I haven't heard a lot of that. But it's not a beloved program by any stretch of the imagination.

DR. CARTER: Yes. We've talked a little bit with folks and my general sense is that the industry has not been terribly focused on the program. They've had sort of bigger fish to fry, in terms of a new payment case mix system that came into play, that took a lot of their attention over the last year and a half, and now, of course, COVID. So I just think the folks, it's not that they've focused on design features. They're not even really focused on it.

And I guess the other thing I would say is the program's really asking them to do things that they're already focused on. To the extent that they can improve it, they're being pressured by hospitals, ACOs, MA plans, to lower rehospitalization rates. So it's not like this program asks them to think about something in a different direction. It just kind of reinforced whatever they were doing already. But I think mostly they haven't
particularly focused on the program.

DR. CHERNEW: Terrific. Dana, were you going to say something?

MS. KELLEY: I was going to say that Larry would like to say something.

DR. CHERNEW: Okay. Larry, you're up.

DR. CASALINO: Yeah, this is the unique situation in my time on the Commission that we actually have time, so I want to ask a general question. One of our core principles for value-based purchasing programs is that there should be patient experience, patient, in this case, maybe family experience. We always say that when we summarize our principles. But I think we give a pretty short shrift, generally speaking, when we're discussing specific programs, and certainly we've done that today with nursing homes. You know, my experience with nursing homes is -- and this may be an illusion -- but in many cases you can walk in the door and within three or four minutes you have a pretty good sense of the place, if you're family. So I guess I have a specific question and a general question. Specific question is, for nursing homes, or long-term care facilities, when we say we want patient
experience measure, what are we talking about, because we also want things to be administratively simple and not expensive, and those two may be in conflict. And then more generally, how do we deal, in our recommendations, with the conflict between wanting to get patient experience, family experience, and wanting things to be administratively simple, not burdensome, not expensive?

MS. TABOR: And those are great points, particularly relevant, and again, thinking about October presentation, that right now there are no national programs for looking at patient experience in nursing homes, and that is, you know, thinking about it from a traditional sense of residents saying "how satisfied were you with your care while you were there?" and another kind of general question, that's a good marker of experiences, "Would you recommend it to others?"

So there are some industry surveys out there that CMS could adopt, and has thought about adopting for SNF quality reporting programs, but has been halted. And I think there are a lot of issues with this population, that Dana mentioned, like, you know, use of proxies and how balanced measures are with using proxies.
So I don't think that's something we can really take off the shelf right away and apply a new value incentive program, but I think the Commission, based on our principles, could continue supporting CMS moving to develop a program.

DR. CASALINO: Thanks.

MS. KELLEY: Pat?

MS. WANG: Yeah. Thank you. You may be addressing this in October, but I had two questions about measures. One has to do with hospital readmissions, whether they're preventable, or cause, or what have you. I guess the interest I have is whether there need to be differences in the measures of hospital readmissions based on whether it's coming from a nursing home or a different setting. We talked about it as being such a core measure, but I feel like every program has a slightly different hospital readmission measure or definition. And, you know, ideally, given the importance and centrality of avoidable hospital readmissions, I hope that maybe you could at least comment in October the similarity or differences in the approach that you're taking to the inpatient program, to the stars program, to other programs that are out there.
That's the first thing.

The second thing, and it's just a question really, the proportion of duals in SNFs is going to be higher, I assume, than in other parts of the Medicare system. And so I wonder whether when we get to the adjustments for socioeconomic status, I don't know what your approach was going to be around peer grouping, whether there needs to be something additional that is more fine-tuned.

Because from the information in the paper, 30 percent share of duals versus a 40 percent share of duals, that's a lot of duals. You're starting with a high density of dualness inside of a SNF, and I just wondered whether you're thinking about more refined additional measures to get at significant differences, or a way of really identifying, you know, facilities that might be treating a higher proportion of vulnerable patients. Thanks.

MS. KELLEY: That's all, Mike.

DR. CHERNEW: Okay. So we're in the fortunate position of being above quality and under budget, setting an example for broad efficiency in how we run all of this. Don't take it as a hallmark of my time here, but I really
owe it to the staff, Carol, and Sam, and Ledia, you've done
an absolutely terrific job, and the comments were really
helpful. So a special thanks to all of you that weighed
in.

I think what we're going to do is we're going to
jump to the next session, and that's going to be Brian and
Carolyn talking about lab fee schedule. So again, we are
going to go with the Rounds 1 and 2 session. If you have a
clarifying question don't hesitate to jump in and let Dana
know. And with that I'm turning it over to, I think Brian
is going to kick us off.

MS. KELLEY: Brian, are you on with us?
MR. O'DONNELL: I am on, but I think Carolyn is
going to start us out.

MS. KELLEY: Okay.
MS. SAN SOUCIE: Can you hear me?
MS. KELLEY: Yes, we can.

MS. SAN SOUCIE: Okay. Good afternoon. In this
presentation, Brian and I will discuss our work towards
fulfilling a Congressionally mandated report. The report's
focus is on the Protecting Access to Medicare Act of 2014's
changes to the Medicare clinical laboratory fee schedule.
The audience can download a PDF version of these slides in the handout section of the control panel on the right hand of the screen.

The Congress mandated that the Commission investigate changes made to the clinical lab fee schedule by the Protecting Access to Medicare Act of 2014. One part of the mandate requires the Commission to examine the methodology that CMS used to set private payer-based rates for laboratory tests paid under Medicare fee-for-service.

Another part of the mandate requires the Commission to report on the least burdensome data collection process that would result in a representative and statistically valid data sample of private payer rates from all laboratory market segments. The report is due in June 2021.

We have four parts to our presentation today. First, we'll provide some historical background on the clinical laboratory fee schedule to set the stage for the changes made to the CLFS under PAMA.

Clinical laboratory tests analyze specimens from the body to diagnose health conditions and help guide treatments. Under Part B, Medicare covers medically
reasonable and necessary laboratory tests when they are provided in a CLIA-certified laboratory.

For laboratory tests that are not bundled in institutional settings or paid under the physician fee schedule, Medicare predominantly pays for tests under the clinical laboratory fee schedule.

The CLFS contains a range of services covered by more than 1,400 HCPCS codes. Some tests are relatively routine and provided by a wide variety of laboratories, such as simple chemistry tests and comprehensive metabolic panels. Other tests are low volume and complex and are often furnished by relatively few laboratories, such as molecular pathology tests.

In 2019, Medicare spent about $7.5 billion on 428 million CLFS tests. These tests were almost entirely furnished by three types of laboratories: independent laboratories (including large chains such as Quest and LabCorp), hospital laboratories, and physician office laboratories.

Prior to 2018, Medicare's CLFS payment rates were set based on local, historical laboratory charges, updated for inflation, and capped at certain amounts. Each
Medicare claims processing contractor established its own fee schedule based on local laboratory charges in 1984 and 1985. This resulted in 57 different fee schedules that were collectively known as the CLFS.

CLFS payment rates were not adjusted to reflect laboratories' improvements in efficiency, changes in technology, or market conditions. Because of how CLFS payment rates were set and updated over time, research suggested that Medicare's payment rates were excessive. A 2013 OIG report found that Medicare paid between 18 and 30 percent more than other insurers for 20 high-volume or high-expenditure laboratory tests.

The Protecting Access to Medicare Act of 2014 made several changes to the clinical laboratory fee schedule, which Brian and I will go into in detail. PAMA required CMS to shift the basis for CLFS payment rates from historical laboratory charges to current private payer rates.

Laboratories must report the payment rates they receive from private payers so that CMS can establish new CLFS rates based on the volume-weighted median of the
Among other requirements, laboratories are required to report their private payer data only if they exceed two thresholds. One is the majority of Medicare revenues threshold, which requires laboratories to report only if they receive more than 50 percent of their total Medicare payments from the CLFS or the physician fee schedule. Another requirement is the low expenditure threshold, which requires laboratories to report if they received more than $12,500 in CLFS payments during the data reporting period. The second threshold was implemented to reduce the reporting burden for small laboratories.

PAMA requires laboratories to report their private payer rates every three years so CMS can recalculate CLFS rates.

Based on the first round of data reporting, CMS estimated that private payer-based CLFS payment rates would reduce Medicare spending by about $670 million in calendar year 2018, including reductions in premiums.

This is because private payer rates were expected to be lower than Medicare's 2017 payment rates for a large majority of laboratory tests. Indeed, GAO found that
private payer-based rates were lower than Medicare's 2017 payment rates for about 88 percent of laboratory tests. PAMA established a long phase-in of payment reductions to mitigate the impact on laboratories and to allow them time to adjust their operations. CLFS payment rates can decrease by no more than 10 percent per year for the first three years under the new payment system and no more than 15 percent per year in the next three years. Because of a one-year delay in implementation and an additional one-year delay in all payment reductions, payment rate reductions resulting from private payer-based rates are expected to be fully phased-in by 2025.

Now Brian will go over the results from the first round of data reporting.

MR. O'DONNELL: During the first round of data reporting, just under 2,000 laboratories reported the private payer rates they received for 248 million individual tests.

Looking at the entities that reported, independent laboratories were overrepresented while hospital and physician office laboratories were underrepresented.
As an example, let's look at the first row of data in the table on the screen. Independent laboratories billed for 48 percent of all CLFS laboratory tests in 2016, but accounted for 90 percent of the volume of tests reported to CMS, meaning such laboratories were overrepresented in the first round of data reporting.

Some stakeholders contend that hospital and physician office laboratories receive higher private payer rates than independent laboratories. Therefore, they have suggested that the lack of reporting from these types of laboratories lead to artificially low Medicare payment rates.

However, CMS modeled the impact of various reporting scenarios, and their analyses suggested payment rates would increase only modestly with greater hospital and physician office laboratory reporting. For example, under one alternative scenario, CMS found that greater reporting by hospital and physician office laboratories would have increased Medicare spending by only a couple percentage points.

Despite evidence suggesting the limited impact of underreporting, CMS made two changes that are designed to
increase the number and variety of laboratories required to report their private payer rates in the future.

Both changes are technical modifications to the "majority of Medicare revenues threshold" so I'll briefly describe them here and will be happy to go deeper on question.

The first change, in the left-hand box, makes it so that laboratories that predominantly furnish tests to Medicare Advantage enrollees will more likely be required to report in the future.

The second change, in the right-hand box, makes it so that hospital outreach laboratories will more likely be required to report. Outreach laboratories are hospital-based laboratories that furnish tests to patients other than admitted inpatients or outpatients.

This next section reviews trends in utilization and spending before and after private payer-based rates were implemented in 2018 as one part of the Commission's review of CMS' rate-setting methodology.

Some stakeholders have suggested that inappropriately low payment rates could lead to access issues. If substantial access issues occurred, those
changes would be reflected in the utilization data.

In the first two years of setting Medicare payment rates using private payer data, we found that utilization was stable.

Overall, we found that utilization increased from 12.8 to 12.9 tests per beneficiary from 2017 to 2019.

These results suggest beneficiaries had stable access to laboratory tests, but as we note in the mailing materials, access trends should be monitored over a longer period of time because payment rate reductions are being phased in slowly.

Moving on to spending, we found that Medicare spending actually increased from 2017 to 2019. The increase was driven by technical changes under PAMA and increased use of new, high-cost tests.

Looking at the figure on the slide, I use three categories of tests to explain key trends that underlie the aggregate growth in spending.

For the first category, chemistry tests, spending decreased by 14 percent, largely in line with expectations under PAMA.

For the second category, panel tests, expected
spending declines have not materialized because of unbundling and a generous phase-in of payment rate reductions under PAMA.

The large spending increase for the third category, molecular pathology tests, is due to the introduction and broader use of new, high-cost lab tests.

Breaking down utilization changes by type of laboratory, we found that volume increased by 2.4 percent for independent laboratories and decreased by about 1 percent for both hospital and physician office laboratories. This shift is part of a longer-term trend of large, independent laboratories growing their market shares.

Looking at the figure, you can see that changes in spending also varied by type of laboratory. Spending grew by about 16 percent for independent laboratories, driven by the use of new, high-cost tests that I spoke about on the previous slide.

In contrast, spending declined for both hospital and physician office laboratories because of small volume declines and because these laboratories predominantly furnish routine, low-cost tests for which spending has been...
declining or flat under PAMA.

In the next few slides, I'll provide an overview of the next steps we plan to take to meet our congressional mandate and seek feedback from the Commission on those plans.

For the first part of our review, we plan to refine our analysis of CLFS spending before and after private payer-based rates were implemented by adding subgroup analyses, such as comparing the utilization of urban and rural beneficiaries.

We also plan to analyze the private payer rate data that has been reported to CMS, highlighting any potential issues we identify and seeking to quantify the payment rates differences between various segments of the laboratory market.

Finally, we'll analyze CMS' revised data reporting requirements for the second round of data reporting, although this analysis will be limited because Congress delayed the second round of data reporting until 2022.

For the second part of our review, we plan to report on the least burdensome data collection process that
would result in a representative sample of laboratories.  

Just to reiterate what I've said before, some stakeholders are concerned that currently collected data are not representative of the full laboratory market.  

However, increasing the number of laboratories that are required to report increases administrative burden.  

One alternative that would collect representative data without the added administrative burden is a survey.  

Therefore, consistent with our congressional mandate, we plan to study how private payer laboratory rates could be collected through a survey. The study will include a range of topics, including appropriate sampling techniques and the sample sizes needed to generate valid estimates.  

So just to recap a few things that Carolyn and I discussed.  

As of 2018, Medicare relies on private payer data to set CLFS rates. Given that Medicare had historically paid far more than other payers for laboratory tests, payment rates for many tests declined substantially.  

Stakeholders are concerned that independent
laboratories were overrepresented in the first round of private payer data collection. Because of that, they contend that Medicare payment rates are too low, which could lead to access issues.

We find no evidence of substantial changes in access in the first two years after CMS implemented private payer-based rates, but further monitoring is warranted given the slow phase-in of payment rate reductions.

Over the same period, Medicare spending increased unexpectedly due to PAMA-related changes and the secular increase in the use of new, high-cost tests.

For future rounds of data collection, CMS has changed the reporting requirements to include more laboratories, but the effects won't be known until 2022.

We've laid out some plans to meet the congressional mandate over the next cycle, including exploring how to collect private payer rates through a survey. The staff seeks feedback from the Commission on these plans.

And with that, I look forward to the discussion, and I'll turn it back to Mike

MS. KELLEY: Mike, I think you wanted me to go
DR. CHERNEW: Yeah, I think we should jump right into Round 1. I know we have a little bit of a queue, so go ahead, Dana.

MS. KELLEY: Bruce, you had a question?

MR. PYENSON: I have a question on page 8 and another one after that. I think Slide 8 mentions the low phase-in, the last bullet there, of reductions. Do you have any visibility into what the reason for that is? Was there concern that there would be access issues if rates came down? It seems like there was a view that the rates are too high, we should bring them down. So it seemed odd to have a long phase-in to get the rates to the right place. That's my first question.

And the second question is: I believe the mandate asks for other recommendations as MedPAC sees fit. Is there a plan for that?

MR. O'DONNELL: Right, so I'll -- go ahead.

DR. MATHEWS: Answer the factual question first, Brian, and then I'll jump in.

MR. O'DONNELL: Right. So, you know, as far as the phase-in goes, that's in the statute. So CMS is
largely following the statute on that. And I think, you
know, as I said in my mailing materials, they knew that a
lot of these tests were going to decline by very large
amounts in percentage terms. And so, you know, I think
folks thought that there could be access issues, and so
they kind of made this very slow kind of phase-in. Now,
whether that would have actually resulted had the phase-in
been shorter, I don't think we know.

DR. MATHEWS: Okay, and then with respect to
recommendations, you know, part of what we are doing in
this session is gauging the Commission's collective
interest in heading down that path. Clearly, if you have
specific things you would like us to work for that involve
analytic work, we need to build that into the work flow in
the upcoming months. And if we were to make bold-faced
recommendations that involved the Commission reviewing
policy options, draft recommendations, voting on a final
recommendation, that builds time into the calendar, and so
we need to know that now.

An alternative approach would be to have a
chapter that reflects a strong sense of the Commission with
respect to a consensus as to where this policy should go,
and we could do that without bold-faced recommendations.

But part of what we are doing here today is figuring out what you collectively want to do.

MR. PYENSON: Thank you.

MS. KELLEY: Marge, do you have a question?

MS. MARJORIE GINSBURG: Great. Thank you.

Perhaps it says this in the report and I missed it. Is this information based entirely on labs that are being used through original Medicare and do not include labs that are contracted through Medicare Advantage plans? I mean, I know big systems like Kaiser do most of their labs in -- I mean, they've created their own labs. But I think they're unusual. And I'm very interested in knowing whether the data include MA plans or exclude them, and if they exclude them, is there a reason why they should not be brought into the analysis?

Thank you.

MR. O'DONNELL: Right, and so just to clarify, all the analytics that we did, obviously that's using kind of data from original Medicare. In terms of the data reporting, which I think you're referring to, you know, the requirement is that a lab must receive at least half of its
total Medicare revenues from the CLFS and the physician fee
schedule. So let's say that you are a lab that
predominantly serves Medicare Advantage beneficiaries,
whether you're Kaiser or whether you're just located in,
you know, Allegheny County in Pennsylvania. And so, you
know, you were likely excluded in the first round of data
reporting because, you know, if you serve 50 percent MA
benes, you did not receive half of your revenue in all
likelihood from the CLFS, which is fee-for-service, and the
physician fee schedule, which is fee-for-service.

And so they were largely excluded if you served
mostly MA benes in the first round. In the second round of
data, CMS made a technical tweak to try to include more of
those labs, but we don't have a good sense for how many
labs, additional labs that will include because the data
reporting hasn't happened yet.

MS. MARJORIE GINSBURG: Okay. So just in terms
of -- and maybe this is a Round 2 comment, but I think more
needs to be done to bring -- I mean, MAs now comprise
almost 40 percent of Medicare beneficiaries, and it's time
we start collecting that data as well. Thank you.

MS. KELLEY: Pat?
MS. WANG: This is related to Marge's question. Are MA payments to labs considered private payer or Medicare fee-for-service?

MR. O'DONNELL: So --

MS. WANG: Yeah.

MR. O'DONNELL: Yeah, so under the definition, when labs report their private payer rates to CMS, Medicare Advantage plans are considered private payers.

MS. WANG: Okay. I think that's appropriate.

The other question I had was more -- slightly different, because there's unit cost or unit payment, I guess, and then there's number of units and the mix of units that are provided. Can you remind us what, if anything -- or what original Medicare does to monitor lab utilization short of the big fraud cases, okay, because that's like really extreme. But does original Medicare have tools to observe lab utilization and detect what it might consider worrisome or inappropriate or emerging trends of, you know, utilization of certain kinds of labs, number of labs, that kind of thing?

MR. O'DONNELL: Right, so that's a good question. And, you know, other than folks like us and CMS and OIG, I
don't think there's things that are kind of built in, if that's what you're referring to, in terms of model relocation.

MS. WANG: Wow.

MS. KELLEY: Okay -- oh, sorry. Is that all, Pat?

MS. WANG: Yeah. That's really disappointing to hear.

DR. CHERNEW: Yeah. I --

MS. KELLEY: Okay.

DR. CHERNEW: Go on, Dana.

MS. KELLEY: Dana Safran?

DR. SAFRAN: Is it my turn?

MS. KELLEY: Yes.

DR. CHERNEW: We're still in Round 1, so I just lost track of the --

DR. SAFRAN: This is a Round 1 question. Sorry, the two Danas throws me off sometimes. I just have a question related to the increase in the high-cost lab tests. In the chapter, if I understood it right, you indicated that this increase, which you show on Slide 13, was occurring in Medicare but not in private payers, if I
understood that right. Or maybe that wasn't there. Maybe
I just wrote a note to myself wondering if we saw the same
increase. I think that's what it was. Excuse me.

So, yes, I was wondering whether we see this same
increase in high-cost tests occurring in Medicare Advantage
data as well as in private sector data, and also wondered
whether we have hypotheses about why we see this happening
in the independent labs but less so in physician or
hospital labs. It felt a bit like an income maintenance
effort in light of the cost decreases that labs are seeing.

So I was just trying to understand what we're seeing in
other venues.

MR. O'DONNELL: Right. So on the first point
about whether we have any sense of this trend happening
among private payers, I really don't think we have a good
line of sight on this. You know, our data are quite
limited, you know, in terms of private payer data. And I
would also note that a lot of these things are really quite
new, so, you know, this trend really kind of picked up
steam in the last five years. So it's quite a new trend.

But to answer your question directly, we don't have great
line of sight.
In terms of why are the kind of, you know, high-cost tests focused in independent labs, you know, we did note that the mix of tests that hospitals and physician office labs tend to be kind of the lower-cost labs and that these independent labs are the ones furnishing these high-cost tests. And I think it could be a couple of things, but I think, you know, within the independent lab kind of bucket, I think you have, you know, at least three sub-buckets, you know, one being kind of the Quests and the LabCorps of the word, the second bucket being kind of like smaller regional labs, but those labs tend to focus in these kind of lower-cost tests as well. And then you have this third tranche of labs, which really focus on doing kind of these higher-cost molecular diagnostic type tests.

And so, you know, I think it's at least part of the market segmentation that's going on. A lot of these new tests are developed by labs, and they focus in those types of tests.

DR. SAFRAN: That's very helpful. Thank you.

MS. KELLEY: Paul?

DR. PAUL GINSBURG: Sure. I've got two questions. The first is when you were talking about the
potential of doing a survey to gather this data, were you
thinking of a survey of labs or a survey of -- could it be
a survey of literature and private insurers?

    MR. O'DONNELL: Right, and, you know, as we've
gone out and kind of talked with folks in the industry, I
think that thought had come up a number of times, and in a
lot of ways it would be cleaner because, you know, they
know the discounts they're giving, and they kind of have
the systems built already.

    I think one of the things that, you know, you
face when you think about that is what hook does the
Medicare program have to require private payers to report
their data. So probably MA, you could get them to report,
but I think sans that, I think that was the concern that I
heard when you talked about, you know, requiring private
payers to report, is that, you know, unlike labs, we're not
directly paying them money. So for labs, we have a hook,
right? We're saying, "We're paying you this money. You
report your private data to us."

    And so we haven't gone deep on that front, Paul,
but that's just kind of what we've heard as we went out and
talked to folks.
DR. PAUL GINSBURG: Good. And my second question is: I take it from reading the materials that these fee schedules continue to be local, and if that's correct, you know, should we potentially be talking about making them broad or even national as far as the recommendations we come up with?

MR. O'DONNELL: Sure. We can clarify this in the paper. I think what happened, the situation was that they used to be very local, but they are transitioning to a national payment rate. So under the kind of private payer paradigm, there is one national payment rate. So that's what it will be kind of going forward.

DR. PAUL GINSBURG: Good. Okay.

MS. KELLEY: Jaewon.

DR. RYU: Thanks, Dana. I just had one question. I think normally we are used to seeing within a type of service either the private payer rates are higher or lower than CMS, the one or the other. And here I was a little bit confused as to how it could be higher for some services, some lab services, and then lower for others. So I think you mentioned that 88 percent of the tests out there, the private payer rates are lower or less than CMS
I'm just curious how that happens. What exactly -- is it part of some weird esoteric formula? You know, how exactly does that come to be?

MR. O'DONNELL: Right, and I think that's a great question, and, you know, I think one of our hypotheses is that when you think about why private payers were able to get lower payment rates than Medicare, I think one of the leading hypotheses is that, you know, a lot of folks can furnish these low-cost, low-complexity tests, so payers were able to go and negotiate with these large laboratories. So I think that constitutes most of the lab tests you generally think about. But for the smaller segment of tests, you know, they might be kind of newer tests. They might be tests that are furnished by fewer labs. And so private payers might have fewer totals to negotiate.

So that's just a hypothesis, and I think what we'll do for the next round of data, the next report that you all receive from us, is we'll take those payment changes, payment rate changes, and we'll stratify by the type of service. And so if we see these clustering of
services, then we'll have probably a better answer for you. But I think that's our leading thought.

MS. KELLEY: Sue, did you have a question?

MS. THOMPSON: I do. And, Brian, take me back, and this is -- I'm just interested in how you're thinking about this. I heard you describe three buckets, if you would, in terms of defining the laboratories: the large Quests, if you will, the smaller that provides services more locally, and then the labs that are developing services that are more high end and sophisticated. Where would you put the hospital-based laboratory that has substantial outreach? In what bucket are you thinking about that one?

MR. O'DONNELL: Right, and let me just clarify. So, you know, we put independent labs up there as one category, and just when I was putting them into those three buckets, I was admitting that within the independent laboratory space, you know, there's gradations in at least three buckets.

MS. THOMPSON: Okay.

MR. O'DONNELL: But, you know, as far as comparable labs, when you look at the mix of services that
they furnish, it does tend to be the more routine kind of common tests that they're performing. So, you know, the indication I gave in the paper was that molecular pathology tests, independent labs, 93 percent; hospital labs were 6 percent; and then physician office labs were only 1 percent. So you can see they do do some of these high-cost tests, but they're really focused in more routine tests.

MS. THOMPSON: Thank you.

MS. KELLEY: And I think, Pat, you had a question?

MS. WANG: It seems like, you know, things have slowed down and the requirement for submission of private payer data is in three-year increments, which is rather long. But however it is achieved, so, you know, I assume that the idea of doing a very slow phase-in of this new methodology in order to prevent access issues assumes that the labs needed to readjust their revenue mix to increase private payer rates while Medicare rates perhaps were coming down so that they could maintain their operation and maintain access. I mean, that's the only thing that makes sense to me in terms of such a long transition. I just wonder whether it is part of anybody's analysis or capable
of not being known, whether, in fact, that is happening,
and as these changes to the fee schedule happen and the
Medicare fee-for-service rates come down, whether, in fact,
private payer rates are coming up or not, because I think
it might be informative about sort of the overall health of
the sector.

MR. O'DONNELL: Yeah, that's a good question, and
I think there's a couple things that complicate that. The
first is that obviously the lab sector this year has been
dealing with, you know, a tremendous drop in volumes on
most tests and then a tremendous increase in volumes on
COVID testing. I'm sure there's that. But, you know, as
you start to see kind of second and third round of data
reporting, I think you'll have a little bit greater insight
in terms of, you know, what's actually happening with
private payers.

But I have to say, you know, I see -- and this is
just anecdotal, but I do see private payers continuing to
be aggressive in terms of negotiating rates for lab tests.
So maybe those are just anecdotes and it's not
representative. That could be the case. But, you know,
that's something we'll have to watch going forward.
DR. CHERNEW: So let me jump in for a second. I fear we're straying past Round 1, so I want to maintain our discipline as to where we're going here, because some of these things are a little less, "What did you mean on Slide 2?" and a lot more broader sort of dynamic questions. So we can save them. Dana, I'm not sure if there's any more Round 1 questions, but I am eager to get on to Round 2 when we get through, and I will emphasize again, the clarifying questions.

MS. KELLEY: We are all done with the Round 1 queue.

DR. CHERNEW: Great. So we're going to move. I think Brian is going to kick us off on Round 2. Again, please be disciplined in the length of your comments. I will say, lacking discipline, that I've never heard Allegheny County mentioned in a presentation before, and since I'm from Allegheny County, a shout-out to Brian. But now to Brian DeBusk.

DR. DeBUSK: Thank you, Michael.

First of all, really interesting chapter, really well done. I'm going to try to follow the order of the mandate. To address the least burdensome aspect, I think
it's pretty obvious that you'd want to do sampling there.

I think we would want to -- I mean, we may want to recommend sampling just the larger labs. I noticed in the mailing materials they're about 50 percent of the volume anyway. And we already have the CMS study that showed that incorporating physician offices and hospitals didn't seem to change the rates that much. So, again, in the name of less administrative burden, I hope we can focus on sampling the larger laboratories.

The other question I would ask is let's say we collect all this, you know, rural hospital data and all these small physician group practices, you know, what would we really want to do with the data anyway? I mean, this feels like a site neutrality issue to me. We've talked about this for years, about how Medicare should pay similar rates for similar care. This seems like a great opportunity to reintroduce and maintain our position regarding site neutrality.

As far as the statistical methods, I think using the median from a sample of larger, what we would presume are fairly efficient suppliers would be the way to go. I think if we were required to take in a sample of some of
the smaller operators, I think then you'd probably use something below the 50 percent median. I mean, I think there you maybe go to the 20th percentile or the 25th percentile just, again, with site neutrality in mind.

Jim, you commented earlier about how far we should go and how close should we stick to the mandate and how much should we make additional recommendations. I do hope that we'll attach some additional recommendations to the report, and I just want to briefly comment on that.

I think collecting the prices in a reporting --

Pat, you alluded earlier to utilization of these tests, and one of my concerns is let's say we collect the private payer rates from a series of tests that have strict utilization tools, lots of eligibility requirements. You may see private payers willing to pay a higher rate when coupled with good tools around eligibility. Well, I would hate to export that rate into Medicare under a necessary and beneficial standard. You're really comparing apples to oranges there. So as we collect prices, it would also be, I think, useful, especially on the higher-spend items, to be looking at eligibility requirements and just to make sure that we're comparing apples to apples when we look at
these prices.

The other thing that really jumped out from in
the mailing materials, there are three categories:
molecular pathology, multianalytic assays, and proprietary
lab analysis. In two years that went from 530 million to
1.4 billion. So those three categories had a 168 percent
increase in two years. They went from 7.4 percent of
spending to 18.6 percent of spending. If you project that
forward two more years, those three categories alone are
going to be over one-third of the entire spending in this
category.

So I think we really need to keep our eye on
molecular pathology, multianalytic assays, and proprietary
lab analysis, and I'm still learning about this, but I do
think there's a trend toward moving some of these higher-
end tests into hospitals.

I think there are companies that are packaging
the reagents along with the bioinformatics back end and
offering -- basically helping hospital systems to go up
market. And I think as long as that doesn't increase
program costs, I don't think that's a problem. But I
wouldn't be surprised to see these higher-end tests moving
inside the hospital over the next few years.

The other thing that I would mention, I think allowing CMS to bundle the rates again I think would be another feature that we should recommend. Unbundling these tests I think is a little bit out of sync with the direction these tests are going. I think a lot of these assays, they go after more and more markers. And I think -- and, again, I'm still learning about this, but there's this concept of test stacking where I might have one assay that looks for 400 markers; well, then the next version of that assay looks for 410 markers. Well, what I'll do is go in and actually redo the entire assay, so I start from ground zero and do all -- look for all 410. I think we just need to be careful. We need to make sure CMS has the ability to unbundle -- or to combine some of those tests because, again, by the next time we revisit this, I'll know a lot more about test stacking.

Then the final thing I want to mention is geographic adjustment. I think I'd be really careful with that because some of these tests are so expensive. I mean, you look at even a 3 percent geographic adjustment on a $4,000 test. That's a $240 swing. That pays for a lot of
overnight shipping. And so I would be really careful there, because if we do feel the need to introduce the geographic adjustment, I think it would need to be very small, and I think it would need to be decoupled from the test price, because, again, even a modest adjustment could get really out of hand there.

Those are my comments. Thank you.


DR. PERLIN: Okay. Well, thanks, Brian and Carolyn, for really a superb presentation on what feels like a very esoteric topic, but the reasons Brian just mentioned about cost, one that's escalating quickly in terms of importance.

When Mike asked me to be a responder on this, I told him this is not my area of deep subject matter expertise. He smiled and said, "It will be." And I think I've learned more about lab testing, particularly from the hospital aspect with respect to the clinical fee schedule, than I ever expected to.

But I think these points about cost really take us from what the statute requires -- balance between representation of different lab types and the burden of
testing -- to really back into the larger question for MedPAC, which is that is -- the balance between cost and sustainability of the program with access to care and services like laboratory.

So this molecular testing aspect is really the driving force in cost escalation in the future. I fear that frankly the emphasis, as they say, is on the wrong syllable. We need to put it back on what's really going to drive cost in the immediate future.

I went to our lab director and I found this out, that there are over 3,500 general lab tests available to physicians. Those are the just regular chemistry diagnostic. There are now over 75,000 orderable genetic tests and approximately ten new tests launched daily, and this is growing about 10 to 15 percent per year in the area of genetic and molecular testing.

The issue of bundling and not just stacking, Brian, but reshuffling makes it extraordinarily confusing and creates some problems in terms of interpretation. In fact, surveys of clinicians indicate they don't know what to do with the answers to the data that they get.

So I want to break this into a couple parts and
then come back to the larger cost driver, but let me talk
about the specific PAMA mandate for balance between burden
and representation.

My fear is this: If you start with the wrong
proposition, you get to wrong answers. And the burden
drives up the cost -- the burden of reporting here simply
drives up the cost of production for the smaller labs,
hospital and physician offices, without adding commensurate
value. It removes focus from, you know, a bigger issue
that I just mentioned.

I think the statute itself is still in conflict.
I know that on page 4 it talked about representation
aspect, but it also says very specifically that the
revenues from the clinical laboratory fee schedule on the
physician fee schedule need to constitute a majority of
Medicare revenues. And so obviously this excludes those
sorts of labs, or at least it would have that effect and
functionally hospital and physician offices don't.

I wanted to talk for a moment just about the
incentives in hospitals. Remember, in hospitals part of
the reason this isn't majority is that the services that
might be offered to a select number of outpatients or
service to a community are a fraction of the testing done inpatient, and the utilization control is that those lab tests are part of a bundle, which is really what -- the intent was that there be judicious use of appropriate tests.

I think intermediate guidance was given that said, okay, it's really difficult to report, so hospitals have got to use a very strange bill pay called a "14x bill." And that's really an artifice that's created because the data do not exist in the format the statute requires reporting on. The data are not mapped to CPT or HCPCS codes, and a great deal of manual labor goes into this. I'll come back to that later. But it is as bizarre as trying to get on the GoToMeeting call that we're on now using Zoom. It just doesn't work. They're different technologies, they're different standard sets, et cetera. So these are incredible operational burdens in determining which claims have reportable data, transferring this data to CMS requirements, the fact that the data systems don't return information at the CPT level, that they don't include secondary insurance, that they don't necessarily reconcile data that are supposed to be eliminated because
they're bundled, they don't match up payments that are made on different dates or test or process in different batches. And so all of those are sorts of things or complexities that actually are more burdensome than doing the study of the lab test itself. So that seems very ironic in terms of taking a focus on really what the point is here, which is cost sustainability and reducing burden.

Now, because something is difficult doesn't mean it shouldn't be done, but because something doesn't add commensurate value does. So I agree emphatically with staff's recommendation to look at alternatives here, you know, use of a survey, returning to the original NPI definition, et cetera. I think those are the important factors. And just in conclusion, the staff were absolutely right when they said that utilization is decreasing, but the increase in cost should be highlighted in the report to Congress. This is really where the challenge is going to be going forward.

I think there is a little bit of text about the effect of the pandemic on the supply chain, and that should be carefully considered when discussing changes to CLFS.

And then, finally, shifting independent labs from
physicians to hospitals, I know Brian just mentioned that some of those labs may be seeking to go upscaling with in-
house certain reagents and package and information systems. But the truth is these assays are now so incredibly complex, so rarefied, and oftentimes so infrequent because there are now so many that they have a limited number of homes. And so the large independent labs serve as the reference labs. And if you're sending your labs either to very specialty independent labs or those very large reference labs, then the idea of geographic adjustment is really not rational because the locations of those labs concentrate the bio for the test regardless of the geography of those that would be using it.

So let me stop there. Again, I thank the staff for great work, and I hope that we see our way to some very concrete recommendations to add value and reduce burden. Thanks.

DR. CHERNEW: Okay. Paul?

DR. PAUL GINSBURG: Thanks. You know, a lot of good stuff has been -- well, first of all, it was a great job on the slides and the chapter, and what Brian and Jon said was very useful. I just wanted to emphasize a couple
of things.

One is, you know, since the current system uses a median, we really don't have to worry about burdening small -- it's a volume-weighted median -- you know, burdening small providers. We just don't need them in the sample, and we really should go sampling as you're suggesting. I don't see why we're not talking about whether we should be sticking at a median or whether Medicare in the sense it's an opportunity to get the services and would continue access but for less should be going to a 30th percentile or something even lower as it probably does in many other areas.

But the other thing is about the new very expensive molecular and other tests. It seems as though this is an issue that's even broader in clinical labs and probably worth the Commission's time -- not as part of this report but in the future -- to take on, you know, what about very expensive new technology items that may be overused. Is there any resistance to, you know, charging the moon for new things? Or is this what I suspect is a particular vulnerability of the Medicare program and maybe even private insurers? But I'd really like to find out how
private insurers handle some of these situations with highly expensive and specialized tests and other technology.

MS. KELLEY: Okay. Larry, you're next.

DR. CASALINO: I really didn't think I'd have anything to say during this session, but it turns out to be very interesting, and Brian and Jonathan's comments were extraordinarily good on top of your presentation. But it seems to me whether it's done by requiring all labs that meet certain criteria to report or sampling, and using that as a way to determine Medicare ordinarily pay, that's an assumption that the prices being sampled are somehow based on costs, right? And I think we've heard enough to assume that that's true for most tests but may not be true for the really expensive molecular diagnostic tests that are coming along, where at this time at least there might be very little competition.

So if a price is based on negotiated leverage and has very little relation to the cost of doing the test, and then Medicare winds up paying that price, you know, whether we're using a median or not -- and the median might not mean much if there's only two suppliers -- I think there's
a problem. So I don't have a solution, but I think that
the underlying assumption that Medicare has been acting on,
if you can just get people to tell you your prices, you'll
kind of know what the costs are with a little profit, and,
therefore, you can use that, that's probably true for most
tests, but not for the ones that are way more expensive and
not for the ones that, as Jonathan pointed out, are really
driving a lot of the spending growth.

MS. KELLEY: Mike, did you want to say something
here?

DR. CHERNEW: I wanted to react to Larry and a
few of the other comments before the other Commissioners
jumped in, because they may be able to react to some of the
things I'm going to say.

So, first of all, obviously, the presentation was
outstanding. The comments were terrific. A few things in
reaction to what Larry and others have said. The first one
is sort of a matter of principle. I'm not sure why we ever
want to put artificially high rates into the averages that
we pay. I'm not sure what "artificially" means. I
essentially mean market power-driven rates, and that puts
us somewhere where Paul was, which is maybe we'd pick a
lower percentile. So that's point one.

Point two -- and I'd love people's thoughts on that. Point two is I think we -- just for everybody's knowledge, at some point we're going to have to have to deal with this issue of new technology and how new technology affects Medicare when new things get put in and there's launch prices and a slew of other issues. This report is probably not the place to deal with that issue generally, although it may certainly come up in that report, and understanding the breadth of this report with regards to that issue matters. I personally love the issue. I'm worried because it is a real conundrum about what to do in a whole variety of ways. Given we were asked to do it, Jim and I will go back and forth about how broad or not to make this particular report, but understand this issue of new things, writ large, be they tests, drugs, whatever, is very much on the agenda.

The third thing that I'd love people's reaction to, it could be yours, Brian O'Donnell's, or anyone else's, is if someone asked me to come up with getting the prices for lab tests, I would start by getting a claims database, of which there are many that might not be perfectly
representative, but might be good enough. There's
Marketscan. There's FAIR Health. There's HCCI. There's
Blue Health Intelligence. And I could see to some extent
what folks are paying.

This whole chapter reminds me of the pitfalls of
fee-for-service, right? The fee-for-service system drives
you batty when you realize all the combinations of
different things can be done, and that may challenge how
this shows up in some of these other data. It challenges
Medicare Advantage, which sort of Marge asked before, if
they're not paying in a fee-for-service way, it's hard to
know what the price was. Not everybody uses the same
codes. So we'll have to sort through that.

But I'd like to get people's reaction on
essentially for the main part as to how we should deal with
the data collection and then what we should do with the
data once collected, and if there's administratively
simpler ways of going about doing this.

And the last thing I'll say is I appreciate any
comments -- some of you have made them -- abut the
geographic adjustment, and those comments are very well
taken and very useful, so going forward, if people want to
add to that line of thinking, that will be another topic that will be useful as we think about what to do with this.

So now on to the rest of Round 2. That was just an interlude.

MS. KELLEY: Okay. Bruce, you're next.

MR. PYENSON: Thank you very much. I wanted to talk a bit about what we should recommend. We've just gone through an exercise with the value-based program for SNF where we said we need to pause on that. I would suggest the same on this situation with labs for several reasons. It is dangerous to base Medicare fees on the private payer fees. An analogy might be dialysis where, again, you have a handful of large organizations, and, fortunately, Medicare doesn't base its payment on private payers. Private payers are paying way more than Medicare. And there's enough potential for problems even understanding what private payers are paying and what the real financial arrangements are.

So I think it is not a good idea. We're seeing the beginning of that perhaps with the very expensive tests where there's only a few sources and there's emphatically different mixes of codes. It's no secret that labs have
probably negotiated and agreed to very low test rates for
commodity tests and higher rates for non-commodity tests,
and that mix is likely to be different between Medicare and
commercial.

So we've got a whole series of fundamental
challenges in basing rates on private payers. In the past,
the analogy of a successful program was DME with
competitive bidding where Medicare was paying more, and
that's probably a lesson to be looked at.

More fundamentally, a commodity chemistry is a
case for deflation, and, frankly, that's happened even in
exotic labs. So, for example, the price of a human genome
test for a single individual has plummeted. So year after
year, we've seen PCR prices go down, down, down. So this
is a test case for deflation that I believe should be built
into Medicare's reimbursement as opposed to spending lots
of time looking at the minutiae of how you do sampling.

Let's create a program that's going to work and
solve the problem that we were talking about in the context
study and, frankly, lab -- when we think of the potential
money that's at lab, that's way more than the 2 percent
that was at stake, I believe, in the post-acute care for
SNF. So this is an important issue, but, Mike, I agree with you on starting with claims databases. But I don't think -- if we don't come up with a better program, we're not fulfilling our commitment this morning in the context session. And I see all sorts of problems with the way the fees are being set, and I think this is an ideal case. It's not huge. It's relatively constrained. The data is understandable with the codes. So let's start here, and let's get to something that will move in the right direction rather than fixing the obvious technical problems.

Thank you.

MS. KELLEY: Jaewon?

DR. RYU: Yeah. I don't have strong feelings on the technical, in the recommendations, I should say. I think what I find unsettling, and I get that this is a little bit out of scope, is it feels like the way the program is set up it's a problem that's only going to get bigger, and maybe this is similar to what Bruce is saying. Ideally, I'd love to say, for the 88 percent of the tests, where the commercial raters and private payer rates are less than CMS, it would be great there to index that to
But the problem seems to be in the other 12 percent. And so I do think there's a danger, to Bruce's point, in indexing to a private payer rate when that 12 percent of the time, or 12 percent of the tests you're indexing to a higher rate, and it's a higher rate that seems like it's just on the cusp of just growing.

In many ways this feels like specialty pharma from six to eight years ago, with the emerging technology, and it just overwhelmed the pharma spend, and with each passing year it's sort of been exponential growth.

I would share Pat's reaction early on, when I find it very concerning that there's really unfettered, no filter around assessing for appropriateness in that high-end molecular and other kinds of tests. You know, whether it's a formulary or utilization management or bundling, I think Jon Perlin mentioned some of the advantages, the natural protections you have there. It feels like we would miss out if we didn't make some mention to call attention to that being the larger issue.

If you extract that, if I'm reading the materials correctly, utilization relatively flat, spend relatively
flat. To the extent there's an increase it's being driven off of that high-end molecular testing. I feel like we have to make some mention around that and try to create the alarm bell sooner so we don't land, five years from now, dealing with a problem that resembles specialty pharma today.

DR. CHERNEW: Yeah. So can I just jump in and react to Jaewon and Bruce real quick? I appreciate both of those comments, and as I said, the analogy of specialty testing is reasonable and we will deal with that. How would you feel -- again, I'm thinking about possible recommendations. There are sort of the simple things one could do. One could recommend that the price is the max of the CMS price and the competitive price, and then you would be able to focus where there are cost-savings opportunities and you'd have a cap on the rest of it, in various ways. You could have other relatively simple formulas to avoid too much of an access problem, or you could set a floor if you needed to, potentially.

So I guess my question for Bruce and Jaewon -- although I know Dana is next so I'm going to come back to you after Dana Safran -- is are there relatively simple
formulaic fixes that would allow us to reduce some of the
overpayment that currently exists to address the fiscal
problems from a context chapter without creating a whole
other set of problems, where I view is a new complicated
set of important tests that are hard to get our heads
around. I'd like to be able to thread that needle as
opposed, because I'd rather not miss the opportunity to
become more efficient in places where we can.

So give that some thought. I think Dana Safran,
you're next in line.

DR. SAFRAN: Great. Thanks. Just very briefly,
you know, the comment I was going to make is just very
similar to something, Mike, that you said on your last
round, which is, to me the issue here, especially around
the high-cost labs, there's a really wonderful case in
point of the context chapter we talked about this morning,
and in particular, the challenges that we have to confront
around new innovations and how those get priced and how we
manage appropriate use.

And so, you know, I heard you say, Mike, that
probably we don't want to tackle that in this chapter, but
I wonder if we want like a text box or something that
really points us to this beautiful case in point. Because, you know, the inflation rates that Brian cited for us, in just this space, are pretty compelling. And so I just wanted to make that point and tie it back to our morning conversation.

And then the other thing I was going to say is I haven't heard any other comments focused on this, so I apologize if I missed it. But the issue that has created the missing data from hospitals and physicians because of the 50 percent rule in the NPI is something we just have to go fix. It was illustrated on your Slide 9, I think, and so apologies if that's already, you know, been hammered to the ground. But I just was going to flag that issue as one that seems just glaringly obvious. Thanks.

MS. KELLEY: Mike, that's the end of the queue.

DR. CHERNEW: Right. I just about to say, is that the end of the queue, and now you've flustered me. So I want to go back to you, Bruce, to have a little bit more discussion. Everybody, please jump in when you want to contribute to this discussion. I'm not going to call you out because, as Jon Perlin noted, this is an area where to get engaged there are a lot of things you have to
understand. And so I don't want to put anyone on the spot, but jump in when you want to, if you want to.

But Bruce, you sort of raised this point about where to do, and are trying to craft some sort of intermediate position between the status quo, which I really don't like for reasons that are clear in the chapter, and this problem, I think, Dana, your idea about a text box or some other thing to notice this, to call this out, is actually a really good idea for this chapter, just so everybody understands. Brian and I, and I think some of the other staff, had an exchange prior to the meeting about essentially the duality of this program, between these new, complicated, high-tech, large test, and the sort of more standard tests that some of this was motivated by.

So Bruce or Jaewon, if you want to expand on your earlier Round 2 comments, I'm all ears. If not, anyone else, or we can move on.

MR. PYENSON: I'm happy. Jaewon, is it okay if I jump in? So in terms of a solution, I think the precedent of the DME competitive bidding program is a good one. The vast majority of lab tests are commodities, right, and we have a scale with the ability to move samples around, you
know, the collection boxes and those sort of things. This is an ideal circumstance where Medicare could consider a competitive bidding program.

More fundamentally, we have a Moore's law kind of situation here where the prices and the ability to produce commodities just becomes cheaper and cheaper, and the technology gets better and better. And some of that is information technology and physical technology and that sort of thing.

So I think it's time we recognize that, that commodities in general should get cheaper over time. The vast majority of labs are commodities. Now even we saw the fancier tests, frankly, are commodities also. You think of things that used to be exotic, like PCR and genome sequencing. It's done very inexpensively today.

So a simple solution from that standpoint is to pick a number, like 5 percent or 10 percent, and say whatever this fee schedule is, is going to go down by 5 percent or 10 percent a year. And there's precedent for that in other federal programs that we could talk about. So those are two basic approaches that I'd suggest, either competitive bidding -- and you could create a bundle; you
could include the fancy tests in that, bid it out on a PMPM basis -- or here's the fee schedule and it's going to deflate every year for the next 5 or 10 years, and we'll look at it.

DR CHERNEW: Jaewon, do you want to add something, or else I'm going to react.

DR. RYU: No, go ahead and react. I don't think I have much to add.

DR. CHERNEW: So my concern, and again, I'm watching the questions coming in, my concern, Bruce, is the vast number of permutations that one can do in tests seems to make this a little bit harder to competitive bid than DME situational. I guess that also might end up driving Brian and Carolyn crazy. But I do think that's a reasonable thing to do. It would require creation of an infrastructure, of a bidding process, which I know that are done in parts of DME. If people are thinking about that, that's valuable.

I guess I would weigh that against using, for a subset of tests, using the data that we're seeing privately, because that's sort of like an off-the-shelf competitive bidding type thing.
MR. PYENSON: I agree. The capitation is being done in the private sector. It's not all that widespread but it's out there. So the other is permutations and combinations, but it's all commodity. And so I think it's an idea situation, and we do have the precedent for doing that in the private sector, and, you know, competitive bidding is a bit different in DME. It's not on a PMPM basis.

So I think those are issues, but I think either of them aren't that much of a stretch. My preference is actually explicit deflation.

DR. MATHEWS: So can I jump in here, Bruce? As we were developing the work for this meeting, over the last several months, we did consider whether or not we should talk about a competitive approach for clinical lab services. And we internally ran into two separate issues that at least for the present time took it off the table, but we could obviously come back and revisit this. But I would like, especially Bruce, to get your reaction here. One with respect to the basic chemistry tests, panels, things like that, that compose the vast majority of the volume that we are talking about. And I agree.
completely that those are commodity products. They are widgets that are being produced. It's just that so much of the volume is concentrated in, you know, two very large entities here, and so the question would be, how much can you squeeze out through a competitive process where they've clearly got the volume to be able to produce rock-bottom per-unit prices, and everyone else who is doing these things -- hospital outreach labs, physician labs -- are going to have a higher per-unit cost. That was one issue that, you know, put the brakes on us.

The second is the opposite situation, where you've got so many of these high-cost, proprietary lab tests that are uniquely provided by a single laboratory. And the question there is, you know, how much competition are you going to be able to get where there is one producer of a test and they are effectively a monopoly, if a payer needs that test.

So could you talk a little bit more about both facets of this question?

MR. PYENSON: Yeah, and perhaps it might be a bit easier to talk about the first and then the second, for me. And for sure further research is needed. But I believe
there are significant regional labs as well, so this might be competitive bidding on a regional basis to allow differences and other players to enter the markets.

But my impression is that the capital needed to get into the lab business is probably not as dramatic as some other kinds of businesses, you know, that we might think about. And there's all sorts of other laboratories in effect for other purposes. For example, veterinary labs do the same stuff, right? It's the veterinary lab at Cornell University that I understand is testing all their students twice a week for COVID.

So I think it would be beneficial to look into some of those issues a little bit further. I agree there is a market domination of a couple of labs, at least on a national basis.

I think on the more exotic tests, my impression is that what you're testing for is not patentable, right? There is a lawsuit on the BRCA gene, for example. And in many cases I believe there's multiple ways to identify, to diagnostics, and we see that with pretty fast competition in some of the cancer genome tests, and even companion diagnostics, where different companies will talk about why
their approach is better than someone else's approach for
the same condition.

Again, I'm by no means an expert in that, but I
think what I've heard says there might be opportunity there
worth exploring.

DR. CHERNEW: Okay. I think Betty had a
question.

DR. RAMBUR: I do. Thank you very much. I'm
working hard to try to wrap my brain around this area, and
I have a question, in terms of explicit deflation, in terms
of how you know where that floor starts, where does it go,
how fast, and all of that.

And I appreciate the idea of not continuing to
pay the price of what something used to cost versus what it
costs now. But my biggest concern, thinking about all of
this, are the new tests that really create micro-diagnoses,
or even identify variants of normal, that then have
downstream costs and effects that even cause harm.

So my question is, as a person sort of trying to
wrap my brain around this for the first time, how do we
prevent that from happening? What's the pricing strategy
that prevents that downstream explosion of additional
costs? And a number of you have talked about that, but I can't understand how you set up the financing to minimize that outcome.

DR. CHERNEW: Betty, that was a terrific point and I think you may have stumped folks, so let's see. We could do Rock, Paper, Scissors for who's going to respond. Again, I think as I said in the beginning, some of this is just an inherent problem with fee-for-service, when you can move things around, and thinking about how to deal with bundling things. This is one motivation for these in the models. As Jon mentioned in his earlier comments, when you're doing this as an inpatient, we don't have all these problems because the tests are bundled in with a whole bunch of other things, and that obviously works a lot better than the complicated set of questions that we're dealing with now.

But we have on the table what we have on the table, so I don't have a great answer for you. I'm going to look to Brian or Carolyn to see if they have an answer.

MR. O'DONNELL: I don't have the answer but I have a comment. So I would just note that, you know, in the Medicare space you can think about price or
utilization. When Betty said how can we get the right test for the right person and now have these kinds of downstream effects, to me that runs to more of a utilization question. How do we get the utilization right?

And, you know, I think of it two ways, one being kind of the ACO model, where there's kind of rationalization within that larger bundle. But also, I don't have a great sense for what private payers do in terms of things like, you know, prior auth or cost-sharing. So, you know, from the Medicare fee-for-service perspective, there's no cost-sharing at all on clinical labs, and obviously you have no prior auth-type mechanism. And, you know, one of the things I was thinking about is getting a little bit deeper in terms of what the private payers are doing in that space.

DR. CHERNEW: So two things. The first one is I agree that it is worth some broader thinking, and certainly in the spirit of this report and the spirit of this policy, which is trying to figure out what we can learn from the private sector to inform what seems to be a pricing problem in the public sector. So I do think that's useful.

The second point is, this has been an absolutely
terrific presentation and discussion. I was where Jon Perlin was beforehand, not knowing a lot about labs. Now Jon Perlin is twice the expert I am. But that being said, what I think we will do to wrap this -- again, I'm looking to see if anyone has other comments -- is we'll take some of this discussion offline and figure out where to go. There's a lot of possibilities on the table. There's the competitive bidding version. There is the sort of baseline deflation factor, if you will. There are versions that might separate out by type of test. You could do things differently, like type of test, and we're going to have to be sensitive to which of these things are CMS things and which of these things require legislative changes. So a lot of institutional detail here that goes on.

I think Bruce's point, that this actually is a big deal for a number of reasons, is true, and so I think it deserves more attention. It is just a really administratively complicated thing. What I would like to avoid is building an ever-more-complicated administrative system to managing the pricing of this over time. I think we should, whenever possible, try to minimize the burden we put on our providers in terms of providing data and doing a
bunch of things, and trying to figure out how to set the
prices as efficiently as we can otherwise. Obviously, we
do need more data in places. I think we can do better than
some of the other things.

But we will take some of that offline. This the
going once, going twice comment. What's next is going to
be another really interesting topic, so let me pause.

There you go. The slide changed, suggesting
that, you know, the gavel came down. So I should say this
to everybody that I can see, all the Commissioners and
staff, but also to the public. There are many, many ways
you can reach out to MedPAC to react to some of the
discussion we've had here today. This is certainly not the
only, and as Glenn Hackbarth, former chair, used to say
when I was on the committee, maybe not even the best way to
make all of your comments.

So please, to the public, we realize we're not in
person, but don't feel that we're trying to avoid comments.
And to the Commissioners, this is not the only time you get
to engage on these topics. So we will reach out as needed,
as we begin to grapple with all those things that were
said, but for now let's move on to Eric, Rachel, and Jeff,
to talk about another mandated -- actually, a congressional request, that we do some stuff on private equity.

So I'm not sure who's going to kick it off. Eric is first on the slide so I am going to say it's Eric, and if it someone else, I am so sorry.

MR. ROLLINS: No. It's me, Mike. Can you hear me?

DR. CHERNEW: Yes. I can hear you. Terrific.

MR. ROLLINS: Okay. Good afternoon. I'm going to conclude today's presentations by talking about private equity and the Medicare program. Before I begin, I'd like to remind the audience that they can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

The chairman of the House Committee on Ways and Means has asked the Commission to look at the role that private equity plays in Medicare. The request does not ask the Commission to make any recommendations. We plan to respond to the request with an informational chapter in our June 2021 report to the Congress.

Today I'm going to summarize the request, provide some background on the private equity industry, and outline
our proposed analytic work plan. After that, we'd like to
get your feedback and guidance on the work plan. We then
plan to come back to you in the spring to share our
findings.

The request asks the Commission to look at four
specific issues, to the extent feasible. First, we've been
asked to look at the current gaps in the data that CMS
collects on provider ownership that may make it difficult
to track private equity investments in Medicare providers.

Second, we've been asked to examine the business
models that PE firms use when they invest in the health
care sector and how those models vary across health care
settings.

Third, we've been asked to examine the effects
that PE investment has on Medicare costs, the beneficiary
experience, and the provider experience.

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

We plan to examine each issue in an objective
manner and will not take a position on the broader debate
about the merits of private equity.

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

Within the health care sector, the growing
prominence of PE firms in recent years largely reflects the
actions of buyout funds. For example, some of the
physician staffing companies that have engaged in the
controversial practice of surprise billing have been owned
by these funds. As a result, we plan to focus on buyout
funds in responding to the congressional request and will
use the term "private equity" to refer to them unless noted
Turning now to slide 5, although private equity has received a growing amount of attention, it's worth keeping in mind that the amount of public equity, which is stock in publicly traded companies, still dwarfs the amount of private equity. Last year, total public market capitalization in the U.S. was about $37 trillion, while the total assets being managed across all types of private equity in North America were about $3 trillion.

Having said that, investment in private equity has been growing quickly, and several factors have contributed to that growth.

First, PE firms often rely heavily on borrowed money when they buy companies, and the corporate tax system favors these so-called "leveraged buyouts" because interest payments lower a company's tax liability.

Second, interest rates have been low for an extended period, which makes it easier for PE firms to borrow money.

Third, changes to accounting standards have forced pension plans to recognize more of their unfunded liabilities, and many of those plans have invested in
private equity in the hope of getting better returns. PE firms vary greatly in size and in the types of companies that they purchase, but their investment activities follow a similar life cycle. That cycle begins with a PE firm raising money from outside investors and pooling it into an investment fund. Most of the money raised for these funds come from what are known as institutional investors such as pension funds, university endowments, and foundations.

Each investment fund operates for a specific period of time, which is usually around 10 years. The PE firm usually serves as the fund's general partner and controls its investment decisions. The outside investors are passive investors and generally cannot withdraw their money before the end of the fund's life span. Most PE firms raise money for new investment funds every few years and thus manage multiple funds.

Once an investment fund has been set up, the PE firm that manages the fund will then buy a variety of companies, which are referred to as "portfolio companies." Most acquisitions take place during the first three to five years of a fund's life span, called the "investment
period." PE firms rely heavily on borrowed money when making these deals, with debt often accounting for more than half of the cost of an acquisition.

PE firms favor the use of debt because it magnifies the potential return on their investments, but one controversial feature of these leveraged buyouts is that the company being acquired, rather than the PE fund itself, usually becomes responsible for repaying the debt.

The PE firm then tries to improve the financial performance of its portfolio companies and increase their overall value. Since the PE firm owns the companies, it has a much greater degree of control than with other types of investments and can make significant changes to the company's business strategy and management team.

Since PE firms need to sell their companies before the investment fund reaches the end of its life span, a PE firm will usually own a portfolio company for somewhere between three and seven years.

Once an investment fund enters the second half of its life span, the PE firm shifts its attention from buying portfolio companies to selling them for a profit. This phase is sometimes known as the "liquidation period."
Private equity firms usually sell their companies to a strategic acquirer, such as a competing company in the same industry, another PE investment fund, or by taking the company public through an IPO. The profits or losses from the sale of an individual company will depend on the extent to which the PE firm can improve the company's performance and find an attractive buyer.

Investors have traditionally paid PE firms using what’s known as the "2 and 20 model." The PE firm receives two types of payments under the model. The first is an annual management fee that equals 2 percent of the total amount that investors have committed to the fund. The second is a performance fee equal to 20 percent of the profits on the fund's investments. These fees are known as "carried interest" and appear to account for most of the revenue that PE firms receive.

There has been debate over whether PE investments have performed better than investments in publicly traded stocks. Some research has found that PE funds outperformed public equity prior to 2006, but there is greater agreement that PE returns have been similar to public equity returns over the past decade. The decline in PE returns relative
to public equity should not be surprising, because overall investment in PE funds has been growing, and this has resulted in PE firms having to pay higher prices for portfolio companies.

As those prices increase, the expected returns should decrease relative to other investments. Although PE returns have been similar to public equity returns in recent years, it's worth noting that PE fund performance varies widely, with funds in the top quartile performing significantly better than the median or average fund.

While PE buyouts first became prominent in the 1980s, their role in health care only became more noticeable over the past two decades.

One major PE firm estimated that in 2019, PE buyout deals involving North American health care providers totaled $47 billion, up from $30 billion the year before.

PE funds have been investing in a wide variety of health care providers, but recently, there has been greater interest in areas such as retail health, post-acute care, and physician practices.

Private equity's interest in health care has been driven by several factors, such as the aging of the U.S.
population, the predictable cash flow for many providers
due to the use of third-party insurance and fee-for-service
payment, at least prior to the pandemic, and the high
degree of fragmentation in many provider markets.
I'm now going to shift gears and give you an
overview of our proposed work plan, and I'll discuss each
of the four issues we've been asked to examine.
I'll start with the gaps in Medicare's data on
provider ownership. Providers submit ownership information
when they first enroll in Medicare, and they must update
that information when there is a change in ownership. CMS
stores this information in a database called the "Provider
Enrollment, Chain and Ownership System," or PECOS.
CMS has largely used this database to support
activities such as provider payment and fraud prevention,
rather than analysis.
The Office of the Inspector General and the
Government Accountability Office have both identified
problems with the PECOS data. For example, GAO found that
it was difficult to use PECOS to identify PE-owned nursing
homes and understand their often complex ownership
structures.
We plan to interview CMS officials, state officials such as those who collect information on nursing home ownership to administer the Medicaid program, and outside experts to see if there are ways to improve the accuracy and usability of the PECOS data. However, collecting good data on PE ownership may be inherently challenging because PE investments can involve multiple limited liability corporations that may not have an obvious relationship to the parent PE firm.

The next issue is examining the business models that PE firms use when they invest in health care. As I discussed earlier, PE firms try to buy undervalued companies, improve their financial performance, and then sell them at a substantial profit. However, the business models that PE firms use to increase the value of their acquisitions can vary, even within a given industry. This variation may be especially true for health care since PE firms have made investments in a wide range of companies.

To better understand these models, we plan to focus on PE acquisitions of hospitals, nursing homes, and physician practices. We've chosen to focus on these providers because there has been significant PE activity in
each area, and they play major roles in caring for the Medicare population.

We plan to conduct interviews with outside experts such as representatives of PE firms, to the extent that they are willing to be forthcoming with us, financial analysts, and providers.

In our interviews, we hope to learn more about issues such as the extent to which PE firms try to improve a portfolio company's profitability by increasing its revenues versus reducing its costs and the relative importance of Medicare versus other parts of the health care sector, such as commercial insurance.

Next slide, please.

The third issue that the Commission has been asked to examine is the impact of PE ownership on Medicare costs, beneficiaries, and providers. We explored the feasibility of conducting some type of quantitative analysis of these issues but have concluded that it would be very challenging in the time we have available for several reasons.

One requirement for such an analysis would be good data on provider ownership, and as we discussed
earlier, the PECOS data that CMS collects can be inaccurate and hard to use.

Some researchers have used commercial datasets to identify PE-owned providers, but this approach would also be difficult because none of the commercial datasets are viewed as comprehensive, and it appears to be very labor-intensive to generate a reasonably complete picture of PE transactions, even for a specific provider type or physician specialty.

And even if were able to get accurate ownership data, we would need to link it to a variety of other data sources, and Medicare's data on service use and quality has its limitations that would make it difficult to assess the effects of PE ownership, especially across multiple sectors.

Given these challenges, we plan instead to review and summarize the available research literature and to discuss some of the challenges involved with using Medicare data to assess the effects of PE ownership.

The last issue we've been asked to look at is PE investment in companies that participate in the MA program. We have begun examining the ownership information for MA
plan sponsors, and our initial exploration suggests that very few sponsors are owned by PE firms.

The health insurance industry is highly concentrated, and most MA enrollees are in for-profit plans offered by publicly traded insurers or not-for-profit plans offered by companies such as Blue Cross/Blue Shield affiliates.

Even if some of the smaller sponsors that we have not yet examined turn out to be owned by PE firms, there appears to be relatively little PE activity at the plan sponsor level.

Having said that, there have been some PE provider acquisitions that appear to focus on the MA population. In particular, Humana, which is the second-largest MA sponsor, has recently launched several ventures with PE firms to acquire home health agencies, hospices, and primary care centers. We plan to learn more about PE involvement with the MA program by interviewing a variety of stakeholders, including representatives of PE firms, MA plan sponsors, and providers. Through these interviews, we hope to better understand how PE firms view the MA program and which parts of the program are seen as better
investment opportunities. We are also interested in learning about situations where plan sponsors themselves make investments in other health care companies, such as venture capital funding for startup companies.

That brings us to the discussion portion of our session. We'd like to get your feedback on our proposed work plan and any suggestions you might have for useful data sources or relevant research on private equity investment in health care.

That concludes our presentation. We will now be happy to take your questions.

DR. CHERNEW: So if I understand correctly, there are no Round 1 questions because that was so clear. What I think might be useful as we go through the set of comments is to get a sense of how you feel we should take this chapter, generally speaking.

I will give my first comment and then see where all of you go, and that is -- and I think it was John who mentioned hair on fire, feet in ice, or hair and ice and feet on fire, some version of that, but the point is I think it's very tempting for people to try and take a concept -- it could be private equity, it could be Medicare
Advantage, it could be labs -- and generalize and then try
and build your policy towards the average, and this strikes
me as an example where the average could be particularly
problematic. Some of the things that I think are most
troublesome and frankly motivated the request to us have
been associated with private equity, but on the other hand,
I do believe there's great potential in other places for
private equity.

So my takeaway -- again, I'm waiting to see -- I
know most of you will have one comment in a minute -- my
takeaway is if there's behavior you don't like, worry about
the behavior. Don't try and find some generalizable trait
of the organization who's behaving badly and then regulate
all like organizations, but that's a Chernew view. It's
not necessarily a view overall. So I think we'll go around
and get as many comments as we can, but if there are no
Round 1 questions, we'll jump into Round 2. And I think
Round 2 is going to kicked off by Larry, unless Marge, I
see -- is yours a Round 1 question, Marge?

DR. PAUL GINSBURG: Actually, after, Marge, I
have --

MS. MARJORIE GINSBURG: Yeah. I think this is
sort of a Round 1-ish question.

So my first reaction in reading this is this seems like a really weird assignment to give us. Am I -- is it just me, or is this really kind of strange? It seems to me there must be other federal agencies that do this sort of thing rather than us. So perhaps Mike or Jim can respond to whether this is really unusual or not.

And the only other comment I wanted to make was on page 15. It says CMS is in the process of redesigning PECOS with the goals of simplifying and speeding up the enrollment process. Is that a goal that we have as well?

So those two are it. Thank you.

DR. MATHEWS: Okay. I'm going to take the first part of the question, and I will defer to Eric or one of the other members of the team for the second.

First and foremost, for our listening public, I would not characterize the assignment as "weird."

It is atypical. It's not something that we have worked with previously in any depth, and during the course of the back-and-forth on the request, we made that clear to the folks who are interested in us doing this work.

Nonetheless, they felt that we could make a contribution
here, even understanding the limitations that we are facing that Eric walked through.

And given the fact that our value to the Congress is being able to provide information, analysis, advice, recommendations, at the end of the day, we took on the assignment.

So it is different. I will admit that, but we're going to try and do the best we can here.

Eric, do you want to take the other piece?

MR. ROLLINS: Sure.

Just to say real quickly, Marge, in terms of whether or not the process for providers to enroll in Medicare is burdensome or time consuming, I don't think that's an area we've looked at very closely. I don't remember any sort of Commission presentation sessions that have been focused on it during our time -- during my time here, which has been about five years. But that doesn't mean anything. It could still very well be a priority for CMS.

MS. MARJORIE GINSBURG: Great. Thank you.

DR. CHERNEW: Still on Round 1.

MS. KELLEY: Go ahead, Betty.
DR. RAMBUR: I have just a question, a Round 1 question. So you had talked about the challenges with doing a quantitative analysis of certain questions that were asked like beneficiaries' experience, and so the thought was to look at the literature. I was just curious. Is there literature out there on this? I'm not really aware of beneficiaries' experience in these type of models, or is there some value, at least some qualitative data collection?

MR. ROLLINS: So we're still sort of feeling our way through the literature and getting a sense of what's out there.

There have been some studies that look at private equity ownership facilities such as hospitals or nursing homes. To the extent that they've tried to see sort of what has been the effect of private equity ownership, they have usually looked at things like cost reports and things like that to get a sense of sort of a provider's financial performance, and to the extent that they get at quality or beneficiary experience, it's a little more indirect by looking at sort of how those providers may be done on CMS.
Star Rating system.

My sense -- and Larry would know better -- is that the research of PE activities for other types of companies like physician practices were limited, and that may be partly due to the fact that that's a newer area where there's been a lot of PE investment. And less time has gone by for sort of the research literature to really build up.

DR. RAMBUR: It would seem that having some understanding of the beneficiaries' experience might be valuable. Just my two cents.

DR. CHERNEW: Thanks, Betty.

I think we're at Paul.

DR. PAUL GINSBURG: Sure. Yeah. The Round 1 question I had is that I noticed that private equity was about a tenth the size of public equity throughout the economy. I was wondering how much of that $3 trillion in private equity used private equity commercial real estate.

The reason I ask that is that commercial real estate, that is the dominant form of ownership in commercial real estate, and that I suspect that how private equity operates in real estate could be distracting from
how it might be operating in health care.

MR. ROLLINS: I don't know off the top of my head, Paul, how much of that is commercial real estate.

My recollection is that buyout funds for most of the activity in private equity is a majority of the dollars that are being managed, but we can look into that and get back to you.

MS. KELLEY: Wayne, did you have a Round 1 question?

DR. RILEY: Yeah. A quick question. In terms of the genesis -- and maybe Dr. Mathews can answer this -- was there some -- on the part of the congressional staff that requested this, was there some concern about the private equity and its role in some of the celebrated hospital closures recently?

I can think of a former teaching hospital in Philadelphia that closed and I believe had some private equity ownership, and that was very disruptive to a number of not only patients, but also young physicians in training, of course, which Medicare pays for.

DR. MATHEWS: So I cannot recall off the top of my head whether hospital closures was a factor or even one
of the factors motivating the original interest in this topic.

What I can do is go back and review the paperwork, the letter that resulted in us doing this work, and I can loop back with you outside of this meeting.

DR. RILEY: Thank you.

MS. KELLEY: If there are no more Round 1 questions, we can move to Round 2. I think Larry was going to go first—oh, wait. I see—

MS. WANG: I tried to put my name in, but maybe it didn't go through. May I?

MS. KELLEY: Of course. Go ahead, Pat.

MS. WANG: Thank you.

Given the difficulty as Eric and the team have noted of using large datasets and kind of doing some big quantitative, qualitative analysis of this, it's just a question, because there have been things written about different transactions, and the information is kind of out there.

Would it make sense or add value to the study to pick a couple of companies and just go through the entire case study life cycle before private equity, after private
equity, maybe transactions if there was additional private
-- or just sort of -- just to do something longitudinal to
follow, to pick from some of the publicly available
information and go a little bit deeper?

If that makes sense, I wonder whether it would be
feasible to add that, like the environmental analysis of
the things that MedPAC is actually really, really good of
doing of, you know, impact on costs in the community or,
you know -- I don't know how you measure beneficiary
access, but other features like that. I just wonder
whether that would add anything to the work plan.

MR. ROLLINS: That is one option that we
considered Pat, and like you highlighted, the pros would be
to sort of get more of a flavor of what's going on in a
particular sector.

I think the concerns that we have are that even
if you kind of focus on one or two sectors, it's still
going to be a pretty heavy lift analytically to put all the
data together to sort of kind of provide any kind of
analysis.

And then I think more broadly, our fundamental
concern was given the variation and PE activity, it just
seemed very hard, and I think we didn't want to be in a position where we were making any sort of general conclusions about what the effects of private equity investment are. We were worried that by focusing just on one or two sectors, we might provide a little more insight as to what's going on in those sectors. But we wouldn't have produced anything that you could really sort of stand back and generalize from.

MS. WANG: Thank you.

MS. KELLEY: Okay. Shall we go to Larry then?

DR. CASALINO: Okay. Thanks.

So I'll try to be brief. I think actually the chair of Ways and Means or Ways and Means -- actually, the four questions they asked are really good ones, and so someone understands some things to be able to put out those questions.

And I'll also say that as usual, it's just routine to say it, but it's true. The staff have produced a really lucid and concise, informative document, I think. Pretty much every month, when we get the staff presentations and mailing materials, I think, gosh, I wish we could hire for my group some of the MedPAC staff, but
then I realize no, no, we can't do that. And we'll never try, never try.

DR. MATHEWS: Don't do that, Larry. Sorry.

DR. CASALINO: We'll never do it. Anyway, I think that would be great, but it does cross my mind once a month.

So Michael asked me to comment a little bit on the tone of the paper, and I think -- and the presentation. I think it's fine for now. I think after their interviews and a bit more literature reviews are done, I think over the next few months, some more quantitative articles are going to probably come out about impact to private equity purchase and the three sectors mentioned. The tone could change if the findings change. I think we should keep that in mind.

So I'm just going to run through the things that I think could be changed in the written materials of the presentation and a few other things I want to say.

I think that private equity has some very significant advantages as an investor. It's not clear that these are necessarily desirable for other stakeholders besides private equity. Brian and Eric mentioned some of...
these, the interest loophole, ability to finance purchases
with debt and then load that debt on to the acquired
entity. Not mentioned in the presentation, but in the
written materials, the ability to force the entity after
purchase, like the physician practice, to pay dividends to
the PE firm or to pay management and consulting fees that
may or may not be appropriate.

So the paper does a good job of describing these
advantages, if you want to call them that, but they're kind
of buried. The description is kind of buried in the middle
of the documents. They're in a logical place, but I
personally would also like to see these things made a bit
more visible by maybe just listing them in the executive
summary and also, I think, certainly in the section on why
PE has been growing because I think these are reasons why
PE in health care is able to grow.

One gap, I think, in the paper, Eric mentioned
briefly in the presentation, a little bit about in the
paper, is differentiating what the paper calls "physician
staffing companies," we call "physician management
companies." But these are companies that basically focus
on hospital-based physicians, especially anesthesiology,
emergency department, immunology, OB/GYN, and then they sign contracts with hospitals to provide services in these specialties. And they employ the physicians then to provide the service.

A lot of these companies are huge, so TeamHealth, MEDNAX, Envision, and they're either owned by private equity now or had significant private equity involvement in the past. And we're talking about big investors like Blackstone and KKR.

So these, I think, need to be clearly differentiated, I think, from the more midmarket or small market private equity firms that are out there acquiring physician dermatology practices and 2 physician dermatology practices, for example. They're different beasts, and they probably have different business plans and maybe a different amount of time for how long they intend to be in the business.

It's just worth saying these big physician management companies or physician staffing companies, they're quite involved in surprise billing and also in providing the dark money to block the surprise billing legislation last fall in Congress.
In terms of the business plans -- so these firms promise annual returns of -- 20 percent return on investment annually to their investors. How often they meet that nowadays is a different question, but that's what they like to claim they'll do. So thinking about physician practices or nursing home or hospital -- but let's just take physician practices. Are there many practices out there that are really so badly run that you can generate 20 percent extra revenue from them every year without stinting on something? I haven't heard a convincing case for that. So how much of the 20 percent annually they can generate from operations is a question, I think.

They can potentially generate money from real estate, and I don't know in detail, but I think the Hahnemann Hospital that Wayne was referring to in Philadelphia was a real estate deal. Buy the hospital in a potential fine area, let it go bankrupt, and then sell the real estate to make a high-end condos.

So real estate can be a play. I think that may be more true in the hospital or post-acute care industry sectors than certainly in physician practices.

And then can they get some of the 20 percent from
these dividends, consulting management fees, I mentioned?
I think they expect to get a lot of the 20 percent annual.
So, in five years, this would be 100 percent, double your money, from their sale.
And then the question is, who are they going to sell it to? There's a nice discussion on this on page 12, and I think that this would be a great thing through interviews for the staff to explore in the next few months.
What is really happening with these sales, especially in the physician practice area? Things are so new that there haven't been many second sales yet, but who is buying the practices, and are they really buying them for a lot more than the original private equity firm paid for them? Because if the private equity firm cannot sell what they bought for a lot more than they bought it for, they're probably not going to be able to give the returns to investors anywhere near that they promised. And so this could actually turn into an unintentional, I think, Ponzi scheme.
Michael, I don't have too much more to say. I'll just add a couple things.
Small point but I think significant is another
possible way to get to these high returns is if you buy a
12-physician dermatology practice, which is really big, you
might pay 12 or 14 percent, what's called EBITDA, and that
can be a lot of money, well over $1 million per
dermatologist.

But then if you start buying two or three
physician dermatology practices to add to this bigger
platform practice and you buy them for twice EBITDA maybe,
so you get them cheap and probably even more cheaply now
after what's happened with the pandemic, you add them to
the bigger practice. And the day that they're added --
they don't have to change their location or anything, but
now they're part of the bigger practice. Now they're worth
12 to 14 times EBITDA too because they're part of this
bigger entity.

Case studies, I think, is a good idea, especially
under the circumstances, maybe two of the three sectors if
the staff proposed a study, ideally to try to find the case
study of a firm that was doing a good job and one that
wasn't.

I agree with Mike that there's probably a lot of
heterogeneity. From what we've heard in a lot of
interviews, there probably really are PE firms that are both capable and well intentioned and then firms that aren't either capable -- or they're not capable and they're not well intentioned either. And there might be some that have one but not the other. So I think that's probably true.

I would say, though, that average effects are also important, and hopefully, we'll be able to get at that quantitatively with a lot of labor -- or in this year. I do wonder how if the high performers are truly high performers or if it's just luck. So if they're in the top quartile, how long do they stay there? It's been shown in a lot of industries that genius stock pickers or genius movie producers who pick hits, they look really good, but actually, if you look at their track record over the years, they turn out to be no better than anybody else. So one wonders with the PE firms.

A few other ideas about who else to interview besides who you mentioned in the paper. I think consultants, attorneys, and also health insurance companies and hospital executives, who are both very effective by PE purchases of practices, for example, or of nursing homes,
so worth talking to hospital executives and insurance executives as well as consultants and attorneys who work in the industry.

And then the last point, it would be interesting to -- I already mentioned it would be good to know who actually makes the second buy after PE firm buys and now selling, how often the entities they bought do in fact go bankrupt, because I don't think we have a good idea of that in the three sectors mentioned.

And in terms of working with trying to make PECOS work better for identifying ownership by PE, for example, I would -- this goes beyond private equity, and I think the fact that it's very, very difficult to determine who owns something in U.S. health care -- and let's just say who owns a physician practice. Is it the physicians themselves? Is it a private equity firm? Is it hospital? Is it a health insurance company? Is it Optum? Very hard to tell.

I would personally love to see MedPAC make recommendations at some point about how CMS could contribute to making ownership more transparent, and I think in that regard, the statement on the bottom of page
17, quote, Commission staff will further examine what change is under way for PECOS and whether those changes might shed light on PE ownership, that's pretty weak in my opinion, I would say. Whether now or at some other time, I would love to see MedPAC try to get Medicare to make ownership more transparent. Without that, I think it's very, very hard to understand the impact of the major organizational changes that are happening in the U.S. And that's it.

MS. KELLEY: Okay. I have Bruce next.

MR. PYENSON: I wanted to compliment Larry on his comprehensive view within the organizations that Medicare makes arrangements with. I think my perspective is similar to Mike's and others that there's a huge variation in what's going on, but I think this is an opportunity for MedPAC to create something like a payment basics role of private equity in health care. It's not quite payment but really a cornerstone piece on this.

My perspective is that we have an opportunity in looking at private equity to expand beyond the organizations that the Medicare program writes checks to
and to look at the organizations that serve those
organizations and perhaps even control them.

As the paper pointed out, of course, the new
Medicare Advantage plans are dominated by huge
organizations. Huge organizations that are publicly traded
typically don't deal with private equity directly.

However, if we're going to think about more
competition in any of the spaces that we've been looking
at, private equity is likely to play a role. We were just
thinking about labs and what it would take to get a lab
going in a region. That's a role for perhaps private
equity.

But where I see -- what I see would be very
helpful is to look a layer deeper at the organizations that
are serving the providers or the MA plans that Medicare
contracts with directly or pays directly.

So there's all sorts of organizations that are
doing data analytics, that are doing billing, that are
doing risk adjustment, risk optimization, and distribution,
various other feeder organizations that are critically
important to the functioning of the health care system.
But they're not getting cut a check directly by Medicare,
and often it's those organizations that are involved with private equity. And I think extending our view to those other organizations would be of benefit to the work of MedPAC in general because often the behaviors that we are examining or are puzzled by are no longer the incentives or the motivations of a physician in a physician office or a hospital, but are driven by the other business entities that are so important to their functioning. So I see that as an important recognition in a report that we put out.

I like Pat's suggestion of a case study kind of approach, but I don't think that has to be generalizable in the extent this is good or bad, but more on a this is the way private equity works, not the conclusions of it, but here's how the money comes in, here's how it goes away, here's the life span, here's a couple of cases of that. So I think that kind of educational approach would be quite useful.

In terms of some of the discussion and the questions of why is private equity interested in health care as opposed to car washes or as opposed to clothing manufacturers, well, that's what we were talking about in the context section. Health care is growing, and the
spend, more and more money is going into health care. So I
don't think it's any surprise that private equity is
interested in it. So I think that's a reflection of the
issues in the context chapter.

So, in summary, my recommendation is that we
recognize these other entities that are normally beyond the
purview of MedPAC as important to health care and important
to private equity, and I think I've suggested doing that in
other contexts as well. I think it's important to really
understand whether what we're suggesting is going to work
or not.

Thank you.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Sorry. I'm not sure I was in the
queue on this one, but I'll make a comment, given that I've
been in an organization that went through the cycle.

I think our chair's comments were just absolutely
accurate. The mean may not belie the spurious on the
edges, having lived through an LBO and come out of it
again.

In our organization, it was simply a capital
structure, and the capitalization was very different from
the operationalization.

It's interesting. There was a recent paper in JAMA that talks about a relative improvement in PE-owned entities relative to others. Truth be known, someone sent it to me, and I begin reading it. I said, "Oh, the story is largely based on my organization."

Now, I'm proud of the fact that we outperform and lifted what appears to be an entire sector, but the truth of the matter is that die was cast even well before the LBO in terms of commitment to changing quality and performance.

So, you know, it is very interesting. I think the reasons private equity in part has been interested in health care is not only because it's a large sector, roughly a fifth of the economy, but because prior to COVID, all the other activity, there was very little place to invest.

I think Bruce and Larry raised some very important points that there are a panoply of approaches to what gets invested in from direct care provision to the fiscal spaces that support health care, et cetera.

I would just encourage the evidence-informed approach of this topic that MedPAC and staff take so
thoughtfully to all topics, not rely too much on anecdotes, especially, you know, get a number of outside experts that would give varying views, but just simply recount the facts, that I think the larger issue is obviously how ownership influences -- how do ownership interests influence such things as utilization and clinical outcomes. Thanks.

DR. CHERNEW: So let me jump in before we get to the Round 2. I'm not sure how deep the Round 2 queue is, Dana. If you could let me know.

But just to give some context, first of all, the author of the paper that Jon is talking about, one of the authors is a colleague of mine, Zirui Song. I happen to know by text, he's been listening to you.

As an aside, although this might be somewhat a typical request, I do think per what Bruce said, this will be an interesting area for MedPAC to learn about even more broadly. Given staff time, I'm not sure how far we're going to be able to go down that route for this activity. That's the sort of discussions that I'll have with Jim.

I will say that for this report, I'm not leaning towards any recommendations, per se. Again, if anyone has
recommendations they're interested in making, this would be a time to get them out on the table we could discuss.

I do think we could have some conclusions. The conclusion I am leaning towards -- and again, I say this to get pro or con reactions from all of you -- is something like private equity can be good or bad. They are likely to be an important source of efficient funding to have efficiency increasing disruptions, but they also can do some things that -- they exploit loopholes, if the loopholes exist, and that we -- and they're not alone in that behavior, and that we should focus policy on leaving the opportunities for negative exploitation and increasing incentives for positive efficiency enhancing disruption. And when we see bad behavior, we should go after the behavior and not the capital structure of those that are behaving badly.

So that wasn't very eloquent, but since we're earlier in this process and I'm an economist, I don't feel bound to be eloquent.

So, with that, I'm interested in comments basically about are there strong recommendations you think we should go after, are there conclusions you think we
should make, or do you want to make comments on the process by which we get there, given the limited time and the data complexities that we're going to inevitably face?

So, Dana, how does the Round 2 queue look?

MS. KELLEY: Our next person is Marge.

MS. MARJORIE GINSBURG: That must have been a previous one. I don't have a comment right now.

MS. KELLEY: All right. I'm sorry.

Karen?

DR. DeSALVO: Thank you.

I guess sort of sticking with the congressional expectation that we don't need to make a recommendation, I think the elucidation is helpful because it's a very active area of work in the industry for reasons that have been outlined. It's a growing industry.

And I just wanted to provide a couple of reflections and then maybe a very concrete couple of suggestions.

The reflection is that thinking about primary care, when you want to innovate primary care practice in the U.S. context, you have to get special money to do it because it's really not quite possible to innovate within
the confines of the typical traditional Medicare construct.

I said that as nicely as I could.

And my first experience with that was after

Katrina when we got resources from HHS to reinvent primary
care for our city, which we did successfully in the vein of
the patient-centered medical home, and that experience was
punctuated by an ending of that grant funding that caused
us to have to go back to a fee-for-service model, which
cau\nded us to have to start letting go of our team members,
community health workers, navigators, mental health
professionals, because there wasn't a fee-for-service fee
schedule weighted to pay for their services.

Over time, the system has started to level out
with Medicaid advancements because most of those are FQHCs,
federally qualified health centers. They've been able to
retain some of the component parts of medical homes, but
you see this story replay over and over and over again,
whether it's a CMMI model or a special grant program that's
funded by the private sector payer.

And I share all that to just remind all of us
that sometimes innovation needs an extra infusion of
flexible resources.
In fact, CMMI is basically a really big PE firm, and it's been trying to infuse capital in a way that can drive innovation into the ecosystem.

Wearing the hat of an MA plan, it's a similar kind of challenge. What you want is primary care practices with aligned incentives about prevention and meeting people where they are in whatever environment that makes the most sense digitally, at home, in the communities' site. A lot of the current constructs of the Medicare program aren't as flexible to support it. We're seeing that happen every day, including even in areas like telehealth, which we'll discuss tomorrow.

So some of the impetus, just because this came up in the presentation, I'm just kind of answering the question as a former board member of Humana. But the interest is how can there be a way to try to innovate a better model of primary care, one that doctors want to practice, is team oriented, that consumers love, that gets you to the kind of outcomes that you want, because whatever we've been doing in the current construct, doctors don't love, patients don't love, the system doesn't love.

There's no secret sauce here. I think it's less
about the financial. It's more about just trying to get to a better model, and I think the more that you talk with executives, I think you might be hearing more of that story.

The two more things I just want to mention before I got off of that, the why, is don't forget to think about venture capital as a smaller portion of this perhaps that's thinking about some of the digital innovations or some of the companies that start to really grow quickly, and Rock Health always keeps a really nice inventory of what's happening in the field across the spectrum of investments. That could be a place where you might want to have a conversation with them and think about if they have ideas of other data sources that would be useful.

And I just want to end by saying I really think talking to the beneficiaries would be so helpful. I really don't think there's a lot of data about if people notice a difference. People did the concierge model years ago, which is essentially what a lot of these new primary care models are predicated on is this idea of a concierge access anytime without the same kinds of constraints. We know a little bit about how consumers felt about it, but those
models weren't designed particularly around reaching populations equitably and doing it with technology in hand. So I think getting the voice of the consumer in this just to inform the field would be useful for everybody involved and I think especially useful for the Commission to have.

MS. KELLEY: Okay. Thanks. Paul?

DR. PAUL GINSBURG: Sure. It's been a great discussion so far.

There's one perspective I want to put out, and I'm not quite sure how we can follow it, is that in much PE, the model is acquire an organization and run it differently to make more money than it was making before.

I think physician practice is probably a prime opportunity because physicians historically have been very well paid in this country, at least in specialties, procedural specialties. There likely are opportunities to manage more aggressively on either the revenue or the expense side.

But my concern is really about managing aggressively on the revenue side and how much of this is exploiting the vulnerabilities of all fee-for-service payments. I think in some areas, it's probably more
vulnerable than others, and that's often where you see PE or other for-profit going. So, in a sense, it's a bit of a wake-up call for Medicare that you need to put more energy into shoring up your loopholes and maybe even increase the urgency of getting away from fee-for-service because the system -- and I think that's what attracts PE to health care. The system is so much more vulnerable than car washes as far as more aggressive management, making a lot of money, without delivering commensurate value to its customers.

MS. KELLEY: David?

DR. GRABOWSKI: Great. Thanks.

Let me start by saying that I'm really pleased that we're looking at this issue around private equity. I believe it was a really important request from Ways and Means.

As Eric said, nursing homes have a relatively longer history with private equity as compared to other sectors like physician groups. As one example, one major nursing home chain is actually on their third private equity owners. So we've seen two sales, private equity to private equity, to get to this third owner.
To Larry's point, real estate has been a big part of these nursing home deals. Indeed, one thing to unpack for Eric and the team is just all the permutations of these nursing home deals. How do nursing home private equity deals differ, if at all, from some of the big purchases by real estate investment trusts and other entities? This is a really complicated space.

In terms of how complicated it is, I love Larry's comment about the challenges of determining ownership in the U.S. health care system.

Let me even go further than Larry to say I don't think this is an accident. We need greater transparency. It's really hard to understand, even scrutinize these deals, if we can't even identify them.

The PECOS data came out of the Affordable Care Act with exactly the idea of allowing greater broker oversight over an increasingly complex ownership structures in the U.S. health care system. It's been incredibly frustrating to me and others that have worked with these data that they haven't been up to the task in terms of either accuracy or usability. It seems that all we've ended up with really is a complex database.
Anything we can do to improve these data -- and
I'm really looking forward, Eric, to your discussion with
the team at CMS about how we can improve these data. Mike,
you asked for what could be a focus of these chapters. I
think if we increase the transparency, the accuracy, and
the usability of the PECOS, those would be tremendous
outcomes from this. Those data right now just really have
some shortcomings.

As Eric noted, because of those shortcomings,
researchers and analysts have had to rely on commercial
databases to identify private equity ownership. Eric's
point about the completeness of these commercial databases
hit home with me.

I did a 2008 paper with my colleague, David
Stevenson, on the first generation of private equity deals
in nursing homes. We obtained a list of the largest deals
from an investment bank. We lived in constant fear that
someone was going to come up with a deal that we missed in
that analysis. In fact, we kept couching our analyses that
these are only for the biggest private equity deals at the
time to give us wiggle room.

We should have been able -- and the PECOS data
were one of the outgrowths, as I said, of the ACA, which
came after our analysis, but the hope had been the next
generation of studies could really leverage the PECOS. And
ey haven't been able to do that.

Two other quick comments. I'm wondering. We
spoke a lot in the last cycle on MedPAC about market
consolidation. I've wondered how private equity
contributes to market consolidation. We did an analysis
with the PECOS where we found lots of joint investment
across hospitals and post-acute sites, including hospice.
How does private equity figure into that? Our analysis was
broader than just PE, but I'm curious whether there is kind
of broader investment that's helped to consolidate those
markets.

The final point -- and we talked about COVID this
morning, and I think COVID has magnified kind of private
equity investment, at least in nursing homes. In good
times, it may be fine to separate ownership and operation
of a nursing home. In these really challenging times
during the pandemic, I'm not certain of the wisdom of
having operations and ownership separate. I know a lot of
operators right now are struggling to pay their lease. We
saw some of the revenue numbers this morning. But I do
think it's worth scrutinizing just the stability of these
arrangements in a pandemic. I realize these are
extraordinary times, but it's not clear to me that these
kinds of ownership operation models are well built to
withstand these kinds of times.

So I'll stop there, and once again, I'm glad
we're looking into this and look forward to everything the
team is going to learn from CMS and others about how to
improve the data infrastructure and how we can understand
these deals going forward.

Thanks.

MS. KELLEY: Okay. Brian?

DR. DeBUSK: Well, thank you, and I will echo
some of the other comments. I do think this is a great
question on the part of Congress.

My comments are going to closely align with
Paul's, Michael's, and Larry's.

First of all, I just want to point out the
obvious limitations. I mean, you guys have already talked
about the limitations of PECOS and the change of ownership
process. I think the other thing we have to face is that
private equity firms don't like to be transparent. They don't like to be measured. So, I mean, I think that's the other thing that we're up against. We have incomplete data, and we have a group of people that don't want to be measured in the first place.

I think in a report, I hope we can recommend that it's probably best to use some indirect methods to gage the impact of private equity and health care. As Michael said, I think they're a combination of good and bad things, but regardless of how we feel about private equity, they're here in health care. I mean, they've arrived, and they're making moves. These are very financially savvy people. They have access to capital, and they love to scale programs. And they like to scale them relatively quickly.

I think we need to focus -- and I think Bruce mentioned this. We needs to focus on where private equity migrates. Look at the mechanism that they're using for their transactions because you have to assume they're going to find a viable business model, build a template, and then try to scale that template geographically. I mean, that's their mechanism of action.

I think this really puts a lot of pressure on
fee-for-service. Paul, I agree with your comments. I mean, these guys are great at finding arbitrage and taking advantage of it. If it's arbitrage that's good for beneficiaries and for taxpayers and for providers, I think that's great. I don't think any of us would complain if a private equity firm was buying up physician practices in an area and building a population health front end so that they can engage with Medicare Advantage plans and alternative payment models and make money off of shared savings and capitated payments. I don't think we'd have a problem with that.

But I think if the same firm were buying these physician practices, aggressively renegotiating rates, sending out-of-network billing skyrocketing, and just slashing costs, I think we would have a problem with it. So I think as policymakers, the real pressure here on us is what opportunities have we left. Where are those arbitrage opportunities in the system? Because I think it's safe to assume with PE being here, I don't think they're just going to go away. And the arbitrage that we may have left in the past, they're going to capitalize on. So, if anything, I think this creates pressure for us to make sure that we
have the incentives correct.

Thank you. Those are my comments.

DR. CHERNEW: Can I just jump in? I know we have a few people --

MS. KELLEY: Oh, of course.

DR. CHERNEW: Dana?

MS. KELLEY: Go ahead, Mike. I'm sorry.

DR. CHERNEW: I'm sorry. I just wanted to jump in because it will help, I think, see where people will go next. I know we have -- Pat, you're going to be after me, then Amol, Jonathan, and I guess Larry again.

First of all, I'm exactly where Brian is in much of what he said. We want to make sure that you make a profit from doing good as opposed to making a profit from doing bad, and the better we can set up the systems to enable that, the better the world will be.

I wanted to talk about actually where Larry and David were about the PECOS. As one of the researchers that's constantly frustrated by PECOS, my concern, which you triggered, Brian, is we could spend a lot of time trying to get better sense of corporate ownership in ways that pe who actually do corporate ownership will be able to
obscure. So I think what we will have to sort going
toward is how much time and effort we should spend or CMS
should spend trying to sort that because I'm afraid they
will inevitably fail, given the potential complexities of
the way in which people can build corporate ownerships and
the definitional issues.

But we'll sort that out later, and I think now we
should probably go to Pat and then move through the queue.

MS. WANG: Okay. Thank you.

DR. DeBUSK: Michael, on that one point -- I'm
sorry to interrupt. On that one point, I do think if we
could in our discussions with Congress, if we could shift
the emphasis toward the mechanism of action and perhaps
away from this perpetual cat-and-mouse game, I think there
would be some benefit there.

MS. WANG: Okay. You know, just picking up on
the important discussion on PECOS and transparency, I think
that the call for transparency is always more powerful if
you can say why you want to know and that you have
information to suggest that greater transparency is
relevant as opposed to we're just we just kind of want to
know because we always like to know what's going on.
In that regard, I think Karen's comments earlier were really striking to me, particularly when she talked about PE funding as being a source of flexible capital for primary care, et cetera. It's really, really an important function.

The difference between PE firms and CMMI, which I think you said something like they're trying a PE kind of function, is the need for the return, the high financial return from PE. CMMI doesn't require that.

So just as we always want to evaluate the impact and the success of the CMMI investments for lasting and sustainable improvement in the health care system, I think that's the question around PE that supports the call for greater transparency and maybe the extreme efforts that would have to be made to improve PECOS.

The reason that I sort of was raising the idea of case studies before is I feel like what's missing from the discussion is a longitudinal understanding of the impact of PE. In the short term, funding innovation, creating new models of care that are not constrained by the typical way that we do business is really, really valuable.

But the question is what then happens to that
investment in a physician practice. What's the next step? Because there is this cycle of transactions that kind of flows from an initial PE investment. I think that's kind of what it's about.

So my interest would be knowing, longitudinally, what are the impacts on consolidation in the system. If you buy a physician practice or an urgent care center, do you then kind of, the law of economics, make it an imperative to acquire more and bundle them so you can achieve those scales? What is the impact of consolidation on the market in terms of cost to payers? I mean, there's more clout. There's more bargaining. Costs should go down in some respects, but maybe they go up in other respects. What's the impact on quality? What's the impact on existing parts of the delivery system, particularly those that have been there for a long time and are expected to serve those whose payer source may not pay very much, if anything?

Those are the kinds of questions that I don't know how to get at that, but that's why I was suggesting a longitudinal case study, just so that at least I, along Bruce's sort of concept of payment basics, can understand
the life cycle of something that has had PE investment and kind of where it goes. Does it eventually get acquired by publicly traded companies? Are there entities that started as not-for-profit who wind up publicly traded? Are there small entities that wind up gigantic? Are there innovations that create a lasting impact in how to take care of the elderly at home? It's that kind of thing.

I don't have the specific suggestion other than trying to pick areas to do case studies that would illustrate at least longitudinally the sort of life cycle of an entity that has had this kind of investment in it.

Thank you.

MS. KELLEY: Amol?

DR. NAVATHE: Clearly a very important topic. I'm very struck by what seems like the heterogeneity of opinion and emotion from folks around this question and its impact on health care, even just across the Commission.

I think I largely agree with the view, Michael, that you've been putting forth, which is there are clearly some publicized bad examples, if you will, of how private equity has affected health care, but I think we want to be careful from taking a view of sort of an indictment of the
entire investment vehicle and the entire investment community with respect to private equity.

So that being said, I think what I am struck by is that from the way that we as MedPAC tend to approach understanding health care, we clearly don't really understand some of the very basics of what the scope and scale of private equity's influence is. I think to the extent that we can work with academic groups that have tried to do that -- I think there's at least a few of them that I'm aware of -- and try to kind of stand on their shoulders, if you will, as well as access some of the other resources, even if it's an incomplete view.

David, to your point, maybe it's not going to be a 100 percent view, but it will be a view. And at least we will have a floor for how big and how wide and how deep this issue runs.

I think there's a couple of pieces that are particularly interesting and I think, to some extent, Pat, to your point, are great calls for transparency or at least a push and perhaps itself is something that we could get back to answering the Ways and Means request is to what extent is the regulated aspect of health care and a vehicle
for -- or an opportunity for arbitrage that private equity is interested in, because one aspect of clearly what MedPAC has an opinion on and influence over and sort of within our four walls, if you will, is the regulatory aspect of health care between Medicare. So I think that makes this sort of squarely important for MedPAC to understand.

To the extent that through our qualitative work and perhaps through other quantitative work we can get there, I think that would be particularly important.

The other piece is that examples like Heinemann exist. So I think while we don't want to cast the entire PE industry, if you will, as bad actors, there's clearly been an impact, and I think some would argue a negative impact, on beneficiaries, on trainees, on physicians, on others who are impacted by decisions made seemingly more based on profit motive rather than social welfare.

And if we can use the case study template here for a second to put a personal view on what the impact can be when the profit motive exceeds the social welfare motive, to some extent, then maybe we can actually be successful in driving towards greater transparency.

I would at least submit that do-gooders are
probably not quite as scared of transparency relative to
the minority perhaps of bad actors. So if an outcome of
this allowed the PECOS conversation that we have had is we
can circle back basically, quantify to some extent first
principles of how big, wide, and deep this problem or issue
is, not necessarily the problem in the negative sense, and
then articulate a reason, even if it's in a few examples
with a personal face on it, why this actually can touch
people in potentially a negative way that interacts with
the regulatory aspect of Medicare, then I think that that
is a pretty powerful case to say we would pursue trying to
get more information and using perhaps congressional
authority and other avenues to try to understand this more
deeply.

The last point I have is while I agree that
there's not a lot of reliable data, from what I understand,
to do deep quantitative analyses, it seems to me that part
of what the congressional request to us is to try to
elucidate what we would need to be able to do that.

There are, again, academic groups who are
starting down that path. So if we can complement our
qualitative work, talking to beneficiaries and the private
equity firms and MA plans, et cetera, et cetera, with at
least an approach of what we would need and how we would
execute those analyses, which hopefully will be less time
consuming, Eric and team, than actually having to conduct
all those analyses and collect all that data, then I think
we can at least paint a picture of all the different
components that would be needed to more comprehensively be
able to sell you this and recognize the limitations in,
again, a very concrete way, if possible.

So those are sort of some reflections of mine in
terms of how perhaps we can try to look under the hood a
little bit more, and largely speaking, I agree with a lot
of the statements that other Commissioners have said.

Thanks.

MS. KELLEY: Jonathan Jaffery?

DR. JAFFERY: Thanks, Dana.

So, like others, I thought this chapter was
great, and this discussion has been phenomenal really. And
I'm learning a ton.

I would say that, like others, I do think that
there is definitely some opportunity to think about both
negatives and positives in this space. I do wonder if the
stated need to have 20 percent annual return ends up creating some inherent conflict with the ability to get enough efficiencies that will also return some of those efficiencies or some of those positive benefits back to the Medicare program and beneficiaries in terms of access, quality, and cost savings, but I don't want to dismiss that possibility out of hand.

So to balance that, one of the things that I'm thinking about in terms of innovation here that I'm not sure we've talked about, although there's been some hints, been some comments that Karen and Brian in particular have made, is thinking about, first of all, the idea of infusing cash into practices, physician practices, and maybe particularly primary care practices, to be able to create a team-based model of care.

One of the things that strikes me -- because there are some health systems that could conceivably do that and have to a certain degree, but one of the barriers to making that sustainable that we've talked about beyond what Karen mentioned in terms of grant funding that goes away is that health system leaders are often stuck in a mode of thinking about their finances and the analytics...
about the finances based on their traditional models. And it's hard for them to parse out things beyond the fee-for-service, and I think evidence of that is -- I don't know how many years now we've heard people constantly talk about having a foot in two canoes. But it's been many, many years now.

So it strikes me that folks who are running PE firms are not going to be burdened by having that legacy model of thinking about financing, and if there's an opportunity to make a sustainable model through the various population health program approaches that Brian was talking about in ACOs and whatnot, they will be wide open to innovating that way.

So that's a long-term assessment. We're not going to understand that in the next paper, but it's something to think about. It's an opportunity, and maybe in this work plan, as you do stakeholder discussions and interviews, maybe there's an opportunity to probe on those things a little bit.

Thank you.

MS. KELLEY: Larry, did you want to say something again?
DR. CASALINO: Yeah. Two quick points and then a specific recommendation.

The first point is I think we're not here to prejudge, any of us, the impact of private equity. I don't think any of us know on the provider side in health care. So, hopefully, in the next six months or whatever time there is, the staff can come up with a bit more information through case studies and review of the grant. I think there will be more peer-reviewed literature by then as well. Then we may have more informed conclusions, although I don't think we'll have definitive conclusions.

The second point is I think we should be clear, at least on the physician practice side -- and I think this is true with nursing homes and hospitals as well. There isn't a lot of private equity money that's interested in value-based purchasing. The incentives aren't strong enough, and the returns are not only meager but uncertain. So most of the private equity money that I'm aware of in the physician practice world is going to the kind of practices that you can make as much money as possible from straight fee-for-service, orthopedics, dermatology, gastroenterology, not to value-based models or primary
Now, there are exceptions. There are private equity investments in primary care groups that want to take the sickest patients they can get and get Medicare Advantage contracts to do well with those patients and take a lot of risk, and that is probably a very positive thing. But that's not where most of the private equity money is doing into practice purchase right now because that's not really where the incentives are, the way the system is set up as a way to make money. So those are the first two points.

Then in terms of the recommendation, someone asked a very good question. If we're going to make a recommendation about knowing who owns what, we need to have reasons. Well, why do we want to know that? I think that's a good question.

I think there's a couple of things, reasons why we want to know who owns what or who owns practices or who owns nursing homes. One is if we don't know who owns what, we really don't know what the effects of private equity ownership are beyond anecdotes or case studies. We just don't.
We also don't know what the effects of hospital ownership of practices are and so on. In fact, through very labor-intensive work, some research teams have got some data on effects of hospital ownership of practices, and it's pretty bad, right? Generally cost, prices go up, quality doesn't change. That would be a summary of the literature, I think.

The ACO world, at least the shared savings world, hospital-based ACOs do quite a bit worse than physician-led ACOs.

So this goes beyond private equity, I think. We're seeing massive and very rapid and probably irrevocable changes in the structure of the delivery system by consolidation of hospitals, consolidation of physicians, and a vertical integration between hospitals and physicians, and then that private equity ownership effect, nursing homes and hospitals as well.

Massive change is happening very fast with very little evidence on the effects. So we're never going to have evidence on the effects if we don't know who owns what.

I agree that it could be very, very difficult for
Medicare to set up a process that's helpful with that, but
I think it could be a lot better than it is. It's kind of utopian. This is something that I've been advocating for years, and it seemed extremely utopian. This is a potential opportunity. Ways and Means has asked MedPAC to comment on how PECOS might be used to identify ownership better, and in this case, talk about PE, but I would just expand it to say we want to know about who owns practices, period, not just PE, but hospitals and so on, their own physicians and so on, and here's some ways we could do it.
So I would recommend talking to as many experts in that, in how ownership could potentially be identified in PECOS data if we could have it just the way we want it and try to use this opportunity to do something about that.
Otherwise, we're still going to have research teams spend enormous amounts of money to make incomplete databases, and it's a slow painstaking process. We should be able to do better than that as a country.

MS. KELLEY: Mike, did you want to --

DR. CHERNEW: Yeah, yeah. I just wanted to react to two things. The first one is I don't know enough to know where private equity is focused, but I do know of some
big examples of private equity or at least for-profit companies in the value-based purchasing space, Halliday, Caravan, Signify, and Remedy, so -- Archway. There's a number of private equity firms that have been moving into the space to support organizations trying to do delivery system transformation.

And I would add, although not by private equity, there's a ton of other consulting firms that are quite for-profit oriented to try to support that system transformation.

I'm not arguing one way or the other about where focus is. I'm just trying to point to it.

To the extent that there are models that people can make money off of it, it is not the case that private equity is sort of ignoring that.

The other thing, I actually think it's easy to make the case about why we would want to know about ownership and private equity. I don't find that a hard case to make. Certainly, we were asked this because people felt it was important.

What I think we will have to explore -- and I'll have to talk to Jim and his staff about how we can do this
-- is is that actually a doable thing.

One of the things as we've -- you should know, actually, we have a grant to look at private equity and try to understand what's going on, and one of the big challenges -- and so it would be great for me to do that.

One of the big challenges that we've faced is the word "ownership" is quite complicated. I used to think you'd kind of own something or you don't. It turns out there's a lot of contractual forms in which you're kind of like an owner, but you're not really an owner until someone else is the owner but you own, somebody's private equity deals, they own the real estate but not the company. They own the company but not the real estate. They own the profits but not the actual company. So the ability of lawyers and others to get around with simple words like "ownership" means is quite complicated in my mind.

What I'm really trying to do actually, Larry, is support what you said, but it might not sound that by my town. But I am actually trying to be supportive.

I do think it is worth exploring how we can make things like PECOS better, and it's always good to have utopians on the Commission. I think that is a really
valuable thing to do, but I don't think we should be under any illusions that it will be an easy thing to do, particularly as Brian said earlier, when people don't want to know that, they may have to figure out how they can structure their contracts to not be owners when in fact they're the ones that keep the profits if in fact you do bad behavior type of things.

The same was true for a whole bunch of other referral pattern issues. You can't refer something you own, but what does "own" mean? That came up with sort of a pay-to-click kind of -- you know, there's so many ways around these things. We have to be really careful about what path we're going down.

But that being said, I share your aspirations, and I absolutely agree that if it is doable, the world will be a better place if it were done.

So, again, I didn't mean to editorialize. I think Jon Perlin is next in the queue, if I understand where we are.

MS. KELLEY: Mike, I think Larry and Brian both wanted to get in on this particular point.

DR. CHERNEW: Okay. Jon, we'll let Larry and
Brian in on this particular point.

DR. CASALINO: Brian, why don't you go ahead.

DR. DeBUSK: Okay. Thank you, Larry.

First of all, I wanted to completely agree with your previous comment. I don't think a lot of private equity right now that's focused at group practices is focused on value-based payments. I think they're focused on optimizing revenue, all the things we've already discussed.

But I did want to throw this out. I mean, this is a somewhat awkward and sensitive question.

When you look at our opportunities for arbitrage -- and these people are experts are arbitrage -- what keeps a private equity firm from building a template where they move into a market, buy up a few key practices, including a primary care practice and orthopedics practices, form a multigroup specialty practice, contract with MA, form their own next-gen ACO, and do all the standard things? I mean, you'll rationalize PAC. You'll do sort of the December wellness visits, all that.

But what if on top of that, they move all the outpatient procedures that they can to their own ACSs, they
move all the ED visits to their own urgent care? You talk about an opportunity for arbitrage. It's almost a can't-fail model, where private equity and convenors or consulting groups could move into a geography and take advantage of the arbitrage and capitated payments and in APMs. You know, how would we feel about something like that? It's guaranteed savings. It's accelerating the adoption of value-based payments, albeit at the expense of hospitals.

DR. CASALINO: Well, I agree that if private equity money going into value-based purchasing, that's a good example, you gave, and some others. I think one goal for the next six months actually could be on the physician practice side to get a sense of how much private equity money is going into VBP deals and trying to get Medicare Advantage contracts and do good things with them as opposed to just scooping up fee-for-service specialties and making as much revenue as you can. They get relative amounts of that.

I also agree with you, Michael, identifying ownership is likely to be hell in part because corporate practice and medicine laws, right? I mean, there's a lot
of states in which a hospital can't really employ
physicians in a practice or owner practice, same with
private equity and so on. So there are all kinds of ways
to get around this, and I agree that I don't know enough to
know if people that really understand these things could
come up with some kind of scheme that would be at least
much better than what PECOS has now in giving you a shot at
identifying ownership.

So that could be something also that one could
try to find out, I think, over the next 6 months.

DR. CHERNEW: Great.

Now I think we're to Jon.

MS. KELLEY: I think that's right.

DR. CASALINO: Michael, I'm sorry. There's one
other recommendation from the report and what you said made
me think of this. The differentiation between growth
capital and buyout capital, in fact, I think there is a
fair amount of growth capital on the physician practice
side.

So if I'm not mistaken, Healthcare Partners was
able to expand much more rapidly than it could have done
otherwise and then sell itself for $4.4 billion to a
dialysis company. It was using private equity money. That
was growth capital, not buyout capital. I think quite a
few other places have done that as well. I think Austin
Regional Clinic has received private equity money to grow
and do some good things and try to do some value-based
purchasing. I think they think that's very valuable, and I
think there's probably a fair amount of that going on,
growth capital private equity investing in pretty large
physician groups so they can grow faster, possibly hospital
chains, nursing home chains as well.

That's something that I wouldn't just forget
about the growth capital side of things.

DR. CHERNEW: And now?

DR. PERLIN: All right. Well, I'm going to make
what's going to seem like an extraordinary link between our
earlier conversation about the clinical lab fee schedule
and private equity.

Really behind our discussion is how certain
mechanisms of capital affect incentives, and so the focus
of our discussion has really been on the incentives of the
investor or acquirer, to your point, Michael, or whatever
acquisition means.
Let's flip that around and look at the incentives of the individual or the entity that's being acquired. Back to clinical laboratory fee schedule, think about the complexity that was inherent in our discussion. Think about what we're asking hospitals, but perhaps even more so, physician practices who might happen to have a lab to do.

When you think about that, I think you have to think about how that's driving a push toward industrialization to solve these sort of existential problems of life and this very complex world.

The point is that really some of our contemporary complexity means that we are, I think, driving the push toward consolidation, and that consolidation is really associated with seeking new mechanisms to solve operational challenges through data, through technology, through different management structures, and ultimately through the promise of investment.

So I just wanted to not let that go unsaid because I know over the past few years, we've had conversations about whether or not our policy drives a certain degree of consolidation, but I actually draw this
linkage to the management structures, the investment, et cetera.

Thanks.

MS. KELLEY: Mike, I think that's it.

DR. CHERNEW: Okay. So everybody take a deep breath. I don't have a ton of wrap-up. I will give a very brief wrap-up of where I think we were.

First, let me thank you all for the comments that you said, and let me thank you all for the comments that you didn't say. I think the right mix of what you say and what you don't is what makes the meeting good. So we are going to come in with what I at least believe was a remarkably good substantive discussion and under time.

If you feel like you didn't get a chance to say your piece, I am really sorry. Let me know, but I think we've done pretty well in that regard.

I just want to make one sentence about where I think we are for each of the afternoon sessions so you can ruminate on them, and we'll go from there.

With regards to the SNF session, my takeaway is that the current SNF value-based purchasing process is worse than none, and it should be paused. And we should
work aggressively and expeditiously to improve the program, and hopefully, MedPAC will have some example of what that might look like in sessions soon to be presented.

With regards to the lab session, I think the key question is, Is there any information of value and private prices? If so, how do we officially get at it and use it, and if not, how can we set payment models to capture growing efficiencies in the production of lab services? I think I will take this back to Jim and the staff and ponder those questions.

With regards to private equity, my general sense is that "private equity" is too broad of a term. It can be both good and bad, and something that Paul said resonates with me. We have to really emphasize to CMS that they need to get as much a handle on their loopholes as possible because, per Brian, they will arbitrage that.

But there are also examples where they might do quite good things, and so we are going to have to make the chapter both recognize that heterogeneity, and then somewhere in there will be a call for more and better information about ownership and behavior per what Larry was saying. And when we figure out more about what that
entails, we'll be able to figure out how to craft that portion of the chapter.

So the to-do is emphasize heterogeneity, call for more information, and emphasize focusing policy on bad behavior as much as capital structure.

So that's my summary of where we were. I say that to give folks a chance to react and send messages if I got anything wrong. Other than that, I'm going to pause for a second.

Again, thank the staff for amazing work. As always, you did a terrific job. I know it's been hard for everybody. I think technology worked better than I feared.

So anyone want the last word? I'm pausing for a second.

[No response.]

DR. CHERNEW: Okay. We --

DR. PERLIN: Hey, Mike?

DR. CHERNEW: Jon?

DR. PERLIN: On behalf of fellow Commissioners, we just shouldn't let the moment pass without saying what a spectacular job you did. So thank you.

DR. CHERNEW: Thank you.
So now we are about to have for the Commissioners and the staff -- we're going to have a virtually, socially distanced happy hour. For the public, thank you for your patience and listening. I wish I could see you all, not really all of you -- that's too many for me to process, but in any case, I am glad that we were able to read all who we did, and we will be starting again on a really important topic at 9:30 tomorrow morning, telemedicine. Don't miss it. It's the hot ticket in town.

So thanks all, and we'll reconvene in a bit and then tomorrow morning.

Jim, Dana, anything else you want to add?

MS. KELLEY: Nothing from me. Jim?

DR. MATHEWS: Nope. All good here.

MS. KELLEY: All right.

DR. MATHEWS: Thank you, everyone.

MS. KELLEY: Thanks, everyone.

DR. CHERNEW: Thanks, everybody.

[Whereupon, at 5:11 p.m., the meeting was recessed, to reconvene at 9:30 a.m., Friday, September 4, 2020.]
MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

VIA GO-TO-WEBINAR

Friday, September 4, 2020
9:30 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
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD
JA EWON RYU, MD, JD
DANA GELB SAFRAN, ScD
SUSAN THOMPSON, MS, BSN
PAT WANG, JD
AGENDA

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DR. CHERNEW: Hello, everybody, and welcome to day two of the September MedPAC meeting. It's probably fitting that our first topic is telehealth, which we will discuss remotely. I won't say much more except this is probably in the top two topics that people on the Hill and others have reached out to us to discuss, and I think we have some interesting material to present, and I'm really looking forward to all of your feedback. So, again, thank you to the public for joining and the Commissioners for attending and the staff for doing all of the work.

With that, I'm going to turn it over to Ariel and Ledia.

MS. TABOR: Good morning. 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.

We would like to thank Bhavya Sukhavasi and Rachel Burton for their input into this work.

Since the COVID-19 pandemic started, telehealth has received a lot of attention. Telehealth has played a
key role in delivering health care to patients during the pandemic, which has raised many questions about its future role in the health care system after the pandemic. This is an opportune time for the Commission to shape the policy discussion around potential expansion of telehealth in Medicare. Therefore, we expect to devote a significant amount of time to this issue during the coming cycle.

The Commission previously examined telehealth in the June 2016 and March 2018 reports to the Congress. Today we'll broadly review the physician fee schedule telehealth policies prior to the public health emergency. We are focusing the discussion on the physician fee schedule because it accounts for the majority of the telehealth expansions that directly impact a payment system.

We'll also discuss corresponding expansions of telehealth under the public health emergency.

Then we'll explore some potential options for making telehealth expansions permanent. Building off the Commission's prior work from the 2018 report to the Congress, Medicare could allow most telehealth expansions to continue for clinicians participating in advanced
alternative payment models. For other clinicians in fee-
for-service Medicare, Medicare could revert back to the
pre-PHE health rules or allow some expansions with
additional safeguards.

Throughout the discussion we assume that Medicare
would continue the current telehealth expansions for the
remainder of the public health emergency.

Prior to the public health emergency, the
physician fee schedule covered a limited number of
telehealth services. Direct-to-consumer telehealth
services could only be provided to beneficiaries at an
originating site in a rural area. There were some
exceptions to the rural requirement for other telehealth
services like remote physiological monitoring.

Medicare utilization of telehealth services had
been increasing, but remained very low with only 0.3
percent of Part B beneficiaries receiving telehealth
services in 2016. As presented in our March 2018 report to
the Congress, commercial insurers also reported low
utilization of telehealth services.

Due to the public health emergency, Congress gave
CMS the authority to temporarily put in place flexibilities
to allow providers to furnish telehealth services to ensure that beneficiaries continue to have access to care and to avoid exposure risks to the community.

First, which patients? Under the PHE, clinicians may provide direct-to-consumer telehealth services to beneficiaries located outside of rural areas and with patients in their homes.

Second, which services? CMS has added over 80 services that can be delivered via telehealth like emergency department visits. Also, Medicare previously did not cover audio-only telephone evaluation and management visits, but under the public health emergency, clinicians can now bill for them.

Third, which clinicians can provide them? Prior to the PHE, physicians and other clinicians could provide telehealth services. During the PHE, physical/occupational therapists and speech language pathologists are now also eligible. All clinicians are allowed to furnish telehealth services to beneficiaries located in other states, but state licensing laws apply.

Fourth, how much are services paid? Prior to the PHE, Medicare paid the physician fee schedule facility-
based payment rate which is less than the nonfacility rate for telehealth services. During the PHE, Medicare pays clinicians the rate for telehealth services as if the service were furnished in person so the facility or nonfacility rate. Medicare also pays the rate for audio-only visits as if the services were provided in person.

CMS made decisions on how to pay for telehealth services to eliminate potential financial deterrents to the use of telehealth.

Fifth, which technology can be used? HHS announced that it will not impose penalties against covered health care providers for noncompliance with HIPAA regulatory requirements in connection with the good-faith provision of telehealth during the PHE. Therefore, a provider can use any non public-facing remote communication product, such as FaceTime or Zoom, to provide telehealth during the PHE.

Finally, what are the costs to beneficiaries? During the PHE, clinicians are permitted to reduce or waive any cost-sharing obligations for telehealth services.

The Congress and CMS are under pressure to make the telehealth expansions permanent after the PHE, and both
are considering making some of those changes permanent. 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 may have the potential to increase use and spending under a fee-for-service payment system. Telehealth companies were recently involved in several large fraud cases related to the ordering of durable medical equipment and cancer genetic tests, resulting in a total of $3.3 billion of losses for Medicare.

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.

Under the Quality Payment Program, CMS designates
A-APM models which include ACOs, episode-based payment models, and primary care-focused models. Most A-APMs assume financial risk for total Medicare spending and are held accountable for the quality of care for their assigned patients. This creates incentives for those providers in A-APMs to improve quality while controlling cost growth. Therefore, the concern that an expansion of telehealth could lead to additional Medicare spending is countered by the incentive for A-APMs to constrain spending. In our 2018 report to the Congress, the Commission also said that MA plans and risk-bearing ACOs could be granted greater flexibility to use of telehealth services.

Also, the Commission has long supported the movement of Medicare payment policy from fee-for-service to value-based payment such as A-APMs. Allowing clinicians who participate in A-APMs more flexibility to provide telehealth services could be another incentive for more clinicians to move into these models.

With regards to other clinicians in fee-for-service Medicare, we'll focus on what expansions Medicare may want to keep for clinicians not in A-APMs, as well as...
additional safeguards to prevent misuse.

I'll now turn it over to Ariel to discuss the policy issues that would need to be addressed for each of the options.

MR. WINTER: In the following slides, we illustrate different choices you could make for clinicians in A-APMs and for other clinicians. These choices are meant to be illustrative and are open for discussion.

The first question is: Which beneficiaries should be able to receive telehealth services after the PHE?

Medicare could allow clinicians participating in A-APMs to continue providing telehealth services to patients outside of rural areas and to patients in their homes. But giving the same flexibility to clinicians who do not participate in an A-APM poses a risk of overuse. However, we are going to discuss some guardrails that could reduce this risk in a few minutes.

Next, which types of telehealth services should Medicare pay for after the PHE?

For clinicians in A-APMs, Medicare could continue covering most of the telehealth services that were covered
during the PHE.

For clinicians who are not in A-APMs, however, Medicare could cover a more limited set of telehealth services.

In our March 2018 report, we said that CMS should pay for telehealth services that balance the principles of access, cost, and quality.

CMS could use these principles to decide which telehealth services provided by non A-APM clinicians should be covered after the PHE.

For example, Medicare could cover telehealth for mental health services because some beneficiaries have problems accessing mental health providers.

A related question is whether Medicare should continue to cover audio-only services after the PHE. Because clinicians are unable to visually examine patients during audio-only visits, it is possible that they will lead to new services instead of substituting for existing ones and, therefore, could increase program spending.

Therefore, policymakers might want to consider not covering audio-only services after the PHE, even when provided by clinicians who are in A-APMs.
The third question is: Should Medicare continue to pay the higher nonfacility rates for telehealth services provided by office-based providers after the PHE?

Prior to the PHE, CMS paid for telehealth services at the lower, facility-based payment rate in all cases. But during the PHE, CMS pays the higher, nonfacility rate to clinicians who typically practice in offices.

The issue is that services delivered via telehealth probably do not have the same practice costs as services provided in a physical office.

Therefore, continuing to set rates for telehealth services that are the same as rates for in-office services could distort prices and could lead clinicians to favor telehealth over comparable in-person services.

In this illustration, Medicare would no longer pay the nonfacility rate for telehealth.

Next, should telehealth technology and services be required to comply with HIPAA after the PHE?

We are proposing that the answer would be yes for both type of clinicians because enforcing HIPAA would help protect patient privacy and reduce the risk of identity
theft. Next, what would be the costs for beneficiaries? Should clinicians continue to be allowed to waive cost sharing for telehealth services after the PHE? Because A-APMs have a financial incentive to control spending, allowing them to waive cost sharing may not lead to higher use. But clinicians who are not in an A-APM don't have this incentive, so reinstating cost sharing for services provided by these clinicians could reduce the risk of overuse.

A related issue is that most fee-for-service beneficiaries have supplemental coverage, which means that they are shielded from most cost sharing. Therefore, we looked into whether the Congress or CMS could prohibit employer-sponsored supplemental coverage and Medigap plans from covering cost sharing for telehealth services.

We found that it would be difficult to do this, as we describe in detail in your paper. There are other safeguards you might want to consider. Here we focus on safeguards to protect against unnecessary spending for telehealth services provided by
clinicians who are not in an A-APM, and we describe two options:

The first is to impose a limit on how frequently specific types of telehealth services could be billed by a clinician for a given beneficiary; for example, a limit on the number of virtual check-ins that could be billed per beneficiary per month. To implement this policy, CMS would likely need to analyze claims data for telehealth services provided after the PHE to identify services that are growing rapidly or that are frequently provided to a single beneficiary.

The second option is to require clinicians to provide a face-to-face visit with a beneficiary to order DME or lab tests above a certain dollar amount. As Ledia mentioned earlier, telehealth companies have recently been implicated in very large fraud cases involving DME and lab tests. And there is a risk that such schemes could become more common if Medicare expands telehealth coverage.

This option would essentially prohibit clinicians from using telehealth visits to order expensive DME or lab tests for beneficiaries.

So for your discussion, we'd like to get your
feedback on the options we discussed as well as any additional information you'd like us to provide.

This concludes our presentation, and we'd be happy to take any questions.

DR. CHERNEW: Thank you. That was terrific.

I'm watching to see if there are any Round 1 questions, but while I wait, I'm going to kick off with a Round 1 question. It really had to do with Slide 7. I think it's Slide 7. The question -- maybe I have my slide wrong -- is: There's this issue about which providers could provide telehealth services. My understanding is everybody can provide telehealth services. This is really about what gets paid for. So could you talk a little bit about the distinction between what is payable and what is provicable? Or is it all really just about how folks get paid?

MS. TABOR: I would say that it's more about how folks get paid. That's the biggest change under the public health emergency, that now physical therapists and occupational therapists could now bill for services that they're providing.

DR. CHERNEW: So as --
MS. TABOR: Go ahead.


MS. TABOR: So physicians and other clinicians could bill for all services that were covered under the list of available telehealth services, and now physical therapists and other types of therapists have been added to that list.

DR. CHERNEW: Yeah, so just to be clear I understand, it was really Slide 8. It says, "Which Medicare beneficiaries could receive telehealth services?" You really mean which providers get paid when they give certain Medicare benefits. Because anyone can receive Medicare benefits no matter what we say -- could receive tele-services; it's just that providers wouldn't be paid.

MR. WINTER: What we're talking about here on this slide is the geographic restrictions that applied before the PHE, which limited telehealth services to beneficiaries who were in rural areas and who receive them in certain originating sites, like hospitals and clinicians' offices.

DR. CHERNEW: What I'm trying to figure out is if it was limited to telehealth service provision or limited
it to telehealth service payment. So an urban patient
could get a telehealth service before the PHE. They just
couldn't get paid for it.

MR. WINTER: That's correct. So the clinician
could not get paid for it. That's true.

DR. CHERNEW: Okay. I understand.

MR. WINTER: So a hospital, if a patient was in a
hospital for an inpatient admission, the hospital could
provide a telehealth service, including -- but the
clinician could not bill for that service. The hospital
would get paid for it as part of their IPPS payment, but
the clinician could not bill for it unless it met these
geographic requirements.

DR. CHERNEW: Okay. Thank you. There's a few
other Round 1 questions, but Betty wants to say something
and set me straight on this point, so, Betty?

DR. RAMBUR: No, I -- your point is exactly
right. I just wanted to give another illustration.
Registered nurses provide telehealth services, care
coordination, et cetera, but even under the public health
emergency they are not allowed to charge for that or be
reimbursed for it. So I think that's the point you were
trying to make, correct, Michael? Service delivery versus who is billing.

DR. CHERNEW: I just wanted to make sure that there weren't licensing or other restrictions about who could receive it versus just how the payment works. And I think I understand now, so thank you, Ledia, and thank you, Ariel. Betty, I'm sure you have a lot of firsthand knowledge with these things. But I think now, Dana, we should just go through the queue, which is I spoke long enough to allow the queue to form, which is good. Sue was jumping in during the presentation, and then we'll know, but for now, Dana, work through the queue.

MS. KELLEY: Okay. Larry, I think you're first with Round 1.

DR. CASALINO: Very nice job, Ariel, Ledia. There's so many specific issues which you've listed very well. It will be very interesting to see how Commissioners' opinions on these evolve over the next few meetings.

I have a specific question about the -- it's on page 8 of the mailing materials, and this is in relationship to the so-called communication technology-
based services, which you say that prior to the public health emergency, CMS was paying for although didn't consider them to meet the statutory definition of telehealth.

So one, for example, is so-called virtual check-ins, and I'm just quoting the paper, in which a patient checks in briefly with the clinician via phone or other telecommunications device to decide whether an office visit is needed. And then a related one is remote monitoring and interpretation of physiological data, like blood pressure digitally stored and transmitted.

So my question is: One potentially very common use of telehealth which could be done by video, could be done by phone, and for that matter it actually can be done through portals or emails, is dealing with chronic diseases. So if you have a patient who you know can accurately check their blood pressure, you've had them bring their device into the office and check it, or they can accurately check their blood sugars and record that, those kind of things, traditionally physicians have had patients come back into the office, most physicians, to discuss their pressure or their diabetes results and maybe
make changes in their regimen. And with patients you know, that is probably a waste of a lot of patients' time, half a day of their time, and also -- well, let's just leave it at that. So patients love to do that kind of thing over the phone in many cases.

My question is: For virtual check-ins, it's the phrase "to decide whether an office visit is needed," that's tripping me up. If you wanted to check a patient's blood -- talk about a patient's blood pressure over the phone that isn't transmitted to you digitally, they're just saying, "Yeah, Doc, my pressure's a little high, it's about 150/95," is that considered one of these communication technology-based services or would that fall under telehealth and, therefore, under the issues that you're raising?

MR. WINTER: That's a good question.

The way CMS defines the virtual check-in codes, which they created, began paying for in 2019, the purpose is to decide whether office visit -- whether the patient needs to come in and see the clinician in person.

They don't talk about the scenario you describe where they just want to get a check on some feedback on
whether their blood pressure is too high and what they
should do to adjust it. That's really a question -- I'll
look into that some more. Maybe they have some FAQs that
address that specifically.

But it does not seem to meet their definition of
this type of service.

DR. CASALINO: That's interesting because this is
potentially usual in visits and also an area in which
there's a lot of variation. Some physicians will say,
"Come back in six months, and we'll check your pressure
again." Others will say, "Come back in two weeks and we'll
check your pressure again," with the identical patient.

Then my other question about these communication
technology-based services, prior to the PHE, what was CMS
paying for?

MR. WINTER: In terms of these communication
technology-based services?

DR. CASALINO: Yeah, the ones that weren't
defined to -- CMS was paying --

MR. WINTER: Right.

DR. CASALINO: -- but were paying the same as
for telehealth or less or --
MR. WINTER: These were specific codes with specific rates that were set by CMS, and so because they were only provided -- these are only virtual services. They are never done in person. There's only one rate for these codes that applies to when it's done virtually, and the difference between pre-PHE and where we are now is that before the PHE, CMS would only pay for these codes, for most of them anyway, for established patients. So the clinician had to have already established -- have an established relationship with a patient as demonstrated by providing a prior in-person service event.

But during the PHE, CMS has loosened those rules and allowed clinicians to provide these types of services to even new patients, ones they've never seen before.

DR. CASALINO: So for these virtual check-ins, for example, has CMS been paying a rate comparable to what they pay for a telehealth visit, or it's less? And if so, can you give a sense of how much less?

MR. WINTER: It is. It's much less, I believe it's about between $10 and $15. I'll look up the exact amount. Whereas, an E&M is in the range -- when it's done in an office is in the range of $70, maybe $75. We'll get
you exact numbers.

DR. CASALINO: That's very helpful. Thank you.

MS. KELLEY: Pat?

MS. WANG: Hi, Ariel. Just to continue what you were just talking about; can you say if the regular physician fee schedule rate for an E&M visit in person is around $75? Prior to the public health emergency, what was the facility-only rate? As a percentage of that overall? I don't have a sense of proportion, but before what CMS allowed and during the public health emergency.

MR. WINTER: So the facility rate, which would be paid when the E&M visit is done in a hospital setting, for example, it's about $50, but I'll have to look up the exact number and get back to you on that.

MS. WANG: Okay, okay. But in that specific example, since about two-thirds of the rate that was allowed during the public health emergency. Okay. That's really helpful.

The other question I had was can you talk a little more -- this idea of liberalizing what A-APMs can do in telehealth, can you talk a little bit more about the tools that an A-APM would have to control payment for
telehealth services? Because that's the implication, and I just am not familiar. Like with an ACO, what kind of control would they exercise to make sure that telehealth services were being appropriately used or what have you?

MR. WINTER: So I think that they could rely on -- it would be the same techniques and tools they would use to control utilization generally, and if they're trying to reduce hospital admissions, for example, or readmissions, they might encourage their clinicians to use telehealth to keep checking on patients, to get them out of the hospital. And if they find that their clinicians are using telehealth inappropriately or there's not much clinical benefit, then because they're part of the same organization, they could presumably -- they have, you know -- if they employ them, they can tell them to stop doing that, or if they're just affiliated with the ACO, they could say, "Look, if you don't shape up, we're going to kick you out of our ACO next year." So it's kind of the same incentives and tools they have to monitor -- to manage utilization generally.

DR. CHERNEW: I want to jump in quickly on this point. This is actually a very complicated topic. I'd like to push it around too so we can get through quickly
Round 1 with just clarifying questions.

But the reason I say that is there's an issue about what we mean by -- is it A-APM providers? A-APM providers providing care to A-APM patients or A-APM patients that could actually get care outside of the A-APM? The A-APM doesn't have the same tools that, say, a Medicare Advantage plan would have. So there's a lot of nuances. In fact, if the attribution is retrospective, you might not even know who the A-APM patient is at the time the service is being received. So there's a lot of complexities that I think fit under the A-APM bucket that are probably more like Round 2 than Round 1 discussion topics. So we should go on to the next Round 1 --

MS. WANG: That's fine. I'm finished with my question. Thank you.

DR. CHERNEW: Thank you, Pat, and that's useful. And this is a really challenging and very unclear topic to me.

Dana?

MS. KELLEY: Jaewon, did you want to jump in on this?

DR. RYU: Yeah. My question -- and it is a
clarifying question, but we could defer it to Round 2. But it's really around this notion of if you're an A-APM clinician who participates but not all of your patients are in the A-APM model, my question was just, is it possible for them to know which of their patients are in, which of their patients are out? I don't know if we've looked at that, and I think it gets to the attribution rules and complexities around that. But that was my question.

DR. CHERNEW: Yeah. So that's the same point that I was making. I think we should have that discussion if we need to about how it would work in Round 2. I think it's complicated, unless Ariel has a quick answer.

MR. WINTER: I think the quick answer is for this iteration, just for illustrative purposes, we assume that it would be the flexibilities would apply to the A-APM clinician. So at the beginning of the year, the A-APM -- well, let's say it's an ACO -- would send a list of the TINs for its participating clinicians, and if a telehealth service were billed a clinician in one of those TINs, then Medicare would apply the looser -- whatever the looser rules are that we decide should apply.

So if an A-APM clinician saw -- whether they saw
an A-APM -- whether they saw a patient attributed to the A-APM or not, they would be able to provide telehealth services under these looser standards. That's what we thought about just for -- you know, for the simplest -- we thought it would be the easiest to implement policy, but you could think about other ways of doing it. But it gets more complicated if you start talking about retrospective attribution, where you don't know at the time whether the patient is going to be attributed to your ACO or not.

DR. CHERNEW: So let's save that when we discuss these processes because it's challenging for a bunch of ways. But that was a good clarification.

MS. KELLEY: Okay. Marge, I think you're next.

MS. MARJORIE GINSBURG: I'll pass because my question and comment also was about A-APM. So I'll wait on that.

DR. CHERNEW: Double thank you.

MS. KELLEY: Jaewon, I have you next. Did you have a different question?

DR. RYU: No. That was my question.

MS. KELLEY: Okay. Then Dana.

DR. SAFRAN: Thank you.
What do we know about what it would cost for providers to go from the current technology to virtual technology that would be HIPAA compliant, assuming that after the public health emergency, if it continues, if telehealth is going to have to be under stricter HIPAA compliance rules? What do we know about what that would cost to amp up the technology in the practices and systems?

MS. TABOR: I don't have any exact numbers to give, but I can give you some qualitative information that we've gathered in our physician focus groups from this summer as well as some conversations we've had with health systems, and I think it would vary.

There are a number of HIPAA-compliant telehealth services that are free, and we did hear from physicians that they were using those. And there's others that are very low cost, less than $100 per year kind of thing. But we also did hear from health systems that they're taking a broader approach to thinking about how to really up their game, I guess, on telehealth and integrate it into the HR as well as kind of operate in various different services. So I would imagine that that would be a more costly investment.
MR. PYENSON: Thank you. Great work.

My question is on the Medigap issue, and as you point out, the Medigap policies are guaranteed renewable. They are under the jurisdiction of state insurance commissioners and may be influenced by the National Association of Insurance Commissioners.

However, did you look at the contract between CMS and the Medigap insurers? Because the vast majority of claim processing is a direct link that's defined by a potential, perhaps government-to-business contract, and if the claims do not get -- if telehealth claims or other claims don't flow through that process, that's a way to perhaps avoid the automatic process of cost sharing coverage.

So my question is I've read what you wrote, but how far did you get into some of the weeds of that?

MR. WINTER: We did not look into the specific contracts that CMS has with the Medigap plans to determine how they cover cost sharing or how they deal with cost sharing that's covered by the Medigap plans, but my assumption would be that those contracts are subject to the terms of the plan's coverage. So if the Medigap plan
covers, let's say, 100 percent of Part B coinsurance, then that's what -- then the MAC would, I assume, build a Medigap plan instead of the beneficiary. So even if -- I don't see how you could change -- I don't see how you could change whether or not the beneficiary would be liable for coinsurance for telehealth services just based on changing that -- how the claims are processed. My assumption would be you would need to change the actual plan policy, but this is not an area where I have a lot of expertise. So we can look into it more.

MR. PYENSON: Okay. Thank you.

MS. KELLEY: Betty, did you have a Round 1 question?

DR. RAMBUR: I do.

Briefly, I have a question about the two accesses that were in the audio only, and my question relates to issues related to the socioeconomic gap and technology acquisition as well as the age-related gap and also the rural areas, places that are not actually rural by designation but still have poor broadband. So I was just a little -- and very -- you know, I understand the concern about additive services, but I was just a little curious
about those disadvantaged populations.

MS. TABOR: I think that is a concern that not all Medicare beneficiaries have access to smartphones or other technology in order to do telehealth visits. So one concern with not covering audio-only visits would be that some people would be at a disadvantage. So I guess we'd encourage other kind of federal agencies to continue to offer financial support to increase broadband connectivity and also just general access to technology. But, yes, I think we acknowledge that that is a concern.

DR. RAMBUR: Thank you.

MS. KELLEY: Paul, did you have a response?

DR. PAUL GINSBURG: It was on the Medigap question. If I'm correct, legislation specifies a limited number of benefit designs that Medigap plans can have. So I would think that saying that they should not cover cost sharing for telehealth would really require making a legislative change rather than just dealing with it in a claims processing way.

MR. WINTER: That's my understanding.

MS. KELLEY: Okay. I think that's all with the Round 1 questions. I can move to Round 2.
Mike, did you want to start off, or shall I just go to Karen?

DR. CHERNEW: I thought Jonathan and Brian might have had Round 1 questions. Did I miss that, Jonathan and Brian? Brian, no?

DR. JAFFERY: Mine is a Round 2.

DR. CHERNEW: Okay, good. Then we're moving to Round 2, and we'll start off with the kickoff folks.

Karen, just so people can get a sense of the -- it was going to be Karen and then Wayne and then Sue, and then I think we're loosely going to have a free-for-all, so that's terrific. So, Karen?

DR. DeSALVO: Wow. I have about 20,000 pages of things that I want to say, so I'm going to try to be a little limited because we have some deep things to consider.

As we've talked about, COVID has been an accelerated use case for telehealth, and so I think if we had any question about whether it could be done, we know that it can. Now the question is, where will it settle out in terms of use and desirability for the beneficiaries and for the health systems, and what's the right way to have a
principled approach so that we're protecting the Medicare program and protecting beneficiaries with an eye on equity and access and making sure there's good outcomes?

Maybe we'll take a couple of broad comments and then kind of get to some of the questions that were asked.

I guess as we're thinking about where telehealth is going, as Bruce said, it's part of a -- or maybe this was you, Larry. It's part of this broader movement towards digital health, which the Commission occasionally touches on, though I think we're going to have to probably be more intentional about considering what it means to meet people where they are using technology and using digital services, because telehealth is but one platform, one version, and even within that, there are multiple categories.

So I think that on the good, this causes us to move into the 21st century and begin to consider it's more about outcomes than about place and about the expectations that beneficiaries are going to travel to a brick-and-mortar facility. We're seeing some of this is technology evolves in areas like end stage renal disease and dialysis but also on the other end of the spectrum for even just management of chronic disease.
What we've seen in telehealth in this rapid fire
in the few months is that the use cases around acute
illness, chronic illness management, mental health
services, specialty consultation, that there are a number
of ways that the health care system and beneficiaries have
been interested in leveraging just the telehealth
component. So, clearly, I think we have to sort out what's
the right way to continue to make it available in a way
that's more flexible than we've had heretofore.

I think what I might do is just say from a
principled standpoint, I like the way that the staff has
laid out, that maybe if you're in an alternative payment
model that tips the scales towards additional
flexibilities, because that's certainly what we want to be
able to do is allow providers and accountable entities to
have the kind of flexibilities to think about outcomes, to
think about moving upstream and doing prevention, to think
about wraparound and holistic services, and really have a
partnership over time with the beneficiary.

It sounds a little lofty for telehealth, but I
think telehealth is one of the tools in the toolbox that
alternative payment model-type systems, especially ones
that are more global budgeted, have as an opportunity, and then the focus is less on the nuances of the fee schedule, which are important, I understand, for those beneficiaries and providers that rely mostly on traditional Medicare, but I do like the pathway of trying to push people more towards value-based care models.

I think in terms of payment, I'd want to just broadly -- I hope that as we're developing this, we think about the fact that though there are unscrupulous actors who are going to try to abuse the system, I think we see that in all areas of Medicare. I do want to try to stay focused on the fact that for beneficiaries and their primary care physicians, this can be augmented and supplemental part of the care continuum, not just for the docs, but for all of the team members that care for them.

Also, thinking about how to emphasize the importance of this as a continuity of care relationship augmentation and a way to give people access to services like mental health that may not be so readily available or that may be more acceptable even virtually because people feel more comfortable doing that in that environment.

There's some data to show it.
We don't have to go entirely back to where we are, and I don't think it has to be the same for every category. Just as I'm asking for a principle of simplicity, I'm asking for a little complexity as we think about which providers we want to pay.

I'll just say quickly about your question about should we expect HIPAA compliance, the answer is yes. And there's probably no need to discuss that anymore. We want to protect privacy for beneficiaries. So it seems that we would stay within that frame.

Here's my last thing, which I bet you it's going to come up in the next commenters, but I want to just call out that even though CMS's early data shows that beneficiaries irrespective of the color of their skin or their geography were making use of telehealth services, there's other data that indicate that this digital availability may exacerbate a digital divide in all kinds of ways.

Kenneth Lam has done some work, recently published in JAMA Network, that shows that as much as almost 80 percent, 78 percent of beneficiaries over the age of 85 have barriers to telehealth or even telephone...
services, and that may be a third or more of beneficiaries across the board would have a challenge in accessing telehealth or even telephone services. Sometimes it's because they don't have the technology. Sometimes it's because they're hearing impaired. Sometimes they have cognitive impairment. Sometimes they don't trust the system. There are an array of reasons that they outline in this one paper, but I think there's other evidence and certainly anecdotal evidence that we've all heard, that we just want to play close attention to making sure that by pushing this technology out and not thinking about what's going to -- if the beneficiaries can receive, much less are interested and ready to receive. I wouldn't want us to exacerbate any of the digital or health divide that already exists.

So thank you to the staff for kind of getting our head around this really giant and highly charged issue. It's a part of 21st century health care. It's a tool that we should make sure is well used to the goal of improving beneficiary health and doing that increasingly in the context of global payments are accountable and entities that are part of alternative payment models but not just in
A-APM but really thinking globally about accountability for someone's health. But do that with an eye on the fact that unscrupulous entities and individuals will try to take advantage of the system, so we have to have some safeguards in place, and most importantly I want to make sure we're keeping a close eye on the fact that not all beneficiaries are able to participate, and we wouldn't want them to have a negative impact in this. Thanks.

MS. KELLEY: Okay. Wayne, you're next.

DR. RILEY: Yes. Good morning, all. Great discussion. A salute to Ariel and Ledia for really framing it superbly in the written paper and also in the slides.

You know, this topic is obviously "ripped from the headlines," in a sense, and like most things in health policy it's a Rubik's cube of risk and reward. And I want to go back first to what Larry said, as a primary care internist, and I know we have some primary care nurses and clinicians among the Commissioners in addition to myself. But chronic disease management is where I really think that telehealth can play a significant adjunctive role, as Karen just said, as a fellow internist.

For example, in taking care of diabetics,
standard that we've always operated on, we'd like to see our diabetic patients a minimum of four times a year, if possible. If they're sort of out of control it may be six to eight times a year to try to manage their glucose. It strikes me that that's where telehealth, again going back to Larry's point, the ability to reach out to your patients via telehealth, whether it by telephone or by video, can be a great tool in the hands of primary care clinicians, but physicians and non-physician clinicians, to help really address chronic disease management.

And this is particularly important, as we now know, in minority communities, which have been impacted severely by COVID, because of preexisting conditions, many of which are indeed chronic. And we know that diabetes and hypertension have been among the top four or five preexisting comorbidities that really contributed to high levels of morbidity and mortality with COVID in certain populations. So as a physician I love the idea of chronic disease management, that this is a tool that could be used for that.

In terms of I think the data in the paper that was laid out, that yeah, folks embraced it during the
pandemic, but as soon as quote/unquote, their doctor's
offices and their nurses and their nurse practitioners and
their PAs became available they went back to them. So, to
me, that is a clear indication that given a preference
between the two, they still prefer to see their provider,
which I think is gratifying in some ways. And again, it
underscores that telehealth is an adjunctive tool in the
larger scheme of things. So I'm glad that there wasn't
this overall rush to do it all digitally, that some of us
feared.

Now even here in central Brooklyn, where we have
a high population of Medicaid, a lot of dual eligibles.
You know, I've worked very closely with Pat Wang and her
great organization in covering some of her members. We
were surprised at how many of our patients embraced
telehealth. Now my suspicion is that it was because their
family members or their caregivers were helpful and
assistive to them accessing us during this pandemic,
because of the obvious reasons. We didn't want them coming
to the hospital, they were fearful to get on the subway,
they were fearful to venture outside, et cetera, et cetera.
So, you know, again, this is the risk-reward of this whole
discussion, in terms of telehealth.

Its impact on the fee schedule, obviously, you know, this is important to the Congress, and it's important to the Commission. And, you know, in terms of the guardrails, you know, as a physician, I could accept guardrails around particularly DME. I think that's a reasonable reform to discuss and debate. And again, you know, that's the risk-reward. The risk part of this equation is any permanency that we recommend to the Congress around this program has to have some sort of guardrails so that it doesn't sort of fall victim to some of the fraud and abuse and waste conditions that sometimes befall some of these programs.

Again, you know, just to wrap up and turn it back to all of you, it strikes me that the Commission's approach avoidance about this historically was right at that time. In this time it probably needs to be adjusted to somewhat of a warmer embrace with obviously a lot of thought and analysis in program design.

So I'll turn it back to you.

MS. KELLEY: Thanks. I have Sue next.

MS. THOMPSON: Thank you, Dana, and thank you
Ledia and Ariel. I suspect the two of you have job security for the next many months as you navigate through this discussion, so thank you for your good and hard work here. And thank you for the opportunity to talk on a topic that you all know that I have a great deal of passion about.

Industries across our country have been focused on consumers and understand the need to build strong digital strategies. Health care currently lags in this area and struggles to keep up to date with consumer expectations. Telehealth is a core digital strategy for health care that, as a result of this pandemic, has become an expectation of our patients going forward.

It turns out patients and their families value their time, and they don't necessarily like sitting in our waiting areas with other contagious patients. The service that they're seeking can be delivered by telehealth. And they truly appreciate not having to leave their home for two to four hours to go to the doctor or to see their mental health professional.

During this pandemic I've heard it said by many of the providers I work with that we advanced telehealth

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work more in six weeks than we had done in the previous six years, and clearly this was enabled by the relaxation of
payers to reimburse services provided by telehealth.

But to be more specific, in the month of April, 31 percent of all professionally billed services at Unity Point Health, my employer, were delivered by telehealth.

In the Quad Cities region, one of our larger markets, 51 percent of professional services were delivered by telehealth. Pandora's box is open.

Telehealth is a core digital strategy for health care that will be an expectation from our beneficiaries going forward. So how does MedPAC respond to this watershed moment? I strongly recommend we embrace it as an opportunity to more deeply engage with our Medicare beneficiaries in managing chronic illness, to improve engagement that will result in improved outcomes, and reducing our costs.

Telehealth is a tool. It's not a service, and let's not confuse the two. Declining to reimburse services delivered by telehealth intentionally delays our opportunity to more deeply engage with our beneficiaries, and it ignores the opportunity to take advantage of
improving access.

There are three core risks in the chapter around telehealth. Number one, increasing volumes will drive increased cost. Number two, concerns for integrity, worrying about inappropriate telehealth practices. And last but not least, large-scale fraud. I fear we have become so constipated in our fear about rampant increase in utilization that we're no longer thinking about what's right to do for our beneficiaries. We profess our commitment to keeping the beneficiary at the center of our policy discussion, and I believe that includes access to health care. And telehealth is a tool to improve access and engagement, while an opportunity to reduce cost.

The worry here then is that the cost impact to increasing patients' access to health care, for as long as I have been in health care, and frankly, as long as I've been a MedPAC commissioner, there's been a constant goal to improve patient access. We worry about availability of primary care. If we believe this, then let's take the opportunity to engage with patients with greater intensity by telehealth.

It's interesting. With the telehealth
reimbursement discussion, concerns are raised in the other
direction. Now we're saying that if we improve access and
convenience too much, we may see patients make
inappropriate visits and raise health care costs. Do we
seriously and intentionally want to make health care less
accessible for the Medicare beneficiary to keep costs down?

I agree, there is risk of abuse by patients and
providers. As with any new technology, there is that risk.
So let's think about telehealth as a tool to gain access
and not a service in and of itself, and apply the same
protections of monetary fraud and abuse to the services
afforded by telehealth that we do to the in-person
services. Whether we're reviewing severity of illness and
intensity of service codes or E&M codes on the ambulatory
setting, services provided by telehealth require the same
coding standards, including CPT coding, and require the
same oversight as those services that are delivered in
person. Let's take the leap into what may be a key to
improving beneficiary engagement, improving quality,
improving our outcomes, and reducing our costs.

During this pandemic, our industry has been
transformed. The utilization of telehealth to maintain
access during this pandemic is part of that transformation.
Let's embrace telehealth as an enabler to support the
triple aim in service to our Medicare beneficiaries, and do
the work to embrace this enabler. Thank you.

DR. CHERNEW: So let me jump in. We're about to
go through the queue. We have roughly a half an hour, a
little bit more, and virtually everybody is in the queue.
So before you talk look at your watch. When you're done
talking look at your watch. If there's more than two and a
half or two minutes gone, you've talked too long. I
apologize for that. There's other ways to repeat. But I
hate to sit next to Jim. He was always looking at his
stopwatch.

So with that Dana's going to run through, and
thanks for your commentary.


DR. DeBUSK: First of all, thank you, and Sue, I
really enjoyed your comments and I really agree with a lot
of the things you said. This is a valuable, beneficial
tool, and I do think it should be expanded.

I mentioned this yesterday. This entire
telemedicine adventure is a great example of provider
resilience. If you look at how they ramped up in three
weeks, it's astounding to me. You know, we have a program
that we manage over decades, and programs that we phase in
over five- and six-year periods. This was three weeks. So
I hope we take note of that as we think about phase-ins in
the future.

I really enjoyed, in the presentation and the
materials, the distinction between A-APMs versus fee-for-
service, and trying to treat telehealth differently. I
think that's a really valuable distinction that we need to
preserve throughout our work.

I will make the comment, though, that that
distinction works both ways. When you expand telehealth,
your opportunities to manage and manipulate attribution
increase geometrically. You're going to have some
incredible opportunities. I mean, I don't mean to sound
cynical, but imagine a bank of people dialing for
attribution, starting about December 8 of each year. You
know, I think we've presented some chapters before about
these wellness visits that seem to occur disproportionately
in the latter half of the year. So I do think we need to
look at how telehealth could affect or otherwise skew
The other thing that I think we've mentioned in the past, and we haven't mentioned this much in the session, we really need to take a look at how telehealth could affect risk scores. I think in the MA enrollee population you do have an outstanding risk that expansion of telehealth is going to create an avenue for additional visits, incremental visits that could be used not necessarily primarily but at least secondarily for the purposes of collecting and driving risk scores.

So there are two things there, both in the A-APM world and the MA world, where we could have some undesirable effects or some unintended consequences with the expansion of telehealth. So I hope we look through that in both areas.

As far as the presentation and the options and the recommendations presented, you know, I think there are a few areas that I really agreed with. I think that moving back the facility rate for sure, I think we do that in telehealth. And I also echo, Wayne, your comments about doing some face-to-face requirements for DME and for lab tests. I think that is absolutely essential. I strongly,
strongly agree and advocate that DME should have face-to-face requirements when they're involved in telehealth.

The areas that the staff presented questions in the presentation, the idea of extending it to non-rural, I like the idea of extending it to non-rural areas. I think that's a little bit of an artificial distinction. I mean, transportation and accessibility isn't just a rural problem. I could see myself in a heavily concentrated metropolitan area having some of the same issues. I also think we're seeing it at home. I think that's a good policy to expand and allow beneficiaries to receive these services at home.

And I do favor limiting the frequency, or at least the ratio of telehealth to in-person visits. Let's say someone wants to do something through telehealth. There's nothing wrong with periodically requiring an in-person visit. So we can start looking at some ratios or some ways to manage that.

The only other thing that I would mention is I think we said no, or the recommendation was leaning toward no toward audio-only visits. I'm not sure how I feel about that. I mean, I think there's some socioeconomic issues
there in limiting audio or not accepting audio-only visits.

And I hope we'll revisit that, because I don't know that we always need a talking head to deliver care. I do think voice will suffice sometimes.

And those are my comments. Thank you.

MS. KELLEY: Thank you. Okay, Bruce, you're next.

MR. PYENSON: Got to start my stopwatch.

I've had a view that at least some, or perhaps most of the telehealth that was delivered during the public health emergency could have been delivered in the 1960s. I have an image of a physician sitting at their desk with a landline and a dial-up phone, before pagers even, and some paper and pencil, and that was the public health emergency. I believe the telehealth of the next several years is going to be dramatically different from that.

So I think that the discussion of what we're setting in place now is going to be used by a very different industry that does things like scoops up the data from the Blue Button, scoops up other information such as the internet phenom of socioeconomic determinants of an individual, and feeds that through a triage process before
getting to a physician. And that's the world of the next several years. It's happening in some startup companies now.

So my concern is that what we're setting in place is dictated by the current structure and the current experience, but the funding and the development for these other technologies are zooming ahead. So I think it's really important that what we set up now addresses that future.

The way to do it, I think, is to realize that that system is going to be very much less expensive and should be reimbursed at a much lower rate than the current telehealth services, and my apologies for running over two minutes.

MS. KELLEY: Thank you, Bruce. Betty, you're next.

DR. RAMBUR: Thank you. Briefly, from my perspective, fee-for-service and first dollar coverage is just the absolutely worst option, and the greater financial risk, the more flexibility there should be. And full risk-bearing organizations or providers should have the flexibility to use all the tools available to them,
including deciding obviously telehealth and audio-only, I would add, and cost-sharing models that they think make sense.

I agree with what's been said about chronic condition management, and my experience has been a little bit different than Wayne's. My experience, and maybe this varies by part of the country, is at least a third of patients are so delighted to not have to go somewhere. I mean, maybe people just don't like to drive in this part of the world, or can't.

I'll save my other comments to just get to one final point. I'm wondering if, in more traditional fee-for-service, if there should be some special recognition, policy recognition, for high-risk, low-mobility patients who are sort of a little bit of a different category and could really perhaps benefit from some differential policies. Thank you.

MS. KELLEY: Thanks, Betty. Paul, you're next.

DR. PAUL GINSBURG: Oh, thanks. Well, I'm going to speak mostly about the A-APM distinction. I like the idea of flexibility in the more managed sector, and that may support giving additional incentives to be in an A-APM
and for the delivery system to move in that direction. But I'm really concerned about many A-APM -- there just is not enough control over the physicians that participate in them, and I would like to raise the possibility of making the additional flexibility for A-APMs contingent on the organization actually asking for it, so it governed the relationship with the physicians that are in their organization. You know, if they want all the flexibility that can be offered, they can have it; but if they don't, they can hold it back until they're ready for it.

Two other points. I think it's very important when we discuss fraud and abuse to avoid no-cost-sharing situations, because a very important tool -- it's not adequate often. An important tool in managing abuse is the patient, and the more aware the patient is that they might have to pay something, that's a real asset.

And the final thing I want to mention is that I don't recall any discussion of MA, and I didn't know whether that means that MA's current policy should continue or they have flexibility to use telehealth as they decide or whether the policies that we're talking about for fee-for-service would directly apply to MA and, thus, we'd
restrict their flexibility and make them conform to that.

I'd rather not do that. I'd rather leave the flexibility
to them as to how they want to use telehealth.

Thanks.

MS. KELLEY: Dana?

DR. SAFRAN: Thank you. So, you know, I want to
underscore my agreement that, you know, the move to virtual
care and the rapidity of that in this time period may be
one of the only gifts that COVID has given us. It's
something that, you know, many have hoped would take shape
in the delivery system, especially with the evolution of A-
APMs, and it just hasn't and suddenly now it has. So I
would love to use this moment to signal to the delivery
system that this is not only a good development but an
expectation ultimately at some point for ability to
participate in Medicare.

I think that we should consider how we can
ultimately leverage the lower infrastructure costs
associated with telehealth to begin to lower the costs of
care overall without -- you know, with lower reliance on
bricks and mortar, we can get there.

I would say that I am certainly among those who
worry about this as a potential burden on our efforts to control the budget and budget growth. But I do think that participation in A-APMs should be a ticket to the ability to continue to use virtual care in whatever forms and functions so long as they are HIPAA compliant and fully secure.

I would say that I feel less comfortable with the idea of a blank ticket for their use in a fee-for-service system. I do wonder whether, if we begin to allow members or beneficiaries to have a lower cost share if they themselves are attributed to an A-APM, will that create a virtuous cycle where we've got beneficiaries who want it not only because they like the convenience but also because they appreciate the lower cost sharing of those visits without the threat of overuse because they're in a system that's going to help manage that.

I know that creates complexities that we have to work through about -- that Michael brought up earlier of, you know, do practices know which patients are in the A-APM, do the beneficiaries themselves know and so forth. But I think, you know, broad lens, that a way to encourage provider participation in these models can be to have
patients continuing to demand access to this, and part of how we can do that is having it be lower cost sharing.

A final point I'll make is that I think that we haven't mentioned the importance of studying its impact as we go, but I think that should be a really clear and important thing that MedPAC articulates. For example, we know very little right now about once it's easily possible to go back to in-person care, will those who have had a virtual visit, especially in the Medicare population, kind of seek out an in-person visit to sort of validate what they've heard because they've lacked that laying on of hands that they've associated, or not? We have questions about quality, et cetera. So I think on the quality and overall utilization, we should be studying the impacts, especially after the public health emergency is over.

Thank you.

MS. KELLEY: Thank you. Jonathan Jaffery, you're next.

DR. JAFFERY: Thank you. I will sort of echo a lot of what people said, but not get too detailed on them in the interest of time, although, Mike, I stopped wearing a watch a long time ago, so I'll just have to trust how
much time it takes.

So, you know, I would agree that we need to allow telehealth services to continue. I think, you know, we've been very focused on people avoiding contact in the clinics during COVID, and hopefully that will fade away before too long, but we shouldn't underestimate the fact that we've got a lot of older beneficiaries who we probably don't want to just routinely come into clinic during flu season if it's avoidable. So there are reasons to continue that.

I'm very supportive of limiting this to the advanced APM models as well, and I guess the one thing I want to emphasize -- or I guess the two things, I would also very much support including audio-only. The reading material indicated that over two-thirds of Medicare beneficiaries have used audio-only relative to the video visits. Our experience, UW Health has been consistent with that as well, and personally I've found that to be actually very useful and have not needed video capabilities for a lot of these visits, particularly the chronic diseases as Wayne and others have said.

The last thing I want to comment on, and I won't reiterate what others have said too much, but this issue
had started to come up in Round 1, which was around whether
or not the capabilities are going to be focused on
providers in advanced APMs or are they going to be matched
to beneficiaries. And what I heard from Ariel was that,
for practical purposes, at least to start with, we would
probably limit it or start off with the provider. But I
think that's going to be a really important thing for us to
grapple with and think about what the implications are in
both ways.

As a specialist who's in an advanced APM through
Next Gen and an academic medical center, a lot of my
patients come from far away, and there's not really a
simple way to guarantee or have those individuals be part
of our advanced APM, be part of our Next Gen. And yet
those are the folks who may be getting a lot of benefit
from increased access to the specialty care and not have to
drive very long distances and take off half a day of work
or have their family members take off half a day of work
for something like that.

So I think we do want to preserve that
capability, and, you know, in the last cycle we talked a
lot about how do we -- or we started to talk, at least,
about how do we think about models for specialists in advanced APMs and how do those align with some of our other models and the ones that are more logically aligned with primary care. And so I think that's a -- there's a line of thinking that we may want to bring into some of our broader advanced APM and ACO discussions going forward.

So I'll leave it at that. Thank you.

MS. KELLEY: Okay. Marge, you're next.

MS. MARJORIE GINSBURG: So I admit I'm a Luddite. I'll get that up front. The arguments many of you have given, particularly you, Sue, have been very persuasive about the importance of it, but I'll tell you, this raises so many red flags for me. I am inherently -- well, let me back up a second.

Our first discussion yesterday was all about how the Medicare budget was going to hell in a hand basket. I am really concerned that just opening this up as a new way for doctors and patients to relate without a whole lot of safeguards means we are going to be looking at extensive increases in the burden to taxpayers and ultimately the burden to patients.

So cutting to the chase, I think the next step
has got to be a very carefully designed study of a certain number of A-APMs who are participating, very closely monitored for two or three years, and to see whether what we are getting is greater benefit to patients and lower costs to the system.

Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you. I'm going to try to be as brief as possible, picking up on many people's comments. First, Ariel and Ledia, great work as usual. Second, I definitely agree, in general support of trying to support providers and beneficiaries in receiving telehealth, as Karen said very passionately and others have already spoken about. I think to pick up on just one thing that Marge said, we have to be mindful about the responsibility. So I support many of those things.

I'm trying to divide my comments into access, payment, and monitoring. So in the context of access, I think generally speaking, to the extent that we can follow something like a targeted strategy -- I think Betty brought up a couple of these points, and then the chapter does, too, actually -- around focusing on those people who -- the
beneficiaries who may disproportionately benefit from this, from an access perspective, those with disabilities, those with neurological impairments, those with mental illness, those people where the impact can be just substantially, you know, disproportionate, clinically speaking.

So I think some sort of targeted strategy may get us to a balance between the risk that Marge is worried about, and I think the excitement a lot of us also hold given the progress that we've made, whether it's six years or from the 1960s, as the brief said.

So another couple points. The one thing -- I've broadly supported -- I think if you look at how MA has done it, at least a little bit of the details that we do have, clearly there is value in telehealth and the whole cost of care management, and there are cost efficiencies there. And so in that sense, I'm excited and supportive of the idea of, you know, giving A-APM participants even more flexibility in the concept of telehealth. I think that make sense.

The one piece that I think gives me pause is if we look at A-APM participation, it has not been uniform across the country based on community characteristics.
Participants who -- or beneficiaries that live in communities with a disproportionate number of duals, for example, has much less access to ACOs or bundled payment participants. This is actually true even in CJR, which is a mandatory program, because of the way that -- the formulas that Medicare had to use to come up with who participated in the candidate pool of MSAs.

So I think we have to be mindful about that because, otherwise, you know, this digital divide concept and disparities in general, we could unwittingly actually support a divergence in how we allow access. Then as we cross that with Betty's points about targeting the beneficiaries, we could actually do a lot of harm rather than a lot of good. And so I think we have to be mindful about that disparity rather than sort of putting blinders on and saying A-APMs are the solution to trying to get telehealth out there.

There's some points in the chapter, in the paper, that talk about new patients versus existing patients, and I wondered in the context of access challenges, again, sort of certain types of specialty care that are less accessible if we should actually explore how to make that perhaps more
available to new patients rather than established patients.

Another point on the payment side, in particular I think there was some discussion in the paper about how to pay or whether to pay for -- and sort of design the payment, if you will. So I think because we know adoption of anything, even if it's free technology, requires a little bit more effort, a little bit more work reorg, et cetera, I think we could explore some concept of a tiered payment there, so thinking about a slightly higher payment for the initial set of visits, if you will, and then subsequently could drop that.

Then another thing I wanted to -- the last piece on this sort of monitoring responsibility piece that I wanted to submit is I know the Commission holds very strongly these principles of how we measure quality and how we think about the quality and monitoring aspect of programs and a common set of metrics, a set of metrics that are outcomes-based. I wonder in this case if we actually need to be making an exception to this rule. We may need to be a little bit more targeted about trying to focus on soliciting inputs from beneficiaries specifically about telehealth, about monitoring access and quality of
telehealth services in particular, because of all of the unicorn reasons that you guys have -- that I've already outlined I think in our discussion. And so I would submit that maybe we should actually be more targeted and telehealth-specific here than we usually are and not rely on the general CAHPS type surveys, the general other types of quality measurement that we do, lest we not be able to actually detect harms to patients or benefits that we would otherwise miss.

Thanks for listening.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Thanks, Dana. And let me start by thanking my fellow presenters, presenters who are so impassioned and articulate, like Karen and Sue, a vision for the future, and Wayne, really in terms of talking about, you know, how this has been part of the armamentarium of the care of chronic disease. And my view is coming from a 20-year history of working with telehealth in the VA where this was simply part of the fabric of caring for veterans around the country and around the world. So, briefly, six points.

First, clearly there's a very different resource
use between telehealth and in person, and I think that's one of the inherent controls in terms of overutilization. If you actually look at excessive use and very low utilization, you'll pinpoint fraudulent or inappropriate use of the technology.

Two, COVID's with us for a while, but there will be something else after it. There's always infectious disease. There are always impairments to mobility. And, you know, I just reflect on my father being delighted as a Medicare beneficiary not to have to be in a physician's office at this particular time.

Three, in terms of access, limitations of access are not just the purview of rural. Urban isolation is well characterized. This is one of the best modalities for connecting with individuals who, for whatever number of structural and systemic reasons, are isolated.

Four, I think it's fundamentally incorrect to sign on the use of a technology or its whole based on the payment model. It really needs to be on the basis of clinical appropriateness. Will we limit with an epidemic of diabetes the use of digital glucometers to just one particular payment model? I think there are any number of
other controls that can be put into place, and I think that's really what needs to be tested.

You know, phone is simply one of the mechanisms for remote care. If the current mechanisms pay for phone care, that's fine. But, you know, I do support that we abide by mechanisms to control security and privacy that are associated with HIPAA, and I'll come back to that because really one of the things that's most interesting now about the use of telehealth is that many of the telehealth mechanisms are simply an extension of the technology of the electronic record. And to disassociate telehealth from the electronic health record is virtually impossible as it's now part of a unified suite of technology.

And, finally, if we were to say let's limit this to the purview of A-APMs, we may be exacerbating the digital divide, particularly from rural individuals, if we think about where the geographic and social sort of concentration of those models exist.

So, in closing, let me just offer one final comment. You know, right now we're deciding how telehealth will be used. I feel fully confident that our successors
will be deciding whether or not Medicare pays for devices, be they physiologic monitoring or communications, for Medicare beneficiaries, because it's hard to envision the world ahead without sort of continuity that really a digital environment not only embraces but requires.

Thanks.

MS. KELLEY: David?

DR. GRABOWSKI: Great. Thanks.

Let me start by saying, similar to others, I do support telehealth expansions in the advanced APMs.

For other clinicians in fee-for-service Medicare, I do worry about excessive use and low-value care if we continue the expansions under the PHE.

As a result, I do believe we need some safeguards in place, and I just wanted to quickly outline three guiding principles here.

First, I do think we should cover all forms of telemedicine for high-risk patient populations where access is most likely difficult, and this would be expanding Medicare coverage beyond rural communities to patients, for example, and federally qualified health centers, community mental health centers, nursing homes, and for people with
substantial physical and mental disabilities.

A second guiding principle for the rest of the Medicare population, I would cover telemedicine only where we see real value or there's a compelling need, and here, we could use conditions as we've been discussing or provider types to determine these coverage decisions.

An example of coverage by condition would be similar to Medicare's current coverage of telemedicine for stroke and for opioid use disorder. We've talked a lot about diabetes. There's probably other examples that the clinicians on the Commission could point towards.

We could also expand services by provider. An example here would obviously be continuity and financing primary care by covering any form of telemedicine visited for primary care. So there are some options there if we see that there's high value to covering these services.

The final guiding principle I would assert is that we do want to pay for telemedicine visits at a rate lower than in-person visits and avoid any sort of telemedicine parity laws. I know that setting up telemedicine requires some significant fixed costs in the short term, but in the longer term, a provider's marginal
cost should be lower for these types of visits. And I think our reimbursement model should reflect that.

And I do believe that at least for some patients, we should have some cost sharing in place for telemedicine. So I'll stop there and just say thanks.

MS. KELLEY: Okay. Thank you.

Jaewon, you're next.

DR. RYU: Thanks, Dana.

A lot of great comments, which I agree with. I think Betty described the spectrum that I would also support, which is the greater that you have financial accountability through an A-APM model, I think you should be afforded greater flexibility, and that if you're on the purely fee-for-service side, I think that's the other end of the spectrum where I think the telemedicine, unless we have firm belts and suspenders in place, I'd be very concerned.

The other is I think there's an opportunity if we rolled it out in that way in the A-APM space to do some of that testing and learning around the impact that the vehicle could have on the total cost of care and on the clinical outcomes.
The other comment is just around A-APMs, and this gets to the question from Round 1. I think there is complexity, but ideally, I'd love to see if we can limit it and afford the greatest flexibility in areas where the provider participates in an A-APM and is aware of a beneficiary who is also attributed to them within that A-APM.

Now, that may not be practical, but I think that's the ideal scenario. These providers will be seeing other beneficiaries who are outside that A-APM. That gives me a little greater pause there.

And then the last comment I'd made is A-APMs bring the financial incentives that I think would make me comfortable, but probably, more importantly, I think there's clinical accountability there in a way that in the fee-for-service world, there may not be. I think telemedicine in a Wild West environment has the potential to fragment versus in an A-APM environment where there's an accountable team, accountable provider, I think it could be used for tremendous clinical benefit.

DR. CHERNEW: Okay. We are at eleven o'clock. We have two comments left. Just giving a time check. I
think Larry is next. Is that right, Dana?

MS. KELLEY: That is right.

DR. CASALINO: First of all, I agree with Brian and Jonathan about not discriminating against audio. I agree with Brian about expensive DME and I'd say really expensive lab tests. You need an in-person visit. I agree with Paul and a few others about the importance of cost sharing for telehealth, and I agree with Bruce and David that I think there shouldn't be parity, that quite a bit less should be paid for telehealth visits.

But that said, I had originally entered the queue because I wanted to make a couple more general comments, which Sue then made extremely eloquently for the second time in two days. I want to reinforce her comments sort of using two trite phrases. One is the genie is out of the bottle. She used "Pandora's box is open."

I could tell you at Weill Cornell, physicians thought telehealth was an issue under the devil, very many physicians. There were also some curmudgeons who really thought it was an issue under the devil. That changed within a week of when people started to use it, and now I would say the overwhelming majority of the thousand
physicians or so in our organization think it's great.
People are using it routinely who I never thought would do it. So that's from the physician's side.
From the patient's side, 20 years of practice, for one reason or another, I'd frequently be in the position of talking to a patient about their blood pressure on the phone, for example, and saving a visit by just modifying their therapy for diabetes or hypertension over the phone. And then I would say, "Why don't you increase your lisinopril with the blood level for your hypertension, and then come see me in two or three weeks. And we'll see how you're doing." And the patient's response was invariably, "Okay. But, Doc, how come I have to come see you again in two or three weeks? Why can't we just do this again?"
So I think the genie is out of the bottle.
There's no substitute for face-to-face visits. You need to have them, patients do like them and physicians like them when there's real value to them. But I think in general, patients who have a good relationship with their doc will be very, very happy to have lots of virtual visits.
So the second trite phrase is don't let the tail
wag the dog, and I think Sue basically referred to this as well. There are fee-for-service incentives out there all over the place. We don't, for example, try to identify physicians who are having too many follow-up visits for hypertension or diabetes, and I don't see a reason really -- I do see a reason to be cautious and thoughtful about telehealth, but I think we do need to ask ourselves why -- we've got to be careful to not discriminate overly against something that could be very valuable tool, while leaving all the other fee-for-services in places they always have been.

I think that if there's cost sharing for telehealth, if telehealth is paid at a lower rate, and if there's monitoring for outliers, I think that will reduce the possibility for abuse a lot.

And the benefits are so great. I just talked about from the physician-to-patient point of view, but I also did want to say -- I forget who mentioned this now, but increasing primary care access -- I think it was Wayne -- is a big deal.

At Cornell, we've had a huge problem with primary care access, huge, and part of it is we just don't have the
space to hire more primary care physicians.

But now we realize we can do a very large number of primary care visits and specialist visits, for that matter, where we also have an access problem, through telehealth. That means that we have more office space open, more staff time free, and we have physicians working two or three days a week doing telehealth, the other two or three days in the office, and we can hire more primary care physicians and more specialists that way and increase access tremendously. That's a huge benefit.

I'm almost done.

I think that limiting telehealth to A-APMs would drastically reduce the potential benefits, as Jon Perlin suggested. I can see reasons for doing this, but I think it would be premature at this stage to let this just become the wisdom of the Commission. I think that Jonathan, Sue, and I -- Jonathan Perlin, Sue, and I at least have some reservations about limiting it to A-APM. So I hope we'll have more discussion about this.

The last two points, let's not make this too complex for all kinds of reasons, including the more complex it is, the more opportunity for gaming and the more
burden on clinicians. And we shouldn't underestimate that.

Clinicians really, really, really hate having to think, "Well, am I allowed to do this for that patient, but I can't do it for this patient?" We don't want anything like that.

And the last thing, I think there should be more attention to telemedicine by Teladoc companies. This whole discussion that we've had for the last hour has been really framed, I think, with the mental mindset of a patient and their physician or physicians. It's quite a different thing, a patient accessing Teladoc services across state lines with a physician who they've never seen and are never going to see again, and I think we don't want to lose track of that as a kind of a separate area that we might want to pay some attention to.

MS. KELLEY: Okay. Pat, you're up.

MS. WANG: So, unfortunately, I think -- because following your comment, Larry, and some of the others about the importance of telehealth, which I agree with -- and I think people are circling around some core areas, chronic care, E&M, urgent care. I would add dermatology to the list for video, behavioral health, et cetera.
But I think that what we've been discussing for years now in the context of A-APMs is how to restrain some of the worst impulses of the fee-for-service system, and so I am also concerned about adding new -- as important as they are, these services, without some sort of governor or some sort of principle around accountability for how the services are delivered, because more is not necessarily better.

Let me just address the Medicare Advantage flexibility that Paul raised, and Brian raised something about Medicare Advantage. So I think these are really important observations, and I would note that within -- but the kind of monitoring that people think is easy in fee-for-service, overutilization and all that, I think it's really hard in fee-for-service. I think that we're always behind the eight-ball in trying to kind of find -- and it's like short of fraud, just kind of like billing patterns, what have you. I don't think the fee-for-service system is really capable of being on top of those and monitoring those things.

Plans do that on a regular basis because they're at risk. Primary care physicians who are capitated or who
are in fee-for-service risk arrangements, there's a
governor there. So it just sort of underscores the
importance of the impulse behind wanting to have an A-APM
or some other accountability structure around new
modalities.

Specifically for Medicare Advantage, I think it's
important to carry over this discussion into the MA work
with respect to risk adjustment because Brian mentions the
risk of it, but there's also the clarification of what will
count for risk adjustment because depending on the answer
to that, MA plans will feel pushed in one direction or
another in terms of the flexibility that they have. I
think that CMS has recognized the difficulty with risk
adjustment during the COVID months because of social
distancing and has shown some flexibility. I think it's
face-to-face telemedicine.

Brian, if it's any comfort to you, at least our
eyear experience with telemedicine claims coming through is
that they were barely coded. So the risk is under-capture,
not over-capture, but it's all emerging. So I think the MA
folks need to kind of be thinking about this in terms of
recommendation of what should count, what shouldn't count,
and it should sync up with what we are recognizing in fee-
for-service.

The final thing that I would strongly recommend
or request is that we do ask CMS to do the work of
understanding what the cost structure is. Right now, it's
this kind of, like, one instrument thing. It's facility
fee versus the fee schedule fee. I think there's enough
here to warrant an actual examination with all the tools
and the science that CMS uses when they do the physician
fee schedule to understand what we're really talking about
in terms of what an appropriate level of reimbursement
would be.

Thank you.

DR. CHERNEW: Great. I know we're a bit over
time, so I'm just going to summarize, and then we're going
to move on quickly.

Karen, you can send your message to the staff or
me, and we can deal with that.

So here's my view. I think for most of these
services, everyone can use -- this is not a question about
who is allowed to use this. Everyone is allowed to use
this. This is really a question about what they get paid
for, and A-APMs effectively get paid, depending on the cost sharing amount, roughly 50 cents on the dollar because it comes out of their bonus or penalty.

So in a fully capitated world, of course, no matter what you pay the A-APMs, it would come out of their bonus or capitation. So they would be effectively paid nothing.

This is really about what we pay in fee-for-service. My sense is what we will end up doing in most cases is control the utilization concerns with lower payment amounts and some cost sharing. We're going to have to work with the staff about how to sort that out and get back to you.

I will say one of the really important questions and comments that really resonates with me, Dana Safran said, which was it's going to be really important going forward to study and adjust is key. I don't think we need to view this as one bite of the apple. This is going to be a process that we're going to put in place, but I do think we're going to have to deal with payment and cost sharing to control potential overuse.

I'll stop and we'll move on to vaccines. Thank
DR. SCHMIDT: Okay. Good morning. Can everyone hear me okay?

MS. KELLEY: Yes.

DR. CHERNEW: Yes.

DR. SCHMIDT: First, we'd like to thank Nancy Ray for her help on this work, and just a reminder to the audience, a PDF of the slides for this session is available under the handout section of the control panel at the right-hand side of your screen.

The COVID-19 pandemic has made us all acutely aware of how important developing and administering vaccines can be for protecting health and the economy. Older adults and people with chronic conditions have higher risk of severe COVID-19 disease. So it's especially important to see that Medicare beneficiaries get vaccinated once a safe and effective vaccine becomes available.

Last spring, the Congress decided that Medicare will cover future COVID-19 vaccinations in Part B with no cost sharing. In this session, we'll discuss Medicare policy going forward. We'll review a recommendation the
Commission made in 2007 to put all vaccine coverage under Medicare Part B on the basis of this discussion. You may want to just reiterate that recommendation or we could come back in the spring for you to consider supporting an alternative recommendation.

Here’s a roadmap to the presentation. First, we'll go over some background about vaccines, including how the government is supporting development of COVID-19 vaccines. We'll review Medicare's coverage policy and how much the program spends today on vaccines. We'll look at rates of vaccination for some of the most common vaccines. Finally, we'll review the rationale behind the Commission's 2007 recommendation and present policy options for you to consider.

As background, let's step back for a minute and think about why governments tend to play a large role in vaccine policy. The key reason is that preventive vaccinations have very large social benefits. They are thought to be among the medical interventions with the highest payoff in terms of preserving health and economic activity and reducing stress on the health care delivery system. Vaccines have positive spillovers. When you get
vaccinated, it not only protects you but also the people
you interact with.

So individuals at risk of catching a disease have
a stake in seeing that other people get vaccinated too, but
there can be a lot of hurdles to getting vaccinated that
may affect whether a population reaches herd immunity.

Also, prior to COVID, the number of manufacturers
developing and producing vaccines had declined. But
governments have a continuing interest in making sure
vaccines remain available. For these reasons, governments
get involved; for example, in the case of state
governments, by mandating certain routine childhood
vaccinations, but for the federal government, by directly
purchasing and stockpiling vaccines, by providing some
liability protection to manufacturers, and by investing in
research and development to develop new vaccines.

In the case of a vaccine for the novel
coronavirus, the federal government has gotten involved in
a number of ways. Last spring, the Congress allocated
about $10 billion towards developing vaccines and
treatments in the CARES Act. The administration set up
Operation Warp Speed to coordinate federal agencies and the
private sector in efforts to develop safe and effective COVID vaccines, with the goal of delivering 300 million doses by early 2021.

To do this, the program is supporting several vaccine candidates. Their mailing materials describe three that are in Phase III clinical trials in the United States. Some of the federal contract with manufacturers fund R&D. Other contracts are pre-commitments to purchase hundreds of millions of vaccine doses, even before we know whether they'll succeed in clinical trials.

This approach reduces financial risk for vaccine manufacturers and allow them to set up large-scale production capacity much earlier than they would normally. It's possible that the Food and Drug Administration may grant emergency use authorization to some vaccine candidates before they are formally licensed.

Medicare's coverage of vaccines spans Part B and Part D. By law, Medicare Part B covers preventive vaccines for seasonal influenza, pneumococcal disease, and hepatitis B for people at high or intermediate risk with no cost-sharing. Part B also covers other vaccines used to treat injury or direct exposure to disease, such as rabies, with
Part B's usual 20 percent cost-sharing. The CARES Act explicitly covers new vaccines approved for COVID-19 under Part B with no cost-sharing. Part D covers all other vaccines such as those for shingles and hepatitis A. As with drugs covered under Part D, private plans can charge cost-sharing for vaccines and there is wide variation in what plans charge. Part D plans can also apply utilization management tools to vaccines, but they rarely do.

MS. NEUMAN: Medicare spent about $2 billion on vaccines across Parts B and D in 2018. Part B paid for about 21 million doses of vaccines, with spending of about $1.4 billion. Influenza vaccine accounted for roughly 80 percent of the doses and half of the spending. Pneumococcal pneumonia vaccine accounted for the most of the rest.

Part D paid for about 4 million doses of vaccines in 2018, with spending of about half a billion dollars including beneficiary cost-sharing. Herpes Zoster vaccine for shingles accounted for about three-quarters of the doses and about 90 percent of Part D vaccine spending.

In addition to payment for the vaccines themselves, Medicare Parts B and D also pays for
administration of the vaccine, which totaled an additional half a billion dollars in 2018.

Let's look at how Part B and D compare in terms of vaccine coverage and payment. First, cost-sharing. Under Part B, beneficiaries face no cost-sharing for preventive vaccines. In contrast, most Part D plans require beneficiaries who do not receive the low-income subsidy to pay cost-sharing for vaccines, and the amount varies by plan and benefit phase.

Next, payment. Under Part B, fee-for-service pays for vaccines at a rate of 95 percent of the average wholesale price, which is a sticker price that does not necessarily reflect market prices. Under Part D, vaccine payment rates are determined through plans' negotiations with pharmacies. If a particular type of vaccines has several competing products, plan sponsors may be able to use differential cost-sharing to gain more leverage in negotiating rebates with vaccines manufacturers, possibly lowering Medicare's spending.

Finally, there are difference is the locations where Part B and D vaccines administered. A wide range of providers can bill Part B for vaccines such mass immunizers
like pharmacies, doctors' offices, hospitals, skilled nursing facilities, home health agencies, and others. Part D mostly covers vaccines in pharmacies, but does have provisions for physician offices to bill Part D.

Vaccination rates within the Medicare population have generally increased or been stable in recent years, but some established goals for vaccination rates have not yet been reached.

In 2010, the Department of Health and Human Services and other stakeholders set national objectives for vaccination rates as part of the Healthy People 2020 framework. For flu and pneumococcal vaccines, the goal set was a 90 percent vaccination rate for the age 65 and older population. According to CDC estimates, about 68 percent of elderly individuals received a flu vaccination in the 2018-2019 flu season, and about 59 percent of elderly individuals received a pneumococcal vaccine covered by Medicare as of 2017.

For shingles vaccines, which is indicated for individuals age 60 and older, the goal set was a 30 percent. That goal has been reached, as an estimated one-third of individuals age 60 and older have received a
shingles vaccine as of 2018.

There are significant disparities in vaccination rates by race and ethnicity in the Medicare population. As shown on this slide, vaccination rates among black and Hispanic beneficiaries are consistently below those of white beneficiaries for vaccines recommended for the Medicare population. These differences occur even when there is no cost sharing, like under Part B for flu and pneumococcal vaccines, and even among Part D for beneficiaries who receive the low-income subsidy and have minimal cost sharing.

So in addition to cost-sharing, other factors contribute to disparities in vaccinations rates. For example, according to researchers, individuals may be reluctant to get vaccinated for a variety of reasons such as misconceptions about the benefits of mass immunization, perceived health risk of a particular vaccine, or general mistrust of the health care system.

[Pause.]

DR. SCHMIDT: We are not hearing you, Shinobu.

MS. KELLEY: Rachel, who is supposed to be speaking right now?
DR. SCHMIDT: Shinobu is supposed to be up.

MS. SUZUKI: Okay. Sorry. As Rachel mentioned,
Congress changed the law to cover all COVID vaccines under
Part B, but going forward, there still remains the broader
issue of what vaccine policy might best serve
beneficiaries, taxpayers, and Medicare.

In 2007, the Commission recommended that all
vaccines be covered under Part B. At the time, there were
two major concerns: one, with Part D just getting underway
most physicians had no direct way to bill Part D plans, and
two, they were concerned that if beneficiaries had to pay
for vaccines up front, the cost may deter some from getting
the vaccine.

Today these concerns no longer apply. Physicians
and other immunizers routinely bill Part D plans, so there
is very little need for upfront payment by beneficiaries.
Nevertheless, there may still be reasons to support the
recommendation.

In the next few slides, we'll discuss the 2007
recommendation and two alternative options. The focus will
be on the tradeoffs between social benefits of broader
access to vaccines and the effects on manufacturer pricing.
Option 1: We could reiterate 2007 recommendation that cover all vaccines in Part B with no cost sharing. Key advantages include wider reach, as more Medicare beneficiaries are enrolled in Part B than Part D, and that there are no cost-sharing under Part B. A wide variety of health care providers are in Part B, so there would be more platforms to reach beneficiaries.

In addition, having all vaccines under one program would be less confusing for beneficiaries and providers. However, as we described in your mailing material, the AWP-based payment places little or no constraints on vaccine prices, and the fee-for-service system have limited tools to encourage the use of lower cost vaccines if multiple vaccines with similar health outcomes are available.

Option 2: Cover new vaccines to prevent highly contagious diseases in Part B with no cost-sharing, and leave all others in Part D. This is a variation on Option 1 that targets Part B coverage to only those that prevent highly contagious diseases. For example, a vaccine to prevent or limit infection of a novel virus that spreads very quickly would be covered under Part B. Viruses that
are less easily transmittable would continue to be covered under Part D. Shingles would be an example of vaccines that would be covered under Part D.

The main advantage of this option is that it would provide for widest coverage for vaccines with largest social benefits, and by continuing to cover other vaccines under Part D, private plans could negotiate with manufacturers over price for formulary placement and potentially obtain larger rebates if there are competing products.

The disadvantages of this option are, as with Option 1, there would be few pricing constraints on new vaccines placed in Part B. Cost-sharing for vaccines in Part D would vary across plans and by benefit phase, which may deter some from getting vaccinated. And it is unclear how well Part D plans could or would constrain prices, particularly if there are no competing products.

Option 3 would keep the current approach to vaccine coverage but eliminates vaccine cost-sharing in Part D. Under this option, coverage of new vaccine products would fall under Part D unless already specified in law as a Part B-covered vaccine.
This option broadens access to vaccines for Part D enrollees by eliminating a financial hurdle to receiving the vaccine. Relative to Option 2, a larger number of vaccine products would be subject to negotiations with plan sponsors over prices and rebates.

However, there are a couple of disadvantages. First, it is not clear how much eliminating cost-sharing would increase vaccine use. Data shows that factors other than cost-sharing play a large role in preventing some beneficiaries from getting vaccinated. In addition, this option would have no effect on access for beneficiaries not enrolled in Part D. Finally, without cost-sharing, plans may have little or no bargaining leverage in their negotiations with manufacturers.

In your discussion today, in addition to any feedback, we are also hoping to get your guidance on a potential recommendation in the spring. The material we just presented to you and any revisions will appear in our June 2021 report to the Congress.

So we will leave you with the three policy options for you to react to, reiterating the 2007 recommendation and two alternative options with different
implications for achieving broad immunization versus placing some constraints on pricing. With that, I'll turn things over to Mike.

DR. CHERNEW: Great. Thank you, Shinobu and everyone else. I think -- hi, Rachel -- I think we have just a few Round 1 questions. This is great because I want to focus our time on people's opinions of the options. Dana, you're in charge of the Round 1 questions.

MS. KELLEY: Mike, you said you had a Round 1 question.

DR. CHERNEW: No, I don't have a Round 1 question.

MS. KELLEY: Oh, I'm sorry. I misunderstood.

DR. CHERNEW: I think it's Brian and Bruce, but there may be others that haven't shown up to me.

MS KELLEY: It is Brian first.

DR. DeBUSK: All right. Thank you. Quick Round 1 question. In the reading materials, page 32, Table 6. You list out the Part D vaccines, and some of them have their own billing codes, some of them have combined codes. How is that determined? Are those performance-based or are those arbitrary? Who decides when we have a separate code?
MS. NEUMAN: So these billing codes are generally established by the AMA. However, CMS does have discretion to modify the billing codes used for vaccines if they find a reason to do so.

DR. CHERNEW: That was a perfect Round 1 question. Bruce.

MR. PYENSON: Thank you. This might have been covered in the reading material and I somehow missed it. My question is, I believe the reading material said that vaccines in Part B are reimbursed on an AWP basis, average wholesale price basis. Did I get that right?

MS. KELLEY: Kim, your mic's not on.

MS. NEUMAN: Oh, sorry. That's correct. Ninety-five percent of the average wholesale price under Part B for the three preventive vaccines.

MR. PYENSON: So my question is if you had looked at converting that to an ASP basis, which other Part B drugs are on, or even a different basis. We had something similar to this in MedPAC for new Part B drugs, I think.

MS. NEUMAN: So, Bruce, I think you're recalling from our June 2017 report, where we, the Commission, made a recommendation that payment for new drugs that lacked an
ASP for the first couple quarters they were on the market, they had been paid at WAC, which is wholesale acquisition cost, plus 6 percent, and the Commission recommended it be reduced to WAC plus 3 percent.

With regard to vaccines and analyzing a conversion to ASP, manufacturers of vaccines are not required to report ASP data so we don't have a sense of where AWP and ASP fall relative to each other for vaccines.

MR. PYENSON: So is that something that could be required, since we're putting major issues on the table here, or is that off the table?

MS. NEUMAN: I don't know if I can opine on whether it's on the table or off the table, but what I can tell you is I think that would require a statutory change.

MR. PYENSON: Okay. Thank you.

DR. CHERNEW: So I think we have Marge next in the Round 1 queue. Marge, you're also one of the reactors, so why don't we blend those together and you can just ask your Round 1 question, and then there's no one else in the Round 1 queue, so we will go right into Round 2. Is that right, Dana?

MS. KELLEY: Correct.
DR. CHERNEW: Great. You're up, Marge, and then we're going to go to you, Jonathan.

MS. MARJORIE GINSBURG: Well, except that I actually didn't have a Round 1 question.

DR. CHERNEW: Marge, you get to make a Round 2 comment.

MS. MARJORIE GINSBURG: All right. I'll make a Round 2 comment. So I confess when I first saw that we were doing a discussion on vaccines I thought we were going to get to decide who's going to be the provider of vaccines for the pandemic, you know, how we were going to make a decision about how people get immunized. So then I got down to reality and actually read the chapter, with some degree of relief.

This is really a phenomenal report with fabulous background. And what I initially thought was going to be a fairly simply topic is, in fact, not simple at all.

The thing that most focused me are the number of people who don't get vaccinated, and it doesn't seem to be a cost-related problem. It isn't about copayments, not if you look at the statistics where you have only 25 percent of people who are on the low-income subsidy who do not have
a cost barrier get immunized.

So I guess what I would like to say, I know that where we are going are what our options here, but I would also like to throw in -- and maybe the research has been done, and maybe there's nothing more than can be done -- but we need to focus more on why people don't get immunized. And I don't know whether this is anything that MedPAC has ever looked at before, in terms of a research topic, but it seems to me this is a really, really important area. And I don't think the immunization rates have improved over time. And perhaps some of you who work more closely with the populations who don't get immunized have some insight as to why, and not only why, because we probably know why, but how do we mitigate that? Is there anything that can be done to convince people it's in their best interest to be immunized?

So having said that, the summary of options, I finally landed on Option 2, and I'm going to be very interested, obviously, in hearing what my colleagues have to say as well. But part of this is keep it simple. Let's not make things any more complicated than they already are. And to me, Part 2 really does that. I don't see a
compelling reason to move everything into Part B, and it just feels like that Part 2 is a good option, and I'm very interested in hearing other people's comments on it. So thank you.

DR. CHERNEW: Jonathan Jaffery?

DR. JAFFERY: Thank you. Well, first off thanks for an amazing chapter and a great presentation. I really think this blended three different things for me: the overview of the importance of the government role in vaccines in general, and COVID in particular, a huge background there. You set up an incredibly rich discussion about the concern over disparities that exists in vaccine uptake in the Medicare populations. And then finally, you led us towards a conversation about a discrete policy question that we need to address. So I think it really spanned this big-picture discussion as well as getting into the weeds that, of course, we need to do.

So let me just -- I'll just make comments about the second two of those things, the disparities issue, and then I'll get to the summary of options.

We're seeing horrible disparities exist and persist in vaccination use, and there is, I think,
certainly a lot of concern that that's going to be the same for COVID where we're already seeing huge disparities in the impact of COVID in different populations and in populations of color. This is complex. It goes back many years for a variety of reasons, including lots of very well-earned mistrust about certain things. But I think any policies that we want to enact or that do get enacted going forward really need to try and mitigate these disparities. And so one thing we can think about perhaps is actually reporting on different kinds of inequities going forward, more so than just in our chapters and our discussions. You know, that whole dictum about you can't improve what you don't measure. If there's an opportunity for us to require reporting on some of the different disparities based on race, ethnicity, language, then hopefully we can take some of that both in metrics for MA plans and perhaps quality reporting in fee-for-service. One of the articles in our reading I think spoke to one of the major health plans' pretty significant investments in trying to move their star ratings, and so there's some evidence that providers and plans do react to these things. So I hope that's something that we can
And then to the second point, and then I'll conclude. In terms of the options, I'm falling in favor of Option 1. I think actually Marjorie mentioned simplicity, and I think having everything in the same -- in Part B may add some simplicity. I'm not sure how much that matters. But the compelling thing for me was the notion that there's such a significant number of beneficiaries, Medicare beneficiaries, who have Part B but don't have Part D. I think it was 8.5 million individuals in the reading. And so for that reason, I think reiterating 2007 recommendations as Option 1 says.

That said, I was going to recommend sort of a modified Option 1, which was to use a different -- was thinking about using average sales price, similar to some of the questions that Bruce was raising. It sounds like maybe that is not -- that's an oversimplification of what could be done. So I think maybe a little more thought or discussion about that, but using Option 1 but a different pricing mechanism. And I recognize it's -- as you said, some of that might require a statutory change, but I don't know that that should necessarily be a barrier to us making
the recommendation that we think is the best policy
decision.

Thank you.

MS. KELLEY: Okay. Brian, you're next.

DR. DeBUSK: Thank you. First of all, great
presentation, very thought provoking. I think your answer
is Option 1 for the reasons you stated on the slide. I
think bringing everything under Part B gives you more
options. It covers the most people. Lots of access.

You're disadvantaged. I think there's a way to
get around that disadvantage, and that is, make -- and not
just coronavirus, but make all these vaccines performance-
based. I think you could set billing codes based on the
performance and characteristics of the vaccine, and what
that would allow you to do is stratify the payments,
because, you know, you make the point that you don't really
have any constraints on pricing if you push this all under
B. Well, if you provide distinct performance categories
for viruses -- I'm sorry, for vaccines, then it will give
us the ability to group the vaccines with similar health
effects and pay accordingly. And if you notice, again,
back on page 32 of the reading material, we've had average
annual price growth of anywhere from minus 0.3 percent up
to what looks like 1.1 percent for over, what, a three- to
five-year period for some of these vaccines that have the
combined billing code. So I think the answer is Option 1
with combined billing codes based on vaccine performance.

Thank you.

MS. KELLEY: Bruce?

MR. PYENSON: Thank you. I would like to amplify
Jonathan and Brian's point. Since we're talking about a
statutory change for Option 1, anyway, which I support, I
would like to suggest an ASP basis. But there's a feature
of Medicaid best price that I think we should suggest here,
which is that, as you know, Medicaid best price has two
components. One is a statutory reduction, and the other is
what you might call an inflation penalty.

I would suggest adding an inflation penalty to
the ASP for vaccines, move it all into Option 1. I
disagree that there is better price control in Part D. I
think there's weak evidence supporting that claim. But the
Option 1 is my favorite, and I think we can deal with the
prices through an ASP or modified ASP basis along with the
grouped HCPCS codes that Brian was referring to.
MS. KELLEY: Larry -- I'm sorry. Paul, I think you're next.

DR. PAUL GINSBURG: Sure. This is very well-done work, and, you know, my reaction to it was I didn't think it was really -- I think the important thing is to have vaccines for highly contagious diseases in Part B because it covers more people and with no cost sharing. But the difference between the options -- that's included in all the options. The difference between the other options to me is so small compared to the challenge of getting -- of purchasing more effectively in Part B. And I think that as we go forward, that's what most of the work should be on, is, you know, whether to use Brian's approach, whether to use an ASP approach, and there may be other approaches. This seems to be something ignored for a long time in Medicare when the markets have changed. And, you know, of course, there are many other examples of that. That's our challenge.

But I would just put all of our energy into finding more effective ways to purchase vaccines in Part B.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, so I think Jonathan, Brian,
Paul, and Bruce have already said what I had planned to say. I'll just reiterate I think Option 1 from what I understand is preferable. It's much simpler, which is important, I think. There's no cost sharing, which I think is great. We are not worried about overuse of vaccines. Quite the opposite.

I think an overwhelming reason is the fact that everyone would be covered. We don't want to make disparities worse than they already are, and, of course, we want everyone covered for vaccines. So a plan that depends on Part D which not everyone has seems to me undesirable.

And then the last point is we've had a lot of work that the staff has presented in the last six months or so suggesting that Part D has not been very good about controlling pharmaceutical prices. I think Medicare could control vaccine prices any way it wants to. It would require a statutory change, but there have been a couple of suggestions about how it could be done. But Part B could pay what it wants to pay, essentially. Obviously, you can't pay two low or we wouldn't have vaccines. But I don't see that Part D would control prices better than Part B.
So, to me, who was very ignorant of this topic before I read the staff's excellent materials, Option 1 does seem superior.

MS. KELLEY: Dana?

DR. SAFRAN: Thanks. Just very brief. Everyone's already made all the important points. I think Option 1 for me is by far the favorite, just for all the reasons described, but in particular creating universal access, as close as we can to universal access, which Part D wouldn't help us do; and avoiding cost sharing as a barrier. And in particular to address the disparities that we know exist, I think we should be lowering every threshold we can, and Option 1 seems to do that best.

Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. This was actually very fascinating to me, and I just wanted to make a couple of comments.

One, I agree the disparities are clearly a concern, but I'm also pondering this anti-vaxxer movement that's happened in the United States and other wealthy countries, and it's really unclear which direction,
whatever happens with COVID, is going to take that. It may
depend on its effectiveness and safety. But I'm not sure
we can take on all of that within this policy space.

So when I was looking at these options, my
initial ranking was Option 2, Option 1, and then Option 3.
And so I've appreciated the other nuances that you have
added, and I'll be looking forward to understanding more
about the details of some of those as we move towards a
final recommendation.

Thank you.

MS. KELLEY: Jon Perlin?

DR. PERLIN: Thanks. I strongly support Option 1. I think it's unconscionable to exacerbate potential
barriers, financial barriers in the face of no disparities
in terms of the access to and equity of use of vaccines.

Second, I have a philosophical issue with the
other options, which is it's a slippery slope when we
decide which vaccines are in and which are out. So, for
example, if indications for the human papilloma virus
vaccine, which is now administered to teens and young
adults to prevent cervical cancer, were expanded to other
individuals, would we say, well, that's not in? And it
gets to all sorts of issues I don't think we should get to. Third, you know, the characteristics of a good vaccine is that they have a positive return on investment in terms of forgone need for additional care and services, and toward that end private insurers and even other programs have offered incentives, additional incentives beyond no cost, to encourage the uptake of vaccine, particularly in the face of, as Betty just offered, as is clinically correctly known, vaccine hesitancy.

DR. RAMBUR: Thank you for that.

DR. PERLIN: Beyond the notion that we should encourage the uptake of vaccines amongst the beneficiaries themselves, I am actually frankly surprised we haven't discussed Medicare provider accountability for vaccinating patients. But toward that end, I would endorse that we do everything we can to make it easy to get vaccinations out, and particularly as we look toward the promise, we hope, of one or more effective COVID vaccines and that we even contemplate mechanisms such as roster billing where there's a one-to-one beneficiary accountability but a mechanism to simplify the administrative burden to make sure vaccination occurs.
Thanks.

MS. KELLEY: Karen?

DR. DeSALVO: Thank you. I support Option 1 for the reasons that have been mentioned. My other comments are more related to public health and COVID considerations. I think we should spend a little time on the language "highly infectious" or "highly contagious" because there are a lot of diseases that are highly contagious but don't have the morbidity and mortality associated with them, and that's really what we're trying to protect for those who we vaccinate. So maybe I can work with the staff on some language that speaks more to what we're really trying to do for protection because it's not -- "contagious" isn't exactly -- I think what you're trying to get to is things that are common and communicable.

The other categories about COVID are the COVID vaccine or vaccines, plural, are likely to be annual and paired with influenza. So as you're thinking about this going forward, wherever it is, it should be married to going to the office and getting or going to the church or wherever you're going to go and getting both concurrently, which also sort of pushes it towards a Part B payment.
I think the other issue is something that Bruce has raised in the last couple of days about deflation and also that Brian talked about with value. And I don't have an answer here, but just for consideration, the first-gen COVID vaccine is more -- is potentially going to be less expensive but maybe not as effective as some of the second-gen and other iterations of the vaccines may be, and they may be more expensive to manufacture since it's new, but they also might have more value because they'll be more likely to prevent not only disease but potentially transmission, the two characteristics.

So this one will be interesting, but probably it'll be more like influenza where it will prevent disease and not transmission. But I just want us to be monitoring the fact that what comes out in the next few months probably won't be what we have longitudinally. And, in fact, certain populations may have certain specific vaccines, so mRNA make more sense for some populations than an attenuated adenovirus.

The last thing I just want to say is I don't know what Medicare policy is about paying for therapeutics that have been approved via emergency use authorization, but if
that seems like a likely pathway for COVID vaccine, it's
that it would be approved by EUA, which may either preclude
additional science on other vaccines or stop the interest
in manufacturing, and that may be the bar that it's held
to. And that may be a Round 1 question, Mike, but I think
it's something we should make sure that Medicare policy
allows us to longitudinally pay for something that hasn't
been through full FDA review.

MS. KELLEY: Pat?

MS. WANG: Thank you. I would echo some of the
earlier comments. I think Paul summarized it really well.
I think, you know, Option 1, Part B, is the superior
distribution mechanism, but the cost has got to be -- we've
just really got to grapple with that, whether it's Bruce's
suggestion or Brian's or what have you. I think it's
really, really important. Part B for distribution channel,
but price has to be addressed.

I do want to pick up on something that Jon Perlin
mentioned, though, about provider accountability, and Jon
Jaffery referred to this. Organizations that are
incentivized because it's part of a quality bonus, as it is
in Stars, to achieve certain flu vaccination rates, for
example, they go in the direction of that signal. And I wonder whether given the importance -- I mean, like we are focused on flu vaccine right now. In advance of COVID, the flu vaccine is critically important for the population. But I wonder whether we can contemplate adding, for example, to ACO metrics flu vaccination rates, ultimately other important vaccine vaccination rates. I don't know how to achieve what Jon Perlin described, but I think we should be thinking about it, because it's a very complex issue why people don't get vaccinated. It's baffling to those of us who routinely get our flu shot every fall that many people misunderstand that they need one, they think they never had flu so they don't need to get a flu shot; they don't have time; they can't be bothered; they're suspicious. It's really multifactorial, and it takes the entire system, I think, to move the needle on achievement of desirable vaccination rates. So I think we should add that into our thinking, how to incentivize that.

Thank you.

MS. KELLEY: Marge?

MS. MARJorie GINSBURG: Yes, I wanted to mention that actually the discussion sort of had me move from
1 Option 2 back up to Option 1. I guess what I want to say
2 really is to endorse Pat's comment about we need to be
3 doing much more to encourage vaccinations of all sorts.
4 The fact that the statistics are so bad really speaks to a
5 great deficit. And I don't think it's because of the cost
6 sharing. I remain skeptical of those X percent of people
7 who don't have Part B coverage, that that might play a role
8 as to why they're not getting vaccinations. I just don't
9 think that's what's going on, but I don't have any proof
10 that, in fact, it's the cost barrier that's keeping people
11 -- it's just intuited to me that that's not the reason.
12 Regardless, whatever authority we have with
13 Congress to move forward in both understanding and
14 mitigating the resistance of so many people to get
15 vaccinated is really important. In a way, this gives us an
16 opportunity. We have -- a door has opened with this
17 pandemic to focus on vaccinations, and I don't want us to
18 lose the opportunity to take advantage of that.
19 MS. KELLEY: David?
20 DR. GRABOWSKI: Great. Thanks. I'll be brief.
21 This has been a super discussion. I also favor Option 1,
22 and I just wanted to stress the point again that Brian,
Bruce, Pat, and others have raised around needing some price controls here. And so I think Option 1 has a lot of advantages, but are there ways of controlling the potential prices. And so, as I said, I'll be brief, but I really like the way this is shaping up. Thanks.

MS. KELLEY: Amol?

DR. NAVATHE: Hi. So I agree generally with much of what's been said. I'll just try to add a couple of pieces here. So just like David said, I think generally speaking I'm supporting Option 1 with some change in the pricing here, to ensure some price constraints, pressure on accountability in the prices.

That being said, a couple of things to consider. So one, if we really wanted to prioritize access, then maybe potentially proposing Part A, since Part A is much more widely adopted as basically an entitlement, relative to Part B, which does require a premium and opt-in, if you will. So potentially Part A as a financing mechanism.

The second thing is I think we all value, likely, innovation, continued innovation in this space. I think the paper did a nice job of actually describing how some diseases, some highly communicable diseases have greater
social impact and there's greater social welfare with broad vaccination. So if we did put everything in Option 1, Part B, and there's no variation, if you will, between the pricing pressure, then you could get in a situation where we actually don't have equivalent, if you will, or even better incentives and rewards for manufacturers to pursue vaccines for these highly communicable diseases. That is one thing that's sort of nice, if you will, about the legacy option or the prior option. So I just wanted to bring that up. If we do put forth an Option 1, do we also want to put something out there about pairing it with a policy to try to promote rewards in the highly communicable disease category.

MS. KELLEY: Paul, I think you said you had something else to say?

DR. PAUL GINSBURG: Sure. Yeah. I also support Option 1. I just wanted to mention that. And I don't know if it's part of this project or something else. I think that increasing vaccine compliance is likely something we should get into, because it's so important, especially in the COVID environment.

And in answer to Amol, I don't think Part A is
the right way to go, because I don't think Part A has any
experience in paying providers and paying clinicians. And
also, I believe that pretty much everyone in Medicare is
enrolled in Part B, unless they already have strong
insurance coverage, and thus Part B would be redundant for
them. So I don't think that necessarily would be a big
difference in coverage.

DR. CHERNEW: Okay. I'm going to jump in.

First, it is amazing how when you all have planes to catch
things go really quickly.

Anyway, I do want to make sure we hear from, I
think, Wayne and Jaewon and Sue, just to get your sense of
the options. But I will say a few things.

First, with regards to the Part A issue, there's
another concern that Part A is paid in the trust fund,
which is going to create a whole other set of problems, but
I don't want to focus on that. I actually -- and this has
been a great discussion. There seems to be a fair bit of
consensus around the principles, and even on some of the
actual strategies of what we will do. And I agree with the
comment that Paul said, and I think a lot of you echoed,
that getting the pricing right is important.
It is challenging because we have to balance the incentive for a program with fiscal integrity, which I care a ton about, with the incentives to actually have the vaccines developed, which I care a ton about. And so there's always this tension in new products between what you want to pay once you have them and what you want to pay before you do, and that's going to make this a particularly challenging thing for us to get into. That doesn't mean we should shy away from it. It comes up in a lot of other parts of our work, so we will do that.

But at least on the narrow question at hand, I think we agree that we want to have the widest access possible, and that seems to be promoted by Part B coverage without cost-sharing, and we will worry or think about or ponder the pricing concerns, as some of you have remarked on.

So that's where I am. I think we're through the queue, so I'm adding to the queue people, mandatorily in this case, so Wayne, do you want to comment quickly or briefly?

DR. RILEY: Yeah. Terrific work by the staff again. I have heard all the comments. I firmly favor
Option 1. And again, you know, the thing that gives me a little queasiness about all this is the low penetrance among black Medicare beneficiaries for, you know, flu, shingles, and pneumococcal pneumonia, which, to me, is a harbinger of how difficult it's going to be to get them to embrace a likely COVID vaccine. And, you know, I think we all know part of the vaccine headwind we're facing is the anti-vaccine sophistry bits in the public domain.

So to the extent that MedPAC feels that it can wade into that space, I think it would -- I agree with Paul. This is something that affects the health of beneficiaries, and it's something that MedPAC should find a way to articulate a strong recommendation to Medicare beneficiaries and to Congress that vaccines should be embraced more fully than we've ever embraced vaccines.

DR. CHERNEW: Thank you, Wayne. I agree. I think there's a lot of positive sentiment towards that view. Jaewon?

DR. RYU: Yeah, I agree with Option 1 as well, but also share people's concern around the pricing.

Thanks.

DR. CHERNEW: And that brings us, I think, to
you, Sue.

MS. THOMPSON: Thank you. And I too agree with Option 1. Again, thank you to the staff for your work on this topic. I also am intrigued with some attachment of adherence, in compliance to the measurements of participating in Medicare by our providers, although I just think that's worthy of more discussion. But I appreciate and want to call our Marge's passion in the opening of this discussion around the importance of us focusing on how do we improve the overall compliance to vaccination for this population.

So those would conclude my comments. Thank you.

DR. CHERNEW: Thanks, Sue. And if I followed correctly, Dana, you had something else that you wanted to say. Am I reading that right?

DR. SAFRAN: No. I did not.

MS. KELLEY: I think Bruce might have something else.

DR. CHERNEW: Okay. Bruce might have something else.

MR. PYENSON: Thanks. This is in response to the enthusiasm of this group, which I share, for promoting
vaccination. And for childhood vaccinations there is a
liability program that exists that encourages manufacturers
to produce vaccines. That does not apply, I believe, to
adult vaccines. And as that is something, if we can figure
out a way to make that part of MedPAC's response domain
relevance, I think would be useful to have staff look into
that.

DR. CHERNEW: Great. Thank you, Bruce. I
believe now we have not only made up for the deficit in
time from our wonderful telehealth discussion, but we are
now ahead of schedule. So I think that's great. It's been
a wonderful morning and wonderful meeting for me, so I want
to again thank all of you for your comments. I want to
really thank the public for tuning in, and I emphasize that
there's ways to reach out to us through the MedPAC staff,
and I think, Jim, you can talk about maybe on the website
to get their comments in. We do miss hearing them in
person.

And a double shout-out to the staff and all of
their work for both preparing this material, their terrific
presentations, and their willingness and skill at answering
all of our questions.
So that's really where I am. I'm going to turn it to Jim and Dana for their final thank-yous and goodbyes. Jim?

DR. MATHEWS: Oh, likewise. I appreciate everyone's engagement in the discussion. You have proven the fact that MedPAC is also able to relatively adapt to new circumstances and new technologies, and I thought this went very well, and you've given the staff a lot to work with as we head back next week.

And lastly, I would like to commend our new Commissioners and welcome you to, you know, what is going to be a six-year interesting, hopefully, experience for you. And in particular, Mike, you did a nice job in your first outing as chair. So thank you, everyone.

DR. CHERNEW: Thanks, Jim. Dana, anything to add?

MS. KELLEY: No. Thanks, everyone, and just let us know if you have any questions. The public can submit comments online, and we, of course, will review them as we receive them.

DR. CHERNEW: Okay. So thank you all. Enjoy the rest of your Friday, and if anything else, to the
Commissioners, comes to mind, don't hesitate to reach out to me. Thanks again and we'll be in touch.

MS. KELLEY: Great job.

[Whereupon, at 12:06 p.m., the meeting was adjourned.]