MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

VIA GO-TO-WEBINAR

Thursday, September 3, 2020
10:19 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
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
SUSAN THOMPSON, MS, BSN
PAT WANG, JD

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

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1 P R O C E E D I N G S

2 [10:19 a.m.]

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

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

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

22 So as in the public meetings in person, the way

1 this is going to work is we're going to start with a staff
2 presentation. Then we will have Commissioner comments and
3 interactions.
4 This first chapter is obviously on an incredibly
5 important topic, the coronavirus, and so I would simply
6 lead in by acknowledging the incredible hardships and work
7 that different people have done. An enormous amount of the
8 burden of COVID has fallen on Medicare beneficiaries, which
9 are our focus. And I think as we go through this meeting,
10 we can't forget the importance of the real group of people
11 we serve, which is the Medicare beneficiaries. And I'd be
12 remiss if I didn't call out an incredible appreciation to
13 providers across the country for all the work they have
14 done in hospitals and nursing homes and home health
15 agencies across the board, and the physicians, obviously,
16 in all of the areas that we touch. There has been
17 incredible dedication and really people putting themselves
18 at risk to provide care to people who need it, and I think
19 it's worth starting this meeting with some acknowledgment
20 of all of the work that they've done and all the
21 populations that have been really seriously affected by
22 COVID.

1 Sometimes you'll see our presentations are a bit
2 dry, which is fine. We are a congressional agency. But
3 understand that I know that all of the Commissioners,
4 myself included, are really understanding of the challenges
5 faced by the program and the beneficiaries, and these are
6 really extraordinary times.
7 Hopefully we'll all be again in person, but for
8 now thank you for joining us, and I'm going to turn this
9 over to Jeff Stensland and some other staff to go through
10 some information that we've compiled on the coronavirus
11 pandemic. So, Jeff, I'm turning it over to you.
12 DR. STENSLAND: Well, before I start, I want to
13 let the audience know that they can download a PDF version
14 of the slides by clicking on the handout button, which is
15 in the control panel on the upper-right-hand corner of the
16 screen.
17 This session is a status report on the effect of
18 the coronavirus on beneficiaries and providers. It is a
19 preliminary analysis using available data and is not a deep
20 dive into all of the ramifications of the pandemic. We
21 will continue to monitor data as it comes available.
22 Now, we are the Medicare Payment Advisory

1 Commission, so we will primarily focus on payment issues
2 and provider finances on the upcoming slides. But by
3 focusing on the financial side of the equation, that should
4 not minimize our respect for the human toll the pandemic
5 has had on patients and health care workers across the
6 nation.
7 In addition to the tragic effects on Medicare
8 beneficiaries, the pandemic has affected provider finances.
9 Today we will discuss the effect on Medicare beneficiaries
10 and then discuss the aggregate effects on the finances of
11 three sectors: hospitals, post-acute care providers, and
12 clinicians. We report aggregate effects on provider
13 finances. However, individual provider experiences will
14 vary. In addition, we are limited to available data, and
15 the comprehensiveness of the data varies by sector.
16 The effect of the coronavirus pandemic on
17 beneficiaries has been stark.
18 Studies estimate that 80 percent of the deaths
19 from COVID-19 in the United States have been in the 65 and
20 older population. In addition, over 40 percent of the
21 deaths have been among residents of nursing homes and
22 assisted living facilities. The pandemic is a Medicare

1 issue.

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

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

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

14 I will start by talking about hospitals. As you
15 know, hospitals' all-payer volume declined dramatically in
16 April. Based on reports from hospital systems, we roughly
17 estimate that hospital volume declined by about 40 percent
18 in April for the average hospital. By May, hospitals
19 reported a partial rebound in volume, with some hospitals
20 still reporting volumes 10 to 20 percent below the prior
21 year. In addition to public sources, we have been tracking
22 Medicare claims data for certain services such as hip

1 replacements. As you can see from the bottom row, Medicare
2 hip replacement volume declined dramatically, but then
3 rebounded largely by June of 2020.
4 By the end of March, it was clear that hospitals
5 would face clinical challenges and material declines in
6 revenue. In response, the Congress enacted on March 27th
7 $127 billion of grants through the CARES Act to hospitals
8 and other health care providers. Importantly, these grants
9 are designed to replace lost revenue. They are not limited
10 to helping hospitals facing losses. Because hospitals can
11 offset lost revenue with declines in costs, or at least
12 partially, the CARES Act created the potential for
13 hospitals with significant cost reductions to see profits
14 increase after factoring in CARES grants. Whether a
15 hospital experienced losses or profits in the second
16 quarter of 2020 will in part be determined by how far they
17 adjusted their costs as patient volume declined. We'll
18 illustrate this over the next couple slides.
19 The declines in volume caused hospitals to lose
20 money in April. The AHA estimated that COVID caused
21 hospitals' April profits to decline by almost $51 billion.
22 This number has been widely circulated in the press.

1 Throughout the summer we have been updating our estimates
2 as data becomes available and now estimate that hospital
3 profits would have declined by between $20 to $30 billion
4 in April if Congress had not provided grant funds. We
5 present a range of possible effects because there is
6 uncertainty as to how much providers reduced their costs in
7 response to their lower volume. Our estimate is about half
8 the AHA estimate, and it reflects our finding that revenue
9 losses were slightly smaller than the AHA assumed, and
10 there were some cost reductions at some hospitals. The
11 details of our methodology are in your mailing materials.
12 Another difference is the AHA assumed April-level
13 losses would also continue in May and June, bringing their
14 total loss estimate to $150 billion for the quarter. In
15 contrast with the AHA, we do not believe the April-level
16 losses can be extrapolated to May and June due to the
17 rebound in volume we discussed in our prior slide.
18 In aggregate, we estimate that enacted grant
19 funds and payment changes will in total direct almost $92
20 billion to hospitals. However, grant funds vary by
21 hospital because only certain hospitals receive the special
22 rural, hot spot, and safety net grants. On average, the

1 grants would cover about three to five months of April-
2 level losses. However, given that volume has partially
3 rebounded since April, the $92 billion of grant funds alone
4 should cover more than four months of most hospitals' COVID
5 losses. Now, that $92 billion can roughly be divided into
6 three buckets. It appears that about half that amount has
7 been received and booked by hospitals as income in the
8 second quarter. About a quarter of that $92 billion was
9 received by hospitals, but has not yet been booked on their
10 income statement. And there's about a quarter of the money
11 that the federal government still has not distributed.
12 It's been enacted but not sent out to providers.
13 Now, in this slide, I present the average effects
14 of COVID losses and grants across hospitals, but there's
15 substantial variation, as we're going to see on the next
16 slide.
17 We do not have complete data for how hospitals
18 performed financially in the second quarter of 2020.
19 However, we do have data from a sample of hospital systems.
20 Here we present data on three large nonprofit systems and
21 four large for-profit systems. The seven systems we
22 present here represent about 10 percent of all acute care

1 hospitals' revenue.

2 Let's start by looking at this first row. It
3 represents three large nonprofit systems. In aggregate,
4 their 2020 second quarter patient revenue (which excludes
5 grant funds) was about $1.5 billion lower than in 2019.
6 This was a 17 percent decline in revenue. In aggregate,
7 their expenses declined by $13 million. The "$65 million"
8 on the slide is a typo. But that only offset 1 percent of
9 their lost revenue. However, they booked $782 million
10 dollars in COVID grants in the second quarter, and this
11 offset 50 percent of their lost revenue. In the end,
12 operating income of these three systems declined in
13 aggregate by about $621 million compared to 2019. After
14 the CARES Act grants were accounted for, operating profit
15 margins in the three systems ranged from negative 13
16 percent for the quarter to positive 5 percent.

17 Next, look at the second line. Here we
18 aggregated data from the four largest publicly traded
19 systems. They had a $3.5 billion reduction in patient care
20 revenue in the second quarter of 2020 relative to the prior
21 year, and that was a 15 percent decline in revenue. This
22 is similar to the nonprofit sample. However, what differs

1 from the nonprofit sample is that the for-profit systems
2 all substantially reduced their expenses in the second
3 quarter. In aggregate, they reduced expenses by $2.3
4 billion, and this offset 65 percent of their lost revenue.
5 In addition, they booked grants equal to 56 percent of the
6 lost revenue. Because the combination of expense
7 reductions and grants offset more than 100 percent of the
8 lost revenue, all four systems saw an increase in profits
9 relative to the prior year in 2020. In aggregate, their
10 operating profits increased by $634 million. The ending
11 operating profit margins varied among the systems from a
12 low of 1 percent to a high of 14 percent. I should also
13 note that these systems all still have some remaining grant
14 funds available for the third quarter.
15 As you can see, the big difference in the two
16 groups of hospitals was not in the reduction of revenue or
17 in the federal grants. The big difference was in how much
18 they reduced costs in response to the decline in revenue.
19 Due to this variability in cost reductions across the
20 systems and incompleteness of data at this point, there's
21 still some uncertainty as to the hospital industry's
22 overall financial condition in that second quarter.

1 Now, Kathryn will discuss the effect of the
2 pandemic on nursing homes.
3 MS. LINEHAN: Hi. Can you hear me okay?
4 [Heads nod.]
5 MS. LINEHAN: Okay. I'm going to review what we
6 know about volume, cost, and revenue for post-acute care
7 settings during the pandemic period. Much of the
8 information about volume and financial effects on post-
9 acute care providers comes from publicly traded companies'
10 SEC filings and investor calls.
11 The impacts of the coronavirus pandemic on volume
12 have varied by setting. The recovery of PAC volume will
13 depend, in part, on recovering hospital volume and will
14 likely vary by market and provider type.
15 Home health agencies and inpatient rehabilitation
16 facilities experienced volume declines during the first
17 quarter of 2020 in the 20 to 30 percent range, largely due
18 to the cancellation of elective surgeries. Publicly traded
19 home health agencies and IRFs reported that volume began to
20 slowly recover in April and had reached at least 95 percent
21 of pre-pandemic levels by late June.
22 Nursing facility volume declined an estimated 10

1 percent from January through May 2020 according to data
2 analyzed by the Wall Street Journal. This reduction was
3 the result of fewer hospital referrals, moveouts, and
4 deaths. Evidence suggests volume has not bounced back,
5 with data from the National Investment Center for Senior
6 Housing showing continued though less dramatic declines
7 through the second quarter. Some volume in nursing homes
8 may not return or may be slower to return than in other
9 sectors if beneficiaries opt to avoid this setting.
10 Turning to long-term care hospitals, the largest
11 publicly traded LTCH company reported a less than 1 percent
12 increase in admissions, so basically flat, and a more than
13 5 percent increase in patient days for the first half of
14 2020 compared to the same period in 2019. Occupancy rates
15 for this company were up in 2020 and have been steady
16 through June.
17 Some of the volume effects shown on the previous
18 slide were likely related to temporary policy changes that
19 affected Medicare payments for LTCHs and SNFs.
20 For LTCHs, CMS waived the site-neutral policies
21 and the required share of stays meeting LTCH criteria. As
22 a result, all LTCH stays are being paid the higher LTCH

1 rates for the duration of the public health emergency.
2 For SNFs, a temporary waiver of the three-day
3 prior hospitalization requirement provides Medicare
4 coverage of SNF services for beneficiaries affected by the
5 emergency. In addition, certain beneficiaries who
6 exhausted their SNF benefits may renew SNF coverage without
7 a 60-day period of non-inpatient status normally required.
8 Publicly traded companies reported these policies had a
9 material and positive impact on their payer mixes.
10 Post-acute care providers have faced increased
11 costs and have also received additional revenue in the form
12 of federal payments, grants, and loans.
13 In terms of costs, SNFs and LTCHs have incurred
14 higher staffing costs as a result of overtime, the use of
15 agency staff, heroes pay, and the need to conduct many
16 tasks one-on-one. Home health agencies reported overall
17 lower staffing costs for the period because their visit and
18 episode volumes declined.
19 Post-acute care providers have incurred higher
20 costs for personal protective equipment, testing, and
21 cleaning. Some SNFs and LTCHs incurred additional costs to
22 establish isolation units. Nursing homes have continued to

1 report a shortage of PPE and testing.

2 The overall magnitude of PPE, supply, and
3 staffing cost impacts have been difficult to quantify.
4 Some industry estimates may be anecdotal or the costs cited
5 may be temporary, and the extent to which reported costs
6 are generalizable and how they vary geographically or over
7 time are still unclear.

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

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

22 Similar to what we did in hospitals, we estimated

1 nursing homes' profit losses and compared those losses to
2 enacted federal relief, but in the case of nursing homes we
3 used some -- we used available but, in some cases, scant
4 data on volume and cost effects due to the pandemic. The
5 data sources and our assumptions, including how our
6 assumptions about costs vary from higher industry
7 estimates, are detailed in your mailing materials.
8 Taking into account volume reductions, the impact
9 of policy changes on payer mix and cost increases for
10 supplies, personal protective equipment, testing (for staff
11 and patients), and labor, we estimate profit losses of a
12 little less than $2 billion per month starting in March.
13 And we estimate that enacted federal support (not counting
14 loans) has offset profit losses for about eight and a half
15 months.
16 I want to note again that this estimate compares
17 aggregate losses to aggregate federal support and
18 acknowledge the variation in the impact of COVID-19 on
19 nursing homes as different parts of the country have
20 experienced outbreaks since March and nursing home cases
21 have in some places increased again in August. Evidence
22 from two large nursing home providers illustrates the

1 uneven and uncertain effects of the coronavirus pandemic on
2 nursing home providers' finances -- with one unsure it will
3 last the year and another returning all federal funds.
4 Sam is now going to tell you about physicians and
5 other health professionals.
6 MR. BICKEL-BARLOW: Similar to other sectors,
7 clinicians saw large reductions in the volume of services
8 provided, starting in March, as many beneficiaries avoided
9 potential exposure to the virus at the doctor's office.
10 However, over the next few months, clinicians' volumes
11 steadily recovered, in many cases returning to pre-pandemic
12 levels by June. Clinicians have received significant
13 federal grants, loans, and payment increases in response to
14 the pandemic, which have helped to offset a majority of the
15 revenue lost from March to May.
16 Office visits from Medicare beneficiaries
17 declined rapidly during the first few weeks of the
18 pandemic, but over the next few months they steadily
19 recovered to pre-pandemic levels.
20 This chart shows the change in Medicare office
21 visits from mid-February to mid-July. All office visits
22 (shown by the red line) declined rapidly in March. At its

1 nadir, weekly visit volume was at 2.4 million -- about half
2 its usual volume.
3 If we set aside telehealth visits and just look
4 at in-person visits (shown by the green line), we see even
5 steeper declines.
6 Telehealth visits, which account for the
7 difference between these two lines, partially offset the
8 decline in in-person visits. Telehealth visits increased
9 rapidly from early March through mid-April, but have
10 declined somewhat since then.
11 Medicare beneficiaries were not the only ones
12 avoiding the doctor's office. This chart uses Phreesia's
13 all-payer data to track the impact of the coronavirus
14 pandemic on outpatient visits at ambulatory care practices.
15 It shows that different types of payers saw strikingly
16 similar utilization trends, with visits declining in March
17 before steadily recovering over the next few months.
18 Though the general trend in volume of visits
19 among different payers is similar, clinicians saw a
20 relatively larger drop in their volume among Medicare
21 patients. But visits among Medicare beneficiaries also
22 rebounded more quickly than patients covered by other

1 payers.

2 Corresponding with the fall in patient volume,
3 clinicians also experienced a fall in their revenue.
4 However, the fall in revenue was not as large as the fall
5 in utilization.

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

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

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

22 To help offset some of those losses, Congress and

1 CMS have advanced billions of dollars in grants, loans, and
2 payment increases during the public health emergency to
3 clinicians through a number of programs and policies.
4 We estimate nearly $5 billion has gone directly
5 to clinicians through the Provider Relief Fund. We also
6 estimate that about $26 billion of Paycheck Protection
7 Program funds went directly to clinician offices. The
8 loans do not need to be paid back if at least 60 percent of
9 the loan was used for payroll costs.
10 In addition, Congress suspended the 2 percent
11 sequestration payment reduction for the remainder of the
12 year, which should result in an additional $1 billion
13 reaching clinicians.
14 It is also worth mentioning that through changes
15 to telehealth payment policy, clinicians have been
16 temporarily able to bill for a variety of additional
17 telehealth services, including audio-only visits, and
18 payment rates for these services have been temporarily
19 increased to rates for in-person visits.
20 Our presentation this morning has focused on the
21 utilization, cost, and provider revenue effects of the
22 coronavirus pandemic. We want to conclude by again

1 acknowledging that the pandemic has imposed costs and had
2 tragic effects on Medicare beneficiaries and health care
3 workers.
4 Though the currently available data we presented
5 has limitations, particularly in some sectors, we have
6 found that the aggregate level of federal subsidies and
7 policy changes have allowed providers to weather the
8 financial impacts of the coronavirus pandemic. However,
9 the experience of individual providers may vary
10 considerably.
11 We will continue to monitor the impact of the
12 coronavirus pandemic on beneficiaries and providers to
13 inform payment update recommendations. We ask you to
14 provide any suggestions about tone, content, or anything we
15 should know as we continue to follow this evolving
16 situation.
17 Now I'll turn it over to Mike.
18 DR. CHERNEW: Great. Thanks, Sam, and to the
19 other presenters.
20 Because of the time and because this is largely
21 an informational session as opposed to something that's
22 going to have particular recommendations associated with

1 it, we're going to skip Round 1 and really just go to Round
2 2 questions. So, Pat, I'd asked if you had some
3 reflections or thoughts on this, and so maybe I'll turn to
4 you first, followed by Jaewon.
5 MS. WANG: Okay.
6 MS. KELLEY: Before we get started, can I just
7 remind people to please keep your mics off unless you're
8 speaking. Thank you.
9 MS. WANG: I'm happy to kick off the comments.
10 So I think it was a great chapter and again, you know, as
11 usual would commend the staff for all of the work done
12 here. My overall comment, I guess, has to do with whether
13 it is possible, as you continue to do this work, to focus
14 in more on Medicare impacts. As was stated at the outset,
15 this is really a Medicare -- you know, COVID hit the
16 Medicare population so deeply, and so while we're viewing
17 the overarching picture of where the money from the CARES
18 Act went, I'm hoping that particularly to inform payment
19 update and other discussions going forward we can focus in
20 a little bit more on where the Medicare money went.
21 So the first comment is just it's amazing how
22 quickly Medicare responded to send money into the system.

1 The release of the sequester, the 20 percent inpatient
2 COVID bump, you know, telehealth payment, SNF relaxation,
3 LTCH payment, you know, across the board I think it should
4 be noted how quickly and fully the Medicare program
5 responded to try to get money in.
6 I think the next question, though, is where did
7 the money go, I mean, especially certainly if you're
8 talking about a COVID inpatient bump, you know, by
9 definition it went to hospitals treating COVID patients.
10 But the rest of it I think was just overall payment policy,
11 so it would be helpful, I think, to understand in aggregate
12 how much money went out the door and the correlation, if we
13 can, on an ongoing basis to understand its correlation to
14 places that actually have a lot of COVID burden.
15 There were a couple of slides in there about lost
16 hospital revenues and the reductions comparison in expense
17 reduction between not-for-profit and for-profit systems,
18 which are just staggering to me. And I have a feeling that
19 other people will comment on those. But, again, sort of on
20 Slide 6, the estimates of reduced operating profit
21 obviously is a combination of lost revenue and increased
22 cost. I think it would be helpful to understand more about

1 the Medicare picture here. A lot more Medicare money went
2 into the system, so was the revenue loss -- whether it's
3 the AHA estimate or the MedPAC estimate, what was the
4 composition of the revenue loss Medicare versus non-
5 Medicare? And if it's even possible to parse the expense
6 increases or reductions, same story.
7 I would love to see more information on the
8 impact on beneficiaries regarding sort of where -- within
9 the intense impact on the Medicare population within the
10 Medicare population on communities of color, on low-income
11 communities, on communities with other characteristics. I
12 think that a very big story that COVID has exposed is just
13 how vulnerable folks in those categories were to really
14 being at the top of the pyramid, the first to get hit by
15 this, devastating. I think that we have an obligation in
16 the Medicare program to understand more about that because
17 it should inform our thinking about social determinants of
18 health, social disparities, and so forth.
19 You know, and I guess that the -- just two quick
20 comments. So from a Medicare Advantage perspective, the
21 notable thing is all of these impacts are a little
22 different if folks are in value-based payment arrangements.

1 And I know that this is a priority for the Commission, but,
2 for example, primary care physicians who were in capitated
3 arrangements saw no change in their revenue. So sort of
4 the information on the impact on physicians looks a little
5 different if you're talking about providers in value-based
6 arrangements, similarly for those in value-based
7 arrangements where certain expenses went down, especially
8 on the commercial payer side. The benefits of those
9 surpluses might well have gone back to the delivery system
10 by virtue of contracts, and so I think that we have to keep
11 our focus on the impact and the importance of value-based
12 payment to keep money in the health care system.
13 A final quick comment. The things that have
14 emerged from COVID and which are evident in this
15 presentation about changes in utilization, et cetera, SNF
16 utilization, for example, I'm hoping that when we get to
17 the payment update portion of our work this year that we
18 can develop some sort of framework of understanding what is
19 the future of the different sectors and the utilization of
20 the sectors, because if folks are not really -- if we think
21 people are not really going to return to certain types of
22 institutional settings, how should we be thinking about

1 that in a payment update? How should we be thinking about
2 the alternative types of care that they might seek for
3 their needs and where changes in utilization might occur as
4 a result of COVID?
5 Thanks.
6 DR. CHERNEW: Thanks, Pat. And now we have 10
7 minutes left, and there are a lot of faces on my screen.
8 So we're going to have to be pretty concise in our
9 speaking. So we're going to go to Jaewon, and then we'll
10 start working through the queue. Jaewon.
11 DR. RYU: Sure. Thanks, Mike. First of all, a
12 big shout-out to the folks who put together the chapter.
13 It's a really complex area, very nuanced, and worse yet,
14 it's quickly evolving. So I thought it was just a great
15 job of amassing a lot of information.
16 At the same time, I think the question Pat raised
17 is exactly the right one. It begs the question of where
18 did these funds go and did it match up well with what the
19 impact was and the dynamics at play.
20 I think to answer that question, it would be
21 helpful to have maybe one deeper layer, one more step to
22 try to get into that a little bit more. And I have a

1 couple areas in particular where I think it might be
2 beneficial to dig into.
3 One is around the timing of the hot spot areas,
4 when COVID kind of made its way through, and how that
5 matches up geographically with the footprint of, you know,
6 the seven systems that you had evaluated -- the four for-
7 profit publicly traded and then the three that were not-
8 for-profit. And you could probably even include more into
9 that not-for-profit mix because as those financials start
10 coming out more publicly, I think there's an opportunity to
11 incorporate more of that picture into evaluating did they
12 have essentially a differential experience, which I believe
13 they may have based on that geographic footprint.
14 Number two is payer mix, and I think you make a
15 reference to the payer mix susceptibility on page 14 of the
16 materials in the chapter. But I think it's also helpful to
17 look at both pre-COVID and post-COVID, those same systems
18 that you looked at, what was the payer mix? Because we all
19 know that preparedness and the cost associated with that is
20 very different for populations that are more vulnerable.
21 And so to the extent that the for-profit systems you looked
22 at have an underlying different payer mix and a different

1 patient population, I think their ability to quickly adapt
2 from a cost structure or cost reduction standpoint is
3 fundamentally different than folks who are really grappling
4 with populations that are vulnerable, that have greater
5 needs, and trying to manage through the pandemic in light
6 of that.
7 Number three, I had a question around the
8 intensity of services. There's a lot of focus on the
9 volume. I think it would be helpful to understand
10 intensity, because even as we start seeing a recovery, I
11 think the persistence of that recovery is a big question
12 mark. And there's a belief out there that maybe a lot of
13 this is just working through a pent-up backlog versus how
14 much of the demand will actually stick. And intensity will
15 also shed some additional light on that.
16 And then, lastly, I think getting back to the
17 not-for-profits space -- and I think this is exactly the
18 slide -- even within the not-for-profits there probably is
19 further segmentation between, you know, whether it's
20 academic medical centers and other nonprofits; but as
21 audited financials come out, I think we continue to see in
22 the media coverage of big nonprofit systems who have had a

1 significantly different experience than what's been shown
2 in the for-profit space. And I think the cost or the
3 ability to reduce cost is one driver of that, and I think
4 you lay that out really well. But I suspect there are
5 others that it would be helpful to try to dig into.
6 Thanks.
7 DR. CHERNEW: Great. Thanks, Jaewon. Terrific
8 comments.
9 Dana is keeping the queue. I think there's about
10 seven or eight people. We have about seven or eight
11 minutes. So let's try and be efficient, and I look forward
12 to all your comments. So, Dana, I'm going to turn it over
13 to you to call out the order that you have people in.
14 MS. KELLEY: Okay. Jon Perlin, you're next.
15 DR. PERLIN: Okay. Can you hear me?
16 MS. KELLEY: Yes.
17 DR. PERLIN: Okay. I just have comments from the
18 perspective of a system that's now treated over 60,000
19 COVID-positive inpatients, done over a million tests,
20 treated over 120,000 outpatients. Let me first start by
21 saying, as, you know, a larger investor-owned system, it's
22 pretty clear there's maldistribution of dollars, and I

1 think Jaewon has hit a number of the reasons why that's
2 true in terms of the geographic variability of the impact
3 of COVID.
4 I think it's also important to contextualize that
5 this is a pretty scary time. There was a period before the
6 CARES dollars started rolling where no one was quite sure
7 where things were going.
8 You know, many of the cost-cutting measures are
9 simply not sustainable. In our organization, the volumes
10 were so reduced, we kept 130,000 staff paid despite the
11 fact they were not working at the hospitals, and
12 essentially mothballing those assets for that period of
13 time is obviously not sustainable.
14 I think it's also important to recognize, perhaps
15 especially for Medicare beneficiaries, that not all of the
16 forgone care was low-value care. We saw decrements in
17 presentations for acute coronary syndrome, stroke,
18 complications of diabetes. We had reports of emergency
19 medical responders really arriving to patients in extreme
20 circumstances, increased rates of mortality there. So
21 these are very difficult issues.
22 This issue about geographic variation is

1 particularly acute, and I think that is the big challenge
2 of this chapter. It reminds me of my favorite Lincoln
3 quote: "The man with his hair on fire and his feet in ice
4 water is on average comfortable." Well, there is no
5 average here, and in our own organization there was a point
6 with the resurgence of COVID where we suspended all
7 elective procedures in the State of Florida for a period of
8 time. And I think that's the lens with which we have to
9 re-approach what comes next in terms of this pandemic and
10 any future preparation.
11 I think one other thing that's not mentioned is
12 that by virtue of that geographic variability, the
13 situational variability of the institutions themselves.
14 There's a mention about, you know, some mechanisms for
15 relaxation of accelerated repayment, because coming out of
16 this, many facilities will be very financially damaged and
17 unstable. I think in terms of assuring adequacy of access,
18 that's one of the issues that should be addressed.
19 So putting it all together, I think, you know,
20 these were extraordinary emergency measures. To some
21 degree, they may have missed the target, but we have the
22 opportunity now to use a scalpel and not a sword going

1 forward.

2 Thanks.

3 MS. KELLEY: Okay. Brian, you're next.

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

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

19 The other comment I want to make just on Chart
20 13, and it was in the reading material as well, the speed
21 that telehealth medicine ramped up, I mean, we went
22 dramatic increases in things like three weeks. My one

1 recommendation there would be the next time we're as a
2 Commission discussing a phase-in period, I think it might
3 help us to remind ourselves that providers can respond with
4 three weeks when pressed. So I think ten years versus
5 three weeks, we might be able to split the difference.
6 Then my final comment -- and, again, Pat touched
7 on this -- I really commend CMS on getting that money out
8 quickly, you know, very effective in what they did. I do
9 hope that we'll spend some developing a reconciliation
10 process to make sure that the money went to the right
11 places and that it was targeted. The money's out there
12 now. I do hope we get a chance to go looking for it and
13 make sure that it all landed in the correct place. And
14 then, furthermore, I think this is a great opportunity for
15 us as a Commission to help develop a plan for how funds
16 could be distributed in the future. I think there's an
17 opportunity here to be more prospective should a public
18 health emergency like this occur again.
19 Thank you.
20 MS. KELLEY: Okay. Amol?
21 DR. NAVATHE: Thanks for a great chapter. I'm
22 going to try to be really brief here, picking up on a

1 couple of comments.
2 So I totally agree with the idea that aggregates
3 can be misleading sometimes and aggregates can hide. So I
4 would support not only looking at this from a geographic
5 variation perspective but variation across multiple
6 dimensions. And we have some evidence from my own research
7 group and others that the way that COVID relief payments
8 actually ended up working out didn't necessarily go
9 prioritized with need per se, and so I think looking at
10 geographic variation, looking at variation based on COVID
11 impact, variation based on public health responses, for
12 example, community needs, community-served populations, as
13 Pat said, looking at the Medicare side versus all-payer, I
14 think these sorts of dimensions may really help us get a
15 slightly more nuanced view of what's happening in
16 communities that really had need were impacted.
17 Thanks.
18 MS. KELLEY: Karen.
19 DR. DeSALVO: Thank you, Dana, and thanks again
20 to the staff. I just want to put a pin in the potential
21 value of us looking at providers who were supported by
22 global payments and for beneficiaries to understand whether

1 that was a stabilizing factor and also a factor in people
2 continuing to have access to care for chronic conditions or
3 preventive care.
4 What I wanted to also ask about was whether there
5 was an opportunity to understand the impact on primary care
6 practices since there's been quite a lot of concern in the
7 primary care community about the potential closure of
8 primary care practices because of the lack of revenue and
9 the difficulties in shifting practice model as quickly as
10 some of the larger organizations did, so really thinking
11 more about independent primary care practices. I know it's
12 a small part of Medicare, but it's a really important part
13 of access to care.
14 Thanks.
15 MS. KELLEY: Okay. Bruce?
16 MR. PYENSON: Thank you, and my compliments to
17 the staff. I wanted to amplify the point that Brian made
18 about phase-ins. I think one of the lessons of this
19 incredible shock to the system is the resilience of many
20 sectors of the health system. This shock was many times
21 the magnitude of the changes in reimbursement that we
22 typically talk about, perhaps orders of magnitude worse.

1 And to think about the responsiveness of many sectors of
2 the system to that and how they were able to respond is in
3 contrast to the phase-in that we typically build into
4 relatively minor changes by comparison.
5 Later in this session we're going to see one of
6 the examples of that in the laboratory reimbursement and
7 how there had been a long phase-in of relatively small
8 changes relative to what we've been through. So let's keep
9 that lesson in mind when we think about changes that are
10 needed and whether a phase-in -- how fast the phase-in
11 should be.
12 Thank you.
13 MS. KELLEY: David.
14 DR. GRABOWSKI: Thanks, Dana, and thanks to the
15 staff for a great chapter. So we know that COVID had been
16 particularly devastating for post-acute care settings. I
17 would love to see us continue to unpack the importance of
18 the relief funds versus the importance of some of the
19 waiver changes that also occurred, such as the changes in
20 the LTCHs with site-neutral payment and with skilled
21 nursing facilities the relaxation of the three-day rule.
22 The chapter introduced this great term, "skilling

1 in place" for SNFs, where they could actually deliver post-
2 acute care without a three-day stay, just convert over a
3 long-stay nursing home resident to skilled status. And
4 they also don't need to have that 60-day window in between
5 episodes. So, conceivably, you could have 200-day SNF
6 episodes back to back. How much is this occurring? Has
7 this been important? I think we're going to get a great
8 window into sort of the responsiveness once again of the
9 post-acute care sector. And I've had a lot of folks over
10 the years tell me we don't need the three-day rule. I'll
11 be really curious to see how much this was utilized and how
12 it was utilized by the different post-acute care providers.
13 So I'll stop there. Thanks.
14 MS. KELLEY: Okay. Larry.
15 DR. CASALINO: There it goes. One thing that was
16 really striking to me was that net revenues after the funds
17 that were pushed in by the government for hospitals and a
18 lot of long-term care or post-acute facilities looked
19 pretty good, at least in the time period studied, and much,
20 much, much less money was shoveled out to physicians whose
21 revenues probably don't look so good. And I can easily
22 understand how that could have occurred, probably for some

1 good reasons and some bad reasons. But the difference is
2 striking. Some hospitals are going to be better off,
3 whereas just about all physician practices are going to be
4 worse off. This may lead to some of them closing, as Karen
5 suggested, for primary care. But it's also, I think, very
6 possibly going to lead to a further acceleration of the
7 trend for hospitals and health insurance companies and
8 private equity firms to acquire physician practices, which,
9 having gone through what they just went through, may be
10 quite happy to be acquired, get a little shelter from the
11 next storm. And this will cost Medicare money. There's
12 pretty good data to show what happens when physician
13 practices are acquired by hospitals, for example. Private
14 equity firms, we don't know yet. But I think the failure
15 to support physician practices as well as other health care
16 providers I think is going to lead to further huge
17 demographic change in the health care system that probably
18 will cost Medicare money in the short and long run.
19 MS. KELLEY: And last, we have Sue.
20 MS. THOMPSON: Thank you, Dana, and thank you to
21 the staff for this very good chapter. I wanted to make a
22 comment about your notation of low-value care, and I think

1 we're in a very unique time when we saw such a dramatic
2 reduction in utilization, whether it was elective
3 procedures, whether it was preventative care, whether it
4 was some of the low-value procedures that at MedPAC we have
5 spent time talking about, you know, whether or not we
6 should continue to even fund. I just think there's a real
7 interesting opportunity in this time to study what that
8 impact might have been, whether it really was unneeded, or
9 perhaps if we're going to see the severity of conditions,
10 as has been well described by my previous peers, and I
11 wanted to just make a notation in this transcript of that
12 opportunity.
13 That would conclude my remarks. Thank you.
14 MS. KELLEY: Okay, Mike.
15 DR. CHERNEW: Great. So you've probably noticed
16 we're about seven minutes behind. We're going to jump
17 right into the context chapter with Rachel and Molly. It
18 looks like we can do that pretty quickly. So I will not
19 take much more time except to say depending on how long
20 this goes, we may again, because this is largely an
21 informational chapter, combine Rounds 1 and 2 to help us
22 catch up on some of the time. But, with that, Rachel and

1 Molly, why don't you take it away?

2 MS. BURTON: Thanks. Good morning.

3 Before I begin, I want to point out for the

4 audience that a PDF version of these slides can be

5 downloaded from the "Handout" section of the webinar's

6 control panel.

7 In the last presentation, we talked about the

8 coronavirus pandemic -- THE contextual factor to be aware

9 of in the short term.

10 In this presentation, we'll shift to the long

11 term -- focusing on Medicare's financial situation today

12 and what it could look like in the future if spending

13 trends continue.

14 I'll note that data sources used in this

15 presentation to project future-year trends generally do not

16 yet incorporate the effects of the coronavirus pandemic, so

17 some adjustments to these projections will eventually be

18 made.

19 This presentation is intended to be contextual

20 information for Commissioners to consider as they weigh

21 payment policy changes this cycle.

22 This information will also be included in our

1 March report to the Congress, to accompany our annual
2 payment update recommendations.
3 In this presentation, I'll describe overall
4 trends in health care spending and then focus in on trends
5 in Medicare spending.
6 I'll then explain how this spending trajectory
7 strains Medicare's three main funding sources and talk
8 about what's driving Medicare's spending growth.
9 For decades, health care spending has grown as a
10 share of the U.S.' GDP.
11 Total health care spending now consumes twice the
12 share of our country's GDP as it did 45 years ago, rising
13 from 7.9 percent of GDP in 1975 to 18 percent in 2020.
14 Private health insurance spending has more than
15 tripled over this period, and so has Medicare spending.
16 When we look at spending per enrollee in more
17 recent years, we find faster growth in spending per
18 privately insured individual, which has grown 24 percent
19 from 2014 to 2018.
20 In contrast, Medicare spending per beneficiary
21 has only grown 10 percent over this same period.
22 Increasing prices paid by private insurers have

1 been largely responsible for this faster spending growth --
2 which occurred at a time of relatively flat growth in
3 health care utilization for the privately insured.
4 That being said, Medicare spending is
5 nevertheless increasing and is projected to nearly double
6 in the next ten years -- rising from $782 billion in 2019
7 to $1.5 trillion by 2029.
8 Medicare constituted 14-1/2 percent of federal
9 spending in 2019 and is expected to grow to 17-1/2 percent
10 by 2029. Spending on the Medicare program alone is already
11 equivalent to 3.9 percent of the country's GDP.
12 Medicare is primarily financed through three
13 revenue sources: the Medicare payroll tax, shown in blue;
14 other general tax revenue, shown in orange; and premiums
15 paid by beneficiaries, shown in red.
16 I'll talk about each of these one at a time,
17 starting with the Medicare payroll tax. This is a tax that
18 is collected from workers and their employers and deposited
19 into Medicare's Hospital Insurance Trust Fund, which pays
20 for Part A services.
21 Over time, the number of workers in the U.S. has
22 not grown as fast as the number of Medicare beneficiaries.

1 As this graph shows, there were four-and-a-half workers per
2 beneficiary around the time of the program's inception, but
3 that ratio has now fallen to just three workers per
4 beneficiary.
5 In the next ten years, this will decline further,
6 to just two-and-a-half workers per beneficiary. As a
7 result of this declining ratio, the Medicare trust fund
8 that relies on workers' payroll taxes was previously
9 projected to become insolvent by 2026. However, just
10 yesterday CBO announced that it's now expecting the trust
11 fund to become insolvent two years sooner, in 2024.
12 I should note that Medicare already spends more
13 on Part A services than it collects through the trust fund.
14 The only reason the trust fund hasn't already been declared
15 insolvent is it carries forward a surplus each year,
16 leftover from years when trust fund revenues exceeded Part
17 A spending. In recent years, this surplus has been
18 dwindling, and within the next few years, the surplus will
19 be depleted -- meaning the trust fund will be operating at
20 a deficit, unable to fully cover its obligations each year.
21 At that point, payments to providers would be reduced to
22 levels that could be covered by incoming revenues.

1 However, lawmakers have never let this happen.
2 To keep the trust fund solvent over the next 25
3 years, the Medicare Trustees estimate that either the
4 payroll tax would need to be increased immediately from its
5 current rate of 2.9 percent to 3.7 percent, or Part A
6 spending would need to be reduced by 17 percent, which is
7 equivalent to nearly $1,000 per beneficiary per year.
8 The next funding source I'll talk about is
9 general tax revenues, which help pay for Part B and Part D
10 services.
11 Since the federal government spends more than it
12 collects each year, Medicare's general revenue transfers
13 are partially funded through federal borrowing -- which
14 pushes the country's debt up.
15 To unpack what I just said, this graph shows
16 spending on Medicare and other federal programs layered on
17 top of each other.
18 The top red line shows the total amount of
19 federal spending for all programs as a share of the
20 country's GDP. The green line, below it, shows the amount
21 of revenues the country collects to pay for this spending.
22 The key takeaway from this graph is that Medicare

1 spending, shown in dark red on the bottom, makes up a
2 substantial share of federal spending. So as Medicare
3 spending grows, it pushes the amount we need to borrow up.
4 By 2038, which is shown with the vertical white
5 line in the middle of this graph, spending on Medicare,
6 other health programs, Social Security, and net interest
7 will equal total federal revenues.
8 This now brings us to Medicare's third main
9 source of funding, which is beneficiary premiums.
10 In original fee-for-service Medicare, there are
11 no premiums for Part A hospital coverage, but the annual
12 cost of premiums for Part B is $1,735 in 2020, and premiums
13 for Part D coverage average another $372.
14 Beneficiaries also face cost sharing, not shown
15 in the prior graph. Cost sharing in original Medicare
16 averaged $415 for Part A services in 2018, $1,513 for Part
17 B services, and $432 for Part D drugs.
18 Taken together, beneficiary spending on premiums
19 and cost sharing consumed 24 percent of the average Social
20 Security benefit in 2020, which is up from 14 percent in
21 2000.
22 The Medicare Trustees estimate that in another 20

1 years, premiums and cost sharing will consume 31 percent of
2 the average Social Security benefit.
3 So now that we've established that Medicare
4 spending is increasing at an unsustainable rate, it's worth
5 asking: What are the factors driving Medicare spending
6 growth?
7 One way to try to answer this question is to
8 split the program into its main parts and look at spending
9 per beneficiary over the last ten years.
10 When we do that, we find that the type of
11 spending that has grown the fastest is actually Medicare
12 Advantage, which now costs about a thousand dollars more
13 than original Medicare per beneficiary.
14 We also find that Medicare Advantage spending per
15 beneficiary has been accelerating since 2014. The
16 relatively faster growth in Medicare Advantage spending per
17 beneficiary may reflect three things.
18 First, there's been an increasing share of
19 enrollees in MA plans receiving higher payments due to
20 their quality bonus status.
21 Second, plans have been reporting more diagnoses
22 -- leading to faster risk score growth for MA enrollees

1 than for beneficiaries in original Medicare.
2 And, third, there's been MA enrollment growth in
3 areas of the country with relatively high MA payments, such
4 as counties where benchmarks are set at 115 percent of
5 original Medicare's spending levels.
6 Another way to decompose Medicare spending is by
7 looking at how much of the average annual expected growth
8 in spending is driven by enrollment growth and how much is
9 driven by growth in spending per beneficiary.
10 The Medicare Trustees and CBO project that over
11 the next ten years, growing Medicare enrollment will
12 account for only two percentage points of Medicare's 7
13 percent average annual expected growth rate. This is shown
14 in the green portion of the bars in this figure.
15 The larger driver of Medicare's spending growth
16 is spending per beneficiary, (shown in red), which will
17 account for four to five percentage points of the program's
18 average annual expected growth rates.
19 Spending per beneficiary captures both increases
20 in the quantity of health care services used and increases
21 in the prices Medicare pays for these services.
22 As the largest payer in the country, Medicare

1 unilaterally sets the prices it pays, which has enabled the
2 program to restrain price growth in a way that private
3 insurers have struggled to do.
4 To try to restrain the quantity of services used,
5 Medicare primarily uses alternative payment models, which
6 I'll talk about next.
7 Alternative payment models, or APMs, are usually
8 voluntary payment approaches that give providers an
9 incentive to practice more efficiently.
10 APMs are usually layered on top of original
11 Medicare's existing fee-for-service payment systems and
12 give providers incentives to more closely manage and
13 coordinate their Medicare beneficiaries' care in order to
14 keep them healthy and reduce the need for costly hospital
15 admissions.
16 The most prominent types of APMs are accountable
17 care organizations, bundled payment models, and advanced
18 primary care models.
19 In ACOs, CMS offers groups of providers bonuses
20 if they can keep their beneficiaries' spending below a
21 target, while maintaining care quality over a one-year
22 period.

1 Bundled payment models differ from ACOs in that
2 they cover a shorter period of time associated with a
3 particular episode of care, such as a hip replacement.
4 Advanced primary care models typically offer
5 primary care providers supplemental monthly payments per
6 beneficiary to expand the breadth and depth of services
7 they deliver and also offer bonuses based on performance on
8 quality measures. We will be talking more about APMs
9 throughout the upcoming meeting cycle.
10 With that, I welcome your questions and your
11 guidance on finalizing the chapter for inclusion in the
12 March report.
13 DR. CHERNEW: Great. Thank you both so much.
14 That is really interesting. It is a sobering presentation
15 to be sure.
16 Before we go to the comments, I do, given the
17 sobering nature of this, want to make one comment for the
18 broad public audience, and that is, it is obvious to
19 anybody that the fiscal situation in Medicare is an
20 enormous concern. It was a concern before COVID. It is
21 certainly a concern after COVID.
22 That said, it's important to understand that our

1 criteria, MedPAC's criteria, when we make our update
2 recommendations, include things like access to care,
3 quality, things like that. We do not have nor are we
4 driven by a specific budget target. I sometimes say in
5 private, I guess now in public, we are MedPAC not IPAC.
6 That being said, it is central to our work to
7 promote efficient payment, and you will see, I think,
8 through the coming presentations today and future meetings
9 that we are very dedicated to finding payment models and
10 other program modifications to promote efficient delivery
11 of care, and what you should take away in part from this
12 presentation is given the financial situation that we are
13 in, there is a never more important time or more salience
14 that we be successful in promoting efficiency, which is a
15 bit different than just saving money.
16 So, with that, I'm going to turn this over to
17 Amol, I think, for some initial comments, then Karen, and
18 then we're going to go through the queue. Amol.
19 DR. NAVATHE: Great. Thanks, Mike.
20 So thank you to the staff for the comprehensive
21 work here. I think obviously there's a lot of work that
22 goes into setting the context for the Medicare program,

1 broadly speaking. I think you guys, as usual, have done an
2 excellent job of collating a lot of evidence and making it
3 digestible and in its early short format.
4 Rachel brought up the fact that the trust fund
5 depletion is only accelerating in the context of COVID and,
6 of course, is even more striking and sobering in a broadly
7 sobering environment.
8 With that as a backdrop, I had a couple of
9 recommendations or thoughts to consider in the future about
10 this chapter as we evolve it. So one point is I think to
11 some extent changes in comments, I think we can maybe do a
12 little bit better in terms of how we're articulating the
13 impact or the sort of real trajectory, if you will, of
14 prices. There's a number of places where we talk about
15 prices in a relative fashion, percent over time, for
16 example. In a couple of places in the chapter, we also
17 make note of the absolute difference may be quite small
18 even though the percentage growth is very different. And
19 so I think in those cases it might actually be helpful to
20 also articulate the absolute differences, maybe even, for
21 example, in the chart with a second axis or a paired chart
22 next to it, just to give that context. I think relative

1 and absolute is something that we want to be mindful of.
2 Similarly, I think we want to be mindful of
3 changes in prices that we might call nominal versus real
4 changes in prices, or net of inflation, net of other sort
5 of comparative changes that are happening around prices.
6 A couple other points. I think I really liked
7 the new Table 1-1, which I think didn't make it into the
8 Power Point slides, for everyone who's basically giving a
9 reflection of what would have to happen for the payroll tax
10 increase basically to offset the trajectory here or at
11 least in part of the spending. I think these types of
12 facts, if I could encourage us to do even more of it, sort
13 of what impact do we have to have on spending in different
14 parts of the program to actually offset this trajectory.
15 To me, it makes it very real. When I see something like
16 there has to be a 17 percent decrease in Part A spending to
17 increase solvency for 25 years, that's really striking. I
18 think that makes it very concrete, makes it relatable, to
19 some extent makes the context much more palpable in some
20 sense.
21 A third point is I think we all frequently think
22 about the aging population as a potential challenge for

1 solvency of the trust fund in the Medicare program
2 generally speaking. I think it might be nice for us to
3 also differentiate fairly explicitly or crisply the
4 difference between changes in enrollment, which are
5 obviously an important factor, with an aging population
6 within the group that is already enrolled. And I think
7 there's a little bit of discussion of this, but you also
8 provide I think important facts and figures around more
9 elderly Medicare beneficiaries utilize at a higher rate and
10 are more costly than younger Medicare beneficiaries. I
11 think that needs to also come out in terms of its impact on
12 the Medicare program as well as the population eventually
13 ages but with increasing costs down the road.
14 The last point I'll make is about the discussion
15 of consolidation, specifically consolidation as sort of
16 logic -- consolidation leads to higher commercial prices,
17 which then eventually will put pressure on the Medicare
18 program to raise prices because of quasi-indirect effects,
19 though, in terms of hospitals and/or physician groups,
20 providers deciding not to accept Medicare anymore. And I
21 wondered if there is any empirical evidence about that. I
22 think that seems like a multi-step process. I don't

1 dispute the fact that consolidation has its ill effects. I
2 think we should think carefully and hopefully back it up
3 with evidence if we can in terms of how it's actually going
4 to impact the Medicare program going forward.
5 So, overall, thank you for a fantastic chapter,
6 and hopefully my suggestions are helpful as well.
7 DR. CHERNEW: Amol, thank you. And for the
8 Commissioners, you may have noticed, given the nature of
9 this chapter and the time, we're going to combine Rounds 1
10 and 2. So I encourage you all to get into the queue, and
11 I'm now going to turn it over to Karen.
12 DR. DeSALVO: Great. Thank you. It was a really
13 nice job on the chapter, and I'm recognizing also that the
14 staff was trying to do some condensing of what can get to
15 be a very weighty topic, which is, frankly, quite
16 important, as Michael has shared. We have an obligation
17 around fiduciary responsibility to the Medicare program,
18 and so I think there's some tradeoffs about what we want to
19 highlight that impact the beneficiary and some of the
20 challenges for the cost. I have probably done four big
21 areas that I just wanted to lift up and get some
22 suggestions/questions in the chapter.

1 I'll say first that I really did like the layout,
2 and I loved the way that the staff listed out the
3 recommendations in chronological order of what we have
4 previously thought would make a difference in changing the
5 trajectory of spending for the Medicare program while also
6 improving access and outcomes.
7 I didn't see in the chapter and I think it might
8 be helpful if there's some way to estimate what we think
9 that the implementation of all those recommendations, what
10 impact that would have on truly bending the spending curve
11 and just get some sort of an accountability or maybe even
12 just a subset, because I suspect it's significant and it
13 might be helpful to quantify that in addition to seeing
14 qualitative recommendations and having to make the report
15 out.
16 The second area is just, again, respecting that
17 we're trying to keep this as brief as possible, I didn't
18 notice in the chapter that you highlighted even in a
19 sentence what is the driver behind the rising cost. Amol
20 was, I think, alluding to this a minute ago. I think a
21 part of it is the demographics of the population, more
22 beneficiaries and older beneficiaries with more medical

1 conditions. It's embedded, but I think just being crisp
2 and clear that this is multifactorial and also just has to
3 do with the fact that we have a larger population to serve
4 that has perhaps more needs, which just drives the impetus
5 that we have to be a lot more thoughtful about prevention
6 and upstream services to help prevent the onset and
7 progression of chronic disease, so something to clarify the
8 importance of changing demographics.
9 I think related to that is just a better
10 reflection of the act that there has been work not only on
11 recommendations by the Commission but by the delivery
12 system, writ large, and by the administrations, plural, to
13 try to address cost and drive value. Again, I think it's
14 in there, but it's not as clear that there have been --
15 there's been work to try to drive down costs, and it's just
16 not really gotten us to where we need to go.
17 The third area is I -- and I feel pretty strongly
18 about this. I think we'd be remiss if we did not call out
19 something around racial and ethnic disparities for the
20 Medicare population, not only in COVID but generally. I
21 think we know that there are differences in health burden
22 and in health outcomes, and we don't need, I think, a

1 detailed accounting of that, but I think we need to
2 acknowledge that the program is different based upon the
3 color of your skin or your geography, and find a way to
4 weave in that important -- that we're seeing this through
5 that lens and have that as a consideration.
6 I know that you referenced the reports, for
7 example, from CMS about COVID and disparities, but I didn't
8 see much lifted into the chapter, and I don't think it
9 needs a lot of attention. I mean, I'd like it to have, but
10 at least some acknowledgment that was more clear in the
11 chapter.
12 And I think the last thing has to do with a
13 figure that you have in there, and you had it on Slide 16
14 about MA, and I just wanted to make sure I understood the
15 treatment of that data. It seemed -- thank you. It seemed
16 like maybe it -- I couldn't tell from the legend, but I
17 don't think it's age adjusted, and I suspect given that you
18 have in other parts of the chapters that you've shared that
19 older Medicare beneficiaries have higher costs, and I think
20 we know that Medicare beneficiaries that are older are more
21 likely to be covered in Medicare Advantage, at least I
22 think that's still the case. So just thinking about how

1 we're comparing the spending and making sure that we're
2 thinking through whether we're actually making a reasonable
3 comparator if we're risk-adjusting for some of the
4 important characteristics that might vary according to
5 original Medicare and Medicare Advantage populations.
6 I'll stop there.
7 MS. KELLEY: Okay. Jonathan Jaffery?
8 DR. JAFFERY: Thank you, Dana. And thanks,
9 echoing others' comments, this is always a great chapter to
10 sort of look at early in the year, and then I think this
11 year's chapter has been fantastic and, as others have said,
12 "sobering" is certainly a word that comes to mind.
13 I just have two comments. One is at one point in
14 the chapter you talk about restraining price growth not
15 being enough, but the quantity of health care services also
16 has to be reduced. And I wonder if there's something that
17 can be said about not just the quantity but the mix of
18 services. Often, we focus on things like, you know, we do
19 too many MRIs, which is probably true, but there's also a
20 mix of services, and it sort of gets to that efficient
21 delivery of care that maybe there's some way to think about
22 wording that.

1 And then my other comment also is a little bit
2 about the efficient delivery of care. So, you know, as
3 Amol pointed out, it's really great to see that table where
4 it lays out some of the ways that we can get to solvency
5 for periods of time that maybe are a little more tangible
6 than thinking about, you know, percent of GDP and how that
7 would translate into action.
8 But I wonder if, you know, when we talk about
9 decreasing costs by $1,000 per beneficiary per year, I
10 wonder if there's something in there that we should think
11 about focusing on that's a little bit different that might
12 inform how we strategize around tactics and not -- by "we,"
13 I mean not only the Commission but CMS and CMMI and others
14 -- about promoting that efficient delivery of care that
15 Mike talked about as our big charge for us.
16 So thinking about ACOs in particular, you know, a
17 lot of what our policies seem to talk about is focusing
18 programs so that all different groups and ACO providers can
19 bring down their costs. And to me, that starts to imply
20 that we're trying to shift everybody's costs down, and
21 that's one way to think about bringing down the average.
22 But another way is to say, well, there's a certain

1 efficient level of care, and there's some providers that
2 are much more costly on average, even adjusted for risk and
3 age and other things. And I wonder if there's a way to
4 model out what is that efficient level of care that we
5 would want to bring groups down to that would get us to the
6 same outcome of solvency and the same outcome in terms of
7 an average decrease cost of care that's $1,000 per
8 beneficiary per year or lower, if that makes sense.
9 I know we've talked about that a little bit
10 before, that, you know, how sustainable is it for us to
11 look at the higher-performing ACOs and ask them to
12 constantly bring down their average cost versus trying to
13 understand what an expected efficient target should be
14 overall. And maybe there's something where we should be
15 focusing on those real high spenders.
16 So I'll stop there. Thank you.
17 MS. KELLEY: Okay. Sue, you're next.
18 MS. THOMPSON: Thank you, Dana, also thank you to
19 the staff for this sobering chapter.
20 Like Karen, I, too, wondered -- as I looked at
21 all the recommendations made by MedPAC that appeared on
22 page 29 through 38 of this reading, these recommendations,

1 you know, they restrain growth, we need to outline the
2 challenges, but I wondered, you know, what's the dollar
3 amount? What would we save Medicare? What's the impact of
4 these recommendations? And it did cause me to reflect,
5 because I wonder, you know, are we bending the curve? Are
6 we moving to help? Are we making a difference for Medicare
7 beneficiaries and the state of health care in this country?
8 Today I'm in my sixth and final year as a MedPAC
9 Commissioner. It's my sixth September of reading the
10 context chapter, and, you know, while it's grounding for
11 the year, this year it's particularly sobering.
12 Upon reading this chapter, you know, the status
13 of the trust fund and the fact it's in much more dire
14 condition other than when I started, basically it's on life
15 support. This very well written and factual narrative
16 seems to disguise a call to action that is necessary to
17 protect Medicare solvency and health care for this country.
18 I found myself reflecting on the ghosts of
19 Commissioners past as I thought about this September
20 meeting and this very chapter. I remember last year -- and
21 I pulled up some of the transcripts. Warner Thomas said,
22 "I feel like I have failed as a Commissioner because I

1 don't think that we have taken bold enough steps to move
2 this curve. We're talking about millions of people that
3 are counting on us to make the right changes."
4 Two years previous, Dr. Rita Redberg said, "So we
5 clearly have our work cut out for us. We're at a crisis
6 stage. This is not going to be here for us. This
7 certainly won't be here for future generations. We have an
8 opportunity to improve it, but we really need to be bold."
9 In that same year, Dr. Craig Samitt, with great
10 emotion, said: "This is the sixth time I've seen this, and
11 it hasn't really changed. And so if it truly were a
12 burning platform, I think the platform has already burned
13 down. I think now would be the time for us to take action.
14 I don't know to what degree we have fully underscored the
15 imperative in this chapter, but certainly heading out of
16 MedPAC this year, I feel a greater sense of urgency to
17 solve this problem than when I started."
18 So with the ghosts of Commissioners past, I, too,
19 am committed more than ever to the work of this Commission
20 and join in the choir of past Commissioners to encourage
21 all of us to be brave and bold and earnest in this work.
22 Thank you.

1 MS. KELLEY: Jim, did you want to get in here?
2 DR. MATHEWS: Yes. Just to address quickly the
3 question that Karen and Sue raised about quantification of
4 the financial impacts of MedPAC's recommendations over time
5 relative to the magnitude of Medicare's funding problem.
6 This is a great question to raise, and as you guys are
7 aware, when we do make recommendations, we do work with CBO
8 to in rough terms quantify the financial impacts of each of
9 our recommendations. And I use the word "rough" because
10 this is very different than the way CBO scores a piece of
11 legislation where they are looking at specific parameters
12 and they are taking into account interactive effects, that
13 sort of thing. They are giving us, you know, broad what we
14 refer to as "buckets" of financial impacts. And, you know,
15 we publish those alongside of each of our recommendations
16 that we make, and, you know, for internal purposes, we do
17 keep track of, in general, how much those recommendations
18 would save.
19 But we do not, you know, update the dollar
20 effects of those recommendations over time, so we might
21 have made a recommendation in 2007, 2012, that had a
22 certain impact, and we leave it lie. So, you know,

1 carrying that impact forward to the present day would be an
2 exercise that we simply do not have enough precision to
3 devote to.
4 So it is a good question. We do pay attention to
5 this, but trying to quantify the magnitude of our
6 unimplemented recommendations against the current financial
7 challenges would be a difficult proposition.
8 DR. CHERNEW: Thanks, Jim.
9 MS. KELLEY: Mike.
10 DR. CHERNEW: Yeah, I also wanted to give a quick
11 reaction to Susan's comment. I was on the Commission for
12 six years before, Susan. I'm not sure I heard as
13 impassioned a speech in the entire six years. Maybe in
14 this group it will be a monthly occurrence, but thank you.
15 What I wanted to say in response to that is first
16 I agree and, whenever possible, I do think it's incumbent
17 upon us to be bold. That said, there are certain
18 challenges, for example, tax policy and how we should deal
19 with taxes as the number of workers per beneficiary shrinks
20 or broad program changes related to things like age
21 eligibility and stuff are probably going to be outside at
22 least where I particularly would like to go and limit

1 ourselves to, unfortunately, a somewhat narrower set of
2 policy options related to efficiencies and payments. So
3 that includes anything we can do in payment to encourage
4 efficient delivery of care. There's a bunch of those
5 things, as you know, and anything we can do in payment to
6 reduce overpayment of services, again, I think you know
7 there will be a bunch of those types of things. So that
8 gets to sort of the P and the Q of things.
9 I say this now, this is my first meeting for the
10 Commissioners, we'll probably avoid other important policy
11 questions related to the fiscal solvency of Medicare
12 related to, for example, tax policy and other broad things.
13 So that's just a little Chernew
14 contextualization. Hopefully we'll get through this, we'll
15 be able to have a Round 3, and we can engage on points like
16 that. But I do want to get through the rest of the
17 commenters. Again, Sue, thank you so much for the passion
18 and the eloquence of your comment.
19 So, Dana, who's next?
20 MS. KELLEY: Brian.
21 DR. DeBUSK: Again, great chapter, very sobering
22 chapter. This is the fourth time -- fifth time I've seen

1 it, and, yes, it is sobering every time.
2 What I want to do is mention I was really glad to
3 see pages 9 through 12 of the reading materials where they
4 looked at the spread between commercial rates and Medicare
5 rates. And I do want to echo Amol's comment about closely
6 following the effects of consolidation. You know, I think
7 consolidation is at best a mixed bag. I think there's some
8 benefits, but there are clearly some detriments, and I do
9 think they may very well raise rates.
10 But, again, I'd really like to see us emphasize
11 the growing spread, for example, in hospital rates between
12 Medicare and commercial payers, because I see that it's
13 almost like an earthquake fault line. You know, there's
14 stress that's building in this crack, and I have to think
15 at some point it will be beneficial. You know, you won't
16 be competing against the marginal benefit of a Medicare
17 payment. What you'll be competing against is the
18 opportunity cost of taking on another commercial payment.
19 And, again, I see this almost like a fault line, and when
20 this fault -- when the earthquake happens, you know, I
21 don't know that we're going to be able to go back with a 5
22 percent or a 10 percent payment update and simply fix the

1 problem. I think as the spread grows; I think the
2 magnitude of the shift that could occur could be quite
3 dramatic. So I think we do need to look for any early
4 signs that there's a shift in not just hospitals but
5 providers in general disproportionately pursuing commercial
6 rates or de-emphasizing or abandoning Medicare
7 beneficiaries.
8 Again, I do see this as a potential threat to
9 Medicare in the upcoming years, especially as the spreads
10 grow.
11 The second thing I want to point out, on page 25
12 of the reading materials, this is always a very sobering
13 chapter, but I always find myself asking, you know, what's
14 the insight? What can we get from this? Page 25 of the
15 reading materials, it really stood out to me the
16 differences in the spending per capita for some of these
17 conditions like diabetes, ischemic heart disease. What
18 really stands out is not just the difference in spending --
19 I mean, there are 60 and 100 percent increases in spending
20 -- but the prevalence rates. You know, you're looking at
21 prevalence rates of, you know, 57 to 27 percent, which were
22 on the table in the reading material. And it makes me

1 think about what's actionable. And, you know, Jon, to
2 build on some of your comments about ACOs, do we need to
3 maybe place more emphasis on condition-specific population
4 health management? Should we be encouraging more special
5 needs plans, for example, in the MA world? Do we need more
6 diabetes SNPs? Do we need CHS SNPS?
7 When we did population health, you know,
8 arguably, MedPAC is a co-inventor of ACOs. When we look
9 back at that, could we have placed too much emphasis on
10 geography and perhaps not enough emphasis on condition? Do
11 we need to capture a very specific geography, you know, all
12 the way from the 65-year-old triathlete all the way to the,
13 you know, 92-year-old with six comorbidities? Should our
14 next round of APMs -- I know, for example, we do this in
15 ESRD. But should our next round of APMs focus on
16 population health, but should they be focusing on maybe
17 condition-specific populations? And is that a way to sort
18 of split the difference between a broad population health
19 solution versus, say, episode-specific bundles in lower
20 joint replacement? Is the solution to start focusing more
21 on these conditions that are called out on page 25?
22 Those are my comments. Thank you.

1 MS. KELLEY: Okay. Jon Perlin.
2 DR. PERLIN: I don't believe I'm in the queue,
3 actually.
4 MS. KELLEY: Oh, I'm sorry. All right then.
5 Betty.
6 DR. RAMBUR: Well, thank you, and thanks to the
7 staff for a fabulous report.
8 So this is my first September, and I would say
9 although I've been aware of these issues, this was very
10 sobering to me. And I personally consider this an issue of
11 intergenerational injustice. As a baby boomer, I think we
12 have a responsibility to leave a better world behind. And
13 I would have to say I agree with Sue that we need to be, I
14 think, much more aggressive. And I won't repeat some of
15 the great comments people had about ways we might do that.
16 But as a clinician who has been in the trenches, I actually
17 see that part of that aggression will probably need to be
18 more mandatory alternative payment models, because I do
19 believe practices do change, and I see many, many things
20 that could be done differently to better use nurse
21 practitioners and nurses and having people really think
22 differently about care, not just medical care.

1 So to the extent that we can create circumstances
2 that really create value, inform practice throughout the
3 disciplines and across the continuum, I think we will have
4 come -- at least taken some steps toward creating a more
5 equitable circumstance by generation.
6 Thank you.
7 MS. KELLEY: Marge.
8 [No response.]
9 MS. KELLEY: Marge, we can't hear you. Just a
10 moment. Let me check your microphone. Can you try now,
11 Marge?
12 MS. MARJORIE GINSBURG: Okay.
13 MS. KELLEY: Yes, thank you.
14 MS. MARJORIE GINSBURG: Great chapter. Very
15 discouraging. I have lots of comments, but I'm going to
16 try to bring them down to just two general comments.
17 I'm very focused on the impact of the high costs
18 on particularly low-income beneficiaries. And I read a lot
19 of mixed messages in here. For example, original Medicare
20 uses beneficiary cost sharing to deter overuse of services.
21 And then as it turns out, only 11 percent of people who are
22 on OM do not have a Medigap plan.

1 But on the one hand, we don't really want people
2 to have a Medigap plan and actually -- so that was a
3 recommendation early on that we charge more to discourage
4 people as a way of trying to temper what people expect and
5 what people are willing to pay for. And then, on the other
6 hand, we are very unhappy because people are paying so
7 much.
8 So there's a lot of the inconsistency here about
9 the role that we should play in trying to do two things
10 which are contradictory: discourage people from getting
11 services that they probably don't need, and yet make health
12 care affordable for everyone. So a lot of areas, and I'm
13 happy offline to point out particular ones that I see
14 inconsistency in this messaging.
15 And the other comment I will make is that have we
16 ever at the end, the summary of all the recommendations is
17 so interesting and so enlightening. At this point it feels
18 like we're faced with such a gigantic problem. Have we
19 ever thought about prioritizing our recommendations, making
20 it really clear to Congress these are the ones, this is the
21 order in which we need to move for you, Congress needs to
22 move forward to get a handle on Medicare costs? And my own

1 personal belief is we've got to go after MA plans. I just
2 think it's sinful that we are paying so much more for MA
3 than we are for original Medicare, and I'm an MA supporter.
4 But I'm not supporting how much we're paying.
5 So thank you.
6 MS. KELLEY: Bruce?
7 MR. PYENSON: Thank you very much. A terrific
8 chapter. I wanted to point out a couple of optimistic
9 things, things that point to success and I think a
10 direction forward.
11 The reading material shows that Medicare has done
12 a much better job than other payers and the commercial
13 payers on controlling spending and controlling largely
14 through fees, despite ignoring many of MedPAC's
15 recommendations. I think that's a very important issue
16 because overall we're seeing health care siphon the
17 resources for things that are much more important to
18 people's health than health care, such as education,
19 housing, infrastructure, and other aspects, other
20 resources.
21 I think this is very relevant because although
22 we're not into tax policy, Part A is funded by payroll tax.

1 And to the extent that workers are paying a lot for their
2 benefits, that puts pressure on funding Medicare.
3 In the past, this chapter has made very
4 interesting comparisons to other countries, and I think
5 that's very valuable information because it puts a path
6 forward and the comparisons have been not just spending but
7 also outcomes and quality. Over the decades, I've been an
8 advocate for efficiency, better efficiency in utilization
9 and prevention. But today I'm seeing those being used as
10 excuses to blame physicians for inefficiency or to blame
11 patients for chronic conditions. I just want to put in a
12 warning that that's not something we should fall into. My
13 view, which is part of the success of Medicare, is that
14 we're just -- we're mostly paying too much. That's not to
15 say we shouldn't strive for efficiency, strive for wellness
16 and prevention. But the issue is the price, and I think we
17 can afford to be bold in recognizing that and pushing that
18 ahead.
19 Thank you.
20 MS. KELLEY: Dana Safran.
21 [Pause.]
22 DR. SAFRAN: Ah, there we go. Can you hear me?

1 MS. KELLEY: Yes.
2 DR. SAFRAN: Yes, okay, great. Just seconding
3 that, the many complimentary comments about the chapter and
4 the sense of how sobering this is, as I enter sort of the
5 back nine of my Medicare Payment Advisory Commission
6 service in year four.
7 I think I'll focus my remarks on really two
8 things. One, just to amplify, I agree with other
9 Commissioners that I really like the section toward the end
10 of the chapter. I don't remember this from past years
11 where you inventory the challenges that have been faced and
12 the solutions.
13 Oh, goodness. I have someone at my door and no
14 one else home to answer it. And I am expecting -- so can
15 you come back to me later in the queue? I'm so sorry.
16 MS. KELLEY: Of course.
17 DR. SAFRAN: Thank you.
18 MS. KELLEY: Paul?
19 DR. PAUL GINSBURG: This has really been a great
20 chapter and a great conversation. I'm really glad that Sue
21 raised the point about being bold because how else can you
22 come away from this chapter without a concern about not

1 being bold enough. And, you know, I think we need to come
2 up with recommendations that are administratively feasible
3 and politically feasible, but I think we can be a lot
4 bolder than we often have been.
5 I think Mike's comment about efficiency is very
6 wise, and there really are two aspects of paying
7 efficiently. While one aspect is that we don't want to pay
8 more than we need to to get the quality and access that we
9 seek, but perhaps even a bigger aspect of it is that we
10 need to pay in an efficient way, which means, you know,
11 fostering alternative payments, not overpaying for Medicare
12 Advantage but shaping it so that it can play a role in
13 providing care efficiently. So I think that we should
14 follow that as our guide and also be bold in what we come
15 up with.
16 I think when we look at the Medicare spending
17 trends per enrollee, you know, they look pretty good. Part
18 of it is that we're not paying the increasingly high prices
19 of private insurance. But another reason they look good is
20 that we've had a ten-year period of our Medicare population
21 getting younger as baby boom people age into it. We have
22 another ten years to go on that, but then it turns a lot

1 bleaker. So this just adds to the urgency that the chapter
2 sets out of really grappling with Medicare's problems as
3 soon as possible.
4 MS. KELLEY: Okay, Dana, do you want to go ahead
5 now?
6 DR. SAFRAN: Sure. Thanks. So sorry.
7 Okay. Just picking up from where I was leaving
8 off, I do really like the piece at the end of the chapter
9 where you inventory what the challenges are and what our
10 recommendations have been to date.
11 I was struck, I guess, by the fact that, you
12 know, the cost per beneficiary spending is so outpacing as
13 a driver of overall spending, the increases in enrollment,
14 and the knowledge that with respect to spending per
15 beneficiary, we know that it's really the utilization much
16 more than the price increases that are dragging that.
17 There were a number of places in the inventory of
18 challenges where you made reference to a kind of lack of
19 mechanisms to address appropriateness, and so I'll just
20 focus a couple of comments there. One is -- and others
21 have highlighted this, too, but I think our recent and at
22 this point many-year emphasis on growing value-based care

1 is really one critical lever for addressing the lack of
2 ability to continue to eat away at inappropriate care and
3 wasteful care. But I think we continue to understand that
4 we need greater adoption and we also need stronger value-
5 based care programs. I know I've emphasized multiple times
6 the importance of creating some models that really start to
7 get fundamentally at hospital payment and not only at
8 physician payment.

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

18 In addition, it does strike me that this year of
19 COVID does provide a kind of natural experiment. We
20 understand -- we just talked for much of the morning about
21 changes in utilization. And I do wonder whether we could
22 use claims data to begin to understand what are the places

1 where forgone care resulted in harm and what are the places
2 where forgone care did not result in harm and maybe even
3 prevented harm and how can that enlighten us around a
4 greater evidence base on appropriateness.
5 And then finally on that topic, you know, we've
6 talked in past year, and I think it bears repeating here,
7 that we lack the mechanisms up front, particularly in the
8 drug space but elsewhere, to identify the cost-
9 effectiveness of new innovations in health care, which will
10 continue to be a driver in upward spending, and to know
11 which of those new innovations are actually providing
12 incremental health benefits and what should that imply in
13 terms of the pricing, their inclusion as a covered benefit
14 and at what price. And so addressing that very important
15 gap in how the program is allowed to run I think is a
16 critical thing that we have to think about, particularly
17 with the oncoming tidal wave of specialty drugs and gene
18 therapy, et cetera.
19 The last comment I'll make, something that Marge
20 started to touch on, is Medicare Advantage. You know, the
21 demonstration of the faster growth in Medicare Advantage
22 spending and the higher spending in Medicare Advantage,

1 even though we know from quite a lot of literature that the
2 population tends to be less sick, is something that we
3 really just can't afford to continue to ignore.
4 I do want to make one small point, which is I
5 wonder about adding in the chapter a line on that visual
6 that would show us the combined original Medicare and Part
7 D spending. Since, in general, those are addressing the
8 same beneficiaries, I think it would be helpful as a
9 comparator to Medicare Advantage. I don't think it will
10 change what we see in that line, but I do think that would
11 be a useful thing to show.
12 That's my remarks. Thank you.
13 MS. KELLEY: Jaewon.
14 DR. RYU: Thanks, Dana. I have two comments.
15 One is -- and I think Jonathan and Betty and some
16 others touched on it a little bit already -- around APMs.
17 I also enjoyed pages 29 through 38 that had the
18 inventorying of all the recommendations, but it did seem a
19 little odd to me that we don't explicitly call out APMs and
20 augmenting or growing or accelerating the development, the
21 movement into those models. And I don't know if that's
22 because it's never risen to a formal recommendation that

1 we've made, but it seems to be an area that does deserve
2 some explicit mention in the chapter as, you know, either
3 formal or informal -- I'll put it in quotes --
4 recommendation.
5 The second point I had was getting back to
6 Brian's comments around -- and I like his term of the
7 "fault lines," -- the differential between the payment of
8 Medicare versus commercial. It would be helpful if there
9 was some way to gauge how close or how far are we from
10 those fault lines. Are the fault lines already there? Is
11 it getting near a point or is there some threshold where
12 the differential becomes so great that we can anticipate
13 that there would be implications on access?
14 Every year when we do the payment adequacy work,
15 I think thus far we've seen that access is sound. It's at
16 a level that we feel comfortable with in the program. But
17 then you look at programs like Medicaid, and we see that
18 the differential there has clearly become great enough
19 where there are implications and effects on access.
20 Somewhere in between I think is where Brian's
21 fault lines may appear, and I think it would be helpful to
22 understand how close or how far do we believe we are to

1 those fault lines.

2 MS. KELLEY: Okay, Larry.

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

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

18 So how much -- this gets back in a broad way, I
19 think, to what Karen initially said and then others
20 supported. It would be nice to get a sense of, over time,
21 what the cost savings could be from the recommendations
22 that the Commission has made and makes.

1 There's a big difference between reducing Part A
2 spending by 17 percent, never mind also reducing Part B
3 spending, and with the kind of savings we're seeing from
4 the alternative payment models that we have now, big
5 difference between 17 percent Part A reduction and, you
6 know, half a percent ACO savings, for example.
7 So I think despite the fact that increasing --
8 you know, making medical care better is what we all care
9 about, I wonder if it falls within the Commission's purview
10 to try to make it a bit more clear how much can we expect
11 from that, and if there's a big gap between what we think
12 we can expect even with bold recommendations accepted by
13 Congress and savings for making Medicare more efficient and
14 what needs to happen to make Medicare financially
15 sustainable, then that obviously does have implications for
16 tax policy and for benefits, which we're not going to
17 address, but policymakers should know about.
18 I myself often feel uneasy about this. I'm very
19 excited about this program or that program, but I think if
20 we're not very sober about what we can expect these
21 programs to do and we just go on year after year this way,
22 while the financial picture looks like this, maybe we need

1 to think in broader terms.

2 MS. KELLEY: Okay, Pat.

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

4 comments.

5 One is -- and Dana Safran touched on it before --

6 I hope that we can keep the focus on the cost of drugs.

7 Inside of this there's a text box in the paper that talks

8 about a share of prescription and I think Part B spending

9 of total spending increasing from 20 percent at one point

10 to 23 percent. I would add to that the cost of drugs as an

11 inpatient -- a cost input for things like inpatient care.

12 You know, we sort of discussed it before when we've talked

13 about the payment updates. I don't know if it's possible

14 to kind of try to tease that out a little bit. I don't

15 want to lose sight of the trend increase in the cost of

16 drugs as one of the drivers. I realize that some of that

17 is Part B, some of that is Part D, and we're talking about

18 Part A trust fund here. But there is an interaction there,

19 so I don't want to lose sight of that because I think it's

20 worrisome.

21 And the second thing is just a general comment

22 about the important discussion that is going on here as

1 concerns APMs. Brian's suggesting maybe we should have
2 more chronic care SNPs, things like that. I think that,
3 you know, we are by definition the Medicare Payment
4 Advisory Commission, but the fact of the matter is that the
5 issues that we're talking about here don't just start at
6 age 65, right? The folks who are becoming dual eligible
7 have been part of Medicaid plans for their lives, and they
8 are entering the Medicare program with conditions that
9 perhaps with different approaches could have been prevented
10 from becoming a very serious chronic condition. Somebody
11 who was on the verge of, you know, getting into serious
12 trouble with kidney disease maybe doesn't enter the program
13 with ESRD or become ESRD requiring. And so, you know,
14 we're Medicare, so I'm not suggesting that we expand our
15 focus -- we can't -- by legislative mandate. But I do want
16 to just raise it as the issue because these things really
17 do interact. The fault lines of commercial and all of the
18 rest, this is a moving target here. Even before COVID, the
19 commercial population was shrinking because people are
20 aging into Medicare. And so, you know, providers are
21 scrambling to sort of -- they have a sudden drop in
22 revenue. It used to be commercial, now it's Medicare, it's

1 lower. And that contributes to the dynamic, I think, of
2 pushing commercial prices higher to try to compensate from
3 that and so forth.
4 During COVID, so many people lost commercial
5 insurance because they became unemployed. They're now
6 Medicaid. They're now Medicaid. So it's in the states
7 that are fortunate enough to have a safety net big enough
8 to have caught them, so that is a -- that doesn't even make
9 it onto the chart in terms of the payment level, it's so
10 far below Medicare.
11 I just raise this because I think there is a
12 broader context. It's Medicare's problem to deal with the
13 accumulation of all these issues when somebody turns 65.
14 But we do exist in a much bigger world, and I think we have
15 to keep sight of that.
16 For the elderly Medicare -- [audio difficulty] --
17 FIDE SNP, there's that huge interaction again with
18 Medicaid. There -- [audio difficulty].
19 MS. KELLEY: We seem --
20 MS. WANG: -- different spending package. The
21 only sort of specific thing I wonder about for our work is
22 whether there is -- we can have that perspective when we

1 talk about ACOs, because a lot of the APMs are bundles for
2 the unit or for the specific condition that is being
3 treated. The ACOs and Medicare Advantage are population
4 health-based, and for ACOs I just don't know whether
5 there's more curiosity that we can have about ACOs and what
6 they're doing to promote wellness of their community so
7 that when people become Medicare-eligible, perhaps they are
8 in better shape than otherwise. It's just a thought. I
9 don't know if there's any way to incorporate that.
10 Thanks.
11 MS. KELLEY: And the last person on my list here
12 is David.
13 DR. GRABOWSKI: Great, thanks. And it's
14 fortuitous I'm going after Pat because I think a lot of my
15 comments really align well with that last point she made.
16 I was just going to make the point, so I'll make it very
17 quickly -- I don't think I can say it more eloquently than
18 Pat -- that Medicare doesn't pay in a vacuum, and many of
19 our beneficiaries don't receive services in a vacuum. So I
20 think this is really important in going back to Mike's
21 original charge about we need to encourage greater value.
22 I'm thinking of the discussions we had with the payment

1 updates every year. Hospitals -- obviously Medicare pays
2 alongside commercial. We're the less generous payer there.
3 We have to think about those issues in terms of a mixed
4 payer model. The opposite issue, obviously the skilled
5 nursing facilities where we're the more generous payer, how
6 do we think about encouraging greater value when you have
7 Medicare existing alongside these other payers.
8 And then I'm really glad Pat raised the duals, so
9 I'll just piggyback on that comment. All of our dual-
10 eligible beneficiaries also receive services through
11 Medicaid. Oftentimes they're long-term care services.
12 We've spent some time on this Commission obviously worrying
13 about how to better coordinate those services. Pat
14 mentioned the model like the FIDE SNPs. How do we actually
15 measure value in that program? We know we spend a lot on
16 services for those duals, but how are we making certain
17 we're getting good value in return?
18 So I just think I'll stop here only to say that
19 value is a really complicated issue here when you're
20 thinking about Medicare not just paying in a vacuum but
21 also a lot of our beneficiaries receiving services from
22 other payers as well.

1 Thanks.

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

4 MS. KELLEY: That is correct.

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

18 I will lastly say we've done a lot of things on
19 drugs in the past. We're going to let some of that sit for
20 now. We will surely turn back to that at some point. But
21 the broader issue that I think we face -- [audio
22 difficulty] -- prices. So we're going to spend our time on

1 some of these big-picture issues, and if you follow us over
2 the course of the year, and I encourage you to do that,
3 we're going to spend a lot of our time on the nooks and
4 crannies and inefficiencies in the system, ranging from
5 coding to a whole bunch of other things where we might be
6 more efficient to try and find ways to help Congress
7 maintain the sustainability of the program, and we will do
8 as much as we can in that regard.
9 So, again, I want to thank all the Commissioners
10 for their comments. We, I think, are now going to now go
11 to lunch. I wish we could go to lunch together. We're
12 going to come back, and if I've got this right, Dana, we're
13 going to be joining a different webinar, or at least
14 relogging on this again at 1 o'clock so we can take up the
15 first sort of real substantive thing, which is important
16 and fits in the theme of this, the skilled nursing facility
17 value-based purchasing program. So we will start there at
18 1 o'clock. Everybody, take a good stretch. I miss seeing
19 you all, and we'll see you all back at 1:00.
20 Did I miss anything, Dana or Jim?
21 MS. KELLEY: No. I think that sounds right. Go
22 ahead, Jim.

1 DR. MATHEWS: All good.

2 DR. CHERNEW: Okay. Thanks, everybody. Eat

3 healthy. Do calisthenics.

4 [Whereupon, at 12:17 p.m., the meeting was

5 recessed, to reconvene at 1:00 p.m., this same day.]

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1 AFTERNOON SESSION

2 [1:05 p.m.]

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

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

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

18 DR. CARTER: Okay. Good afternoon.

19 Before I get started, I want to note that the
20 audience that they can download a PDF version of these
21 slides in the handout section of the control panel on the
22 right-hand of the screen.

1 A value-based purchasing program creates
2 incentives for providers to furnish efficient, high-quality
3 care. Payments are tied to performance measures, with
4 payments increased for providers with better performance
5 and lowered for providers with worse performance.
6 CMS is increasingly tying Medicare's payments to
7 value. As required by the Protecting Access to Medicare
8 Act of 2014, or PAMA, CMS implemented a VBP for skilled
9 nursing facilities that affects payments beginning on
10 October 1, 2018.
11 PAMA also required MedPAC to evaluate the VBP
12 program. The statute requires us to review the program's
13 progress, assess the impacts of beneficiaries'
14 socioeconomic status on provider performance, consider any
15 unintended consequences, and make any recommendations as
16 appropriate.
17 Our report is due June 30th in 2021, and we plan
18 to include it as a chapter in the June report.
19 To meet this due date, we'll be working on the
20 following timetable. Today we'll review the current
21 program design and its results for the first two years of
22 the program.

1 We should have third-year results later this
2 year, and we can add those to our analyses.
3 Today we will also identify the shortcomings of
4 the current design.
5 Next month, we will outline an alternative design
6 and assess its potential impacts, and compare its impacts
7 with those of the current design. Depending on that
8 discussion, the Commission may consider replacing the SNF
9 VBP with an alternative design.
10 In January, we will consider an alternative
11 design for the VBP as when it was a policy option.
12 In March and April, we'll review the draft and
13 final reports, and based on your discussions, the report
14 may include recommendations.
15 So let's start with an overview of any VBP
16 design, and there are four key elements. First are the
17 measures that are used to gauge performance. Then there's
18 a volume minimum, and that's a threshold that helps ensure
19 that the measure results are reliable. Providers with
20 volume below the minimum are held harmless from the
21 program, and their payments are neither increased nor
22 decreased.

1 Scoring translates a provider's performance into
2 a payment adjustment. For providers with sufficient
3 volume, their performance during a performance period is
4 compared to other providers or to some performance scale
5 and then scored. This score is then converted to a payment
6 adjustment that is specific to each provider. This
7 adjustment is then applied to each payment during the year.
8 Finally, there is a method to finance the
9 program. Often the financing is done with an amount
10 withheld from each payment. These withholds create a pool
11 of dollars that is then distributed back to providers.
12 Now to the specifics of the SNF VBP. PAMA
13 requires that the program use one measure -- all-cause
14 hospital readmission rate. This measure counts any
15 unplanned readmission within 30 days of discharge from the
16 hospital.
17 The statute requires that this all-cause measure
18 be replaced with a potentially preventable measure as soon
19 as practicable. This fall, CMS plans to submit the
20 potentially preventable measure to the National Quality
21 Forum for endorsement, and then CMS will assess the timing
22 of a transition after the NQF has completed its review.

1 CMS has stated that it does not have the
2 authority to add measures to the program.
3 In terms of scoring, the statute requires that
4 each SNF performance be gauged for improvement and
5 achievement, and the incentive payment must be based on the
6 higher of the two.
7 The improvement score awards points if a SNF's
8 readmission rate during the performance period is lower
9 than its rate was during a baseline period, and more points
10 are awarded for larger improvement.
11 The achievement score awards points based on how
12 much better a facility's performance is relative to a
13 threshold.
14 The baseline and performance periods are one year
15 in duration.
16 To convert a SNF's performance into an incentive
17 payment, CMS uses an S-shaped exchange function to
18 translate the total performance score into a multiplier
19 that is applied to each payment, and the law requires that
20 payments must be lowered for providers with the lowest 40
21 percent of rankings.
22 Regarding a minimum volume, the VBP assesses

1 penalties and rewards for providers with at least 25 stays
2 in a year. SNFs with fewer stays are held harmless by the
3 program.
4 In terms of financing, the statute requires that
5 the program is financed by a 2 percent reduction to
6 payments. The statute also requires that aggregate
7 incentive payouts be between 50 and 70 percent of the total
8 pool of dollars collected, with the program retaining the
9 remainder as savings. CMS opted to pay out 60 percent of
10 the withheld amounts, with the program retaining 40 percent
11 as savings.
12 And now Sam will go over the results of the first
13 two years of the program.
14 MR. BICKEL-BARLOW: In each of the first two
15 payment years of the program, fiscal year 2019 and 2020,
16 the majority of providers had their payments lowered by the
17 program, 73 percent in 2019 and 77 percent in 2020.
18 Many SNFs earned back essentially none of the 2
19 percent amount withheld, 21 percent of SNFs in fiscal year
20 2019, and 39 percent of SNFs in 2020.
21 A small share of SNFs received the maximum
22 increase. In 2019, 3 percent of SNFs earned the maximum,

1 which was 1.6 percent. In 2020, fewer SNFs earned the
2 maximum, which was 3.1 percent.
3 This chart shows the distribution of adjustments
4 to payments in each of the first two years of the program.
5 In 2020, the distribution was more spread out, with a
6 higher share of SNFs receiving the minimum payment
7 adjustment and a higher share receiving a larger maximum
8 payment adjustment than in 2019.
9 We also looked at the consistency in individual
10 SNF performance across years. Many SNFs that received a
11 large reduction in payments in 2019 also received a large
12 reduction in payments in 2020. Except for these SNFs,
13 there was little consistency in performance across years.
14 Compared with 2019, in 2020 more SNFs received a lower
15 payment adjustment than received a higher payment
16 adjustment. The lack of consistency in performance across
17 years could indicate that the minimum count is too low.
18 Our mandate requires that we look at performance
19 of SNFs by social risk factors. We used the share of
20 patients that are fully dual eligible for Medicaid as a
21 proxy for social risk. We found that adjustments to
22 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 In multivariate regression work, we found that

10 incentive payments increased for providers with higher

11 volume, higher occupancy rates, and for hospital-based

12 providers. Hospital-based providers typically have lower

13 readmission rates than freestanding facilities.

14 Incentive payments decreased for providers who

15 treated patients with higher risk scores and higher shares

16 of fully dual-eligible beneficiaries.

17 Across the two years, we did not find a

18 consistently statistically significant effect of staffing

19 levels or ownership.

20 DR. CARTER: Before turning to the shortcomings

21 of the design, I want to review the Commission's principles

22 for quality measurement because they help us identify the

1 shortcomings of the current design.
2 The Commission's principles state that quality
3 should be gauged using a small set of outcomes, patient
4 experience, and value or resource use measures that are not
5 burdensome to report.
6 A provider's performance should be scored against
7 absolute performance standards that are known in advance.
8 The scoring should convert performance to payment
9 using a continuous scale that avoids cliffs in penalties or
10 rewards.
11 Finally, as necessary, the value-based payment
12 should take into account differences in providers'
13 populations, including social risk factors through peer
14 grouping and not by adjusting the performance scores.
15 In identifying the shortcomings of the VBP, I'll
16 note where the current design features do not meet these
17 principles.
18 The mandate requires us to make recommendations
19 as appropriate, and the first step in doing that is to
20 identify any shortcomings in the current design.
21 A key shortcoming is that the program only uses
22 one measure to gauge performance, and yet we know quality

1 is multidimensional. Further, the Commission stated that
2 value-based programs should gauge outcomes, patient
3 experience, and resource use.
4 We also have issues with the measure itself,
5 which are discussed in the paper. Most notably, it does
6 not hold providers accountable for all readmissions that
7 occur on their watch; that is, during the entire
8 beneficiary stay.
9 A second shortcoming of the design is the minimum
10 count. It is too low. It does not meet a commonly used
11 standard of good reliability. CMS reported that the
12 measure is at the low end of moderate reliability, which
13 may not differentiate performances especially for small
14 providers.
15 Another shortcoming is that the scoring does not
16 encourage all providers to improve. SNFs in the bottom 40
17 percent of rankings must have their payments lowered, and
18 the scoring includes thresholds that create scoring cliffs.
19 The design also does not account for social risk
20 factors of the patients treated by a provider, and yet we
21 found that providers with high shares of fully dual-
22 eligible beneficiaries were more likely to receive

1 penalties than rewards. Facilities with poorer performance
2 may lack the resources needed to improve.
3 Last, the 2 percent withhold may be too small to
4 motivate providers to improve.
5 In October, we will outline an alternative design
6 that corrects these shortcomings. We will estimate the
7 impacts of the alternative design and compare these to the
8 impacts of the current design. Based on your discussion,
9 we will then outline policy options for replacing the SNF
10 VBP with an alternative design.
11 Today we'd like to hear your reactions to the
12 results of the program and the shortcomings we've
13 identified.
14 And now we'll turn back the mic.
15 DR. CHERNEW: Great. That was terrific. Thank
16 you for all the material.
17 I have asked Dana Safran -- actually, I take that
18 back. Dana Kelley. We're going to start with Round 1.
19 How is our Round 1 queue looking?
20 MS. KELLEY: I have Jaewon, and also, Paul, did
21 you want to be in Round 1 or Round 2?
22 DR. PAUL GINSBURG: Round 2, please.

1 MS. KELLEY: Okay. Then I just have Jaewon.
2 DR. CHERNEW: Thanks, Dana. A fantasy Round 1.
3 DR. RYU: I just had a quick question. I'm not
4 sure I'm understanding the risk adjustment commentary
5 correctly on page 19. It sounds like the higher the risk
6 score, the less likely that the entity would receive the
7 positive adjustment, but it also says that we think the
8 risk adjustment model is complete. Do we have other
9 working hypotheses on what we think is going on, then? Is
10 it that there's other correlations at play that's driving
11 that? I would just love to hear a little bit of thought on
12 that aspect.
13 DR. CARTER: We think the risk adjustment is
14 pretty good. So it's possible and -- but, of course, no
15 risk adjustment is perfect. So it's possible that there
16 are, I'm sure, other dimensions of care that probably, at
17 least I don't see a way to gathering, using easily and
18 readily available administrative data.
19 It's just, I guess, I think I'm thinking these
20 providers actually perform more poorly. So it's not in the
21 risk adjustment. It's actually in the performance.
22 David, I think you have an article that came to

1 the same conclusion; is that right?

2 DR. GRABOWSKI: Yeah. We used a slightly

3 different readmissions measure, Carol, where we used kind

4 of a longer lookback period. So we got around the small

5 sort of numbers problem. We used a three-year lookback

6 versus the one.

7 And then we also risk-adjusted for those social

8 factors, like the percent of duals, which this program

9 doesn't. And that was going to be my response to Jaewon.

10 Maybe there's some correlation with the acuity and the

11 social risk factors that they're not accounting for here.

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

13 also?

14 MS. WANG: Thank you.

15 It's just a question about the readmission

16 measures. You mentioned that CMS has created a potentially

17 preventable readmission measure. How is this different

18 from the current HEDIS specifications around potentially

19 preventable? Can you comment on whether there are

20 characteristics about nursing home readmissions that need

21 to have different components or measure differently? Is

22 this a different readmission measure than is used in other

1 settings that are the NCQA definitions?
2 MS. TABOR: I can take this, Carol.
3 The measures are conceptually the same, looking
4 at the readmissions within a certain time period, all using
5 30 days, so hospitalization is 30 days after discharge. I
6 will say the risk adjustment models are different, and some
7 of the definitions of how you calculate the numerators and
8 nominators are different, and you've got the problem -- you
9 know, we kind of see across programs, that in different
10 sectors, the measures, again, are kind of conceptually the
11 same, trying to move providers into reducing readmissions,
12 but how it's populated, there are differences.
13 MS. WANG: Is this one homegrown by CMS?
14 MS. TABOR: They work with the contractors to
15 develop this one, yes.
16 MS. WANG: Thank you.
17 MS. KELLEY: Paul?
18 DR. PAUL GINSBURG: Oh, sure.
19 MS. KELLEY: Oh, wait. I'm sorry, Paul. Can I
20 interrupt you for one second? I'm sorry. I've missed one
21 Round 1 question.
22 Larry?

1 DR. CASALINO: The question on page 24, you have
2 a nice discussion of the readmission measure, what it
3 probably -- evaluation and what it doesn't, and then some
4 discussion of alternatives. But in the end -- the
5 discussion was interesting, but in the end, I wasn't really
6 clear about the alternatives and then particularly the last
7 sentence, "The Commission supports a separate measure."
8 So just in the work for the next meeting where
9 you talk about alternative designs, can you tell us a
10 little bit more about what a readmissions measure or
11 measures you're considering?
12 DR. CARTER: Well, let me just say one thing
13 about the current measure, and then we can give you a sneak
14 peek at the measure that we're proposing for next time.
15 This measure, because it includes 30 days from
16 discharge from the hospital, depending on the length of the
17 stay of the SNF stay, it's going to scoop into that
18 measure, days when the patient has been discharged and
19 either is in home health or home or maybe been in another
20 PAC setting and days during the stay. So it's actually
21 conflating two very different sets of kind of
22 responsibilities, the SNF and what they're responsible for

1 during the stay and a good transition to the next post-
2 acute care or home. And it's kind of mixing both of those.
3 I think CMS did that because it was by statute
4 could only use one measure, and I think it was concerned
5 that if it only looked at readmissions during the stay,
6 that it would encourage SNFs to discharge a patient if they
7 thought they were going to be readmitted, and then they
8 wouldn't have a measure to capture the readmissions after
9 discharge.
10 So one of the things that we've always said you
11 need a measure that's for the stay and one after the stay
12 because they capture pretty different things about the care
13 process. So the measure that we're thinking about, we have
14 a couple of measures, and they will correct both of those.
15 DR. CASALINO: Carol, you don't want to say right
16 now what those are?
17 DR. CARTER: Well, we actually last year
18 presented them. One is a hospitalization measure. So it
19 includes hospitalizations, readmissions, and observation
20 stays, and then a second measure is safe discharge home.
21 And that is a measure of when the beneficiary went home,
22 were they readmitted, or did they die in the first 30 days.

1 And so it sort of deals with both of those pieces of the
2 process of care.
3 DR. CASALINO: Thank you.
4 DR. CARTER: You're welcome.
5 MS. KELLEY: Wayne, did you have a question?
6 [No response.]
7 MS. KELLEY: Wayne, I'm sorry. We can't hear
8 you.
9 DR. RILEY: Okay. Let me see. Hello.
10 MS. KELLEY: There you go. Yes.
11 DR. RILEY: Thank you.
12 Good afternoon, Mr. Chairman and fellow
13 Commissioners. Delighted to be a part of this great group.
14 The erudition is just amazing.
15 A question, in terms of -- was there any
16 geographic variation in the average increase in rate of
17 readmissions? I'm curious. Did you see any regional
18 differences?
19 DR. CARTER: Yes. And there's a little bit in
20 the paper that talks about the variation by state. This is
21 similar to the variations you see in all kinds of measures
22 in health resources. Yes, there is quite a bit of

1 variation.

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

5 DR. SAFRAN: Okay, great. I'll be very brief.
6 Thank you, Dana.

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

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

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

20 I think the staff knows very well that there's an
21 excellent and well-accepted methodology in the field for
22 computing the minimum sample sizes needed for reliability.

1 Back when I was at Blue Cross, I had that number
2 for this measure, and I don't remember it. But it was more
3 than 100. It may have been 200. It's certainly not 25.
4 So the fact that we see institutions year over year
5 balancing from one category to the next tells us what we
6 need to know about the reliability and stability of this
7 information.
8 So I think that this has to be -- it has to be
9 addressed, or the program perhaps has to be paused until we
10 have sufficient sample. You do a nice job in the chapter
11 of exploring some options, you know, multiple years of
12 data. We've talked before about how that's problematic,
13 especially for low performers who then have an anchor that
14 they're dragging around year by year as they try to show a
15 better performance.
16 We could consider an all-payer version of this
17 measure. I think that's an option to consider, to see if
18 we could get closer to the sample sizes required.
19 And then the two other points, I guess, I would
20 make are, number one, that we make a little bit about the
21 concern around duals, and if, in fact, that is not noise
22 also, then I agree it's concerning. But I am fearful that

1 what we're seeing with respect to the duals finding here
2 could also be noise. So I'd ask us to consider that. But
3 for sure, we'd want this program to use the same approach
4 to social risk factor stratification that we recommended in
5 others.
6 Then, finally, there's some commentary in the
7 chapter about questioning whether 2 percent is adequate.
8 There's some citations from folks in the industry saying 2
9 percent is, in fact, a number that's not at large and not
10 large enough to overcome the cost that would be required to
11 make improvements. That surprised me just because I think
12 the margins for SNFs are quite small, and so 2 percent in
13 that context, it seemed to be quite significant. So I just
14 had a question about that.
15 The last comment I'll make is I'd be more than
16 happy -- I think David probably has the best breed of any
17 of us because of his expertise in long-term care space for
18 thinking about what other measures might be possible. For
19 sure, we'd want some patient experience, though that's
20 complex for this population, and we don't want to have to
21 rely on proxies. We'd want outcome measures more than
22 process, but if it's useful to the staff to have a session

1 of thinking about what the options are so we can make some
2 affirmative recommendations about other measures, I'd be
3 very glad to be part of that.
4 Thanks.
5 MS. KELLEY: Okay. David, I think you're next.
6 DR. GRABOWSKI: Great. Thanks, Dana.
7 My comments line up really well with Dana
8 Safran's. I'll just say at a high level, the SNF VBP is
9 just a terrible policy.
10 In the spirit of full disclosure, I was part of
11 the team that evaluated the nursing home value-based
12 purchasing demonstration, or the NHVBP, which was the
13 predecessor or the demo with which this current program is
14 built on. We had a lot of ideas for CMS. Unfortunately,
15 they fixed some of them but created other problems and
16 didn't end up fixing other parts of the program, and so
17 we're left with really a flawed program. It's never a good
18 sign when the MedPAC staff can't even fit all the
19 shortcomings on one slide. Carol actually had to go into a
20 second slide there.
21 And I think the two most damning shortcomings or
22 the two most important in my mind -- Dana did a great job

1 of focusing in on this first one, that readmissions as
2 currently constructed are really poor measure of quality.
3 As Dana suggested, it's largely noise with very little
4 signal there, and I also -- Dana was troubled by just the
5 lack of consistency across the two program years in terms
6 of which facilities received rewards and penalties.
7 The second, I think, most important shortcoming
8 is just this idea that the measure, the program is
9 regressive. It's really rewarding to haves and penalties
10 the have-nots. The program is taking dollars out of low-
11 resource SNFs that nominally care for duals and giving them
12 to facilities that care for fewer duals. This is obviously
13 not the kind of program we want to have in place.
14 I would suggest that there's a number of
15 potential fixes here. First, we want to fix the
16 readmission measure. We want to account for social risk
17 factors. We want to fix the minimum count threshold, as
18 Dana was suggesting.
19 I really like where Carol was going with fixing
20 readmissions during and after the stay. I think that's a
21 really important issue.
22 I did want to quickly again mention that paper

1 that Carol raised. It's the Rahman and colleagues paper
2 that's cited in the chapter.
3 We've validated a readmission measure. So I do
4 think there is some validity to measure, but our measure
5 that we looked at was very different in terms of sample
6 size, in terms of incorporating the social risk factor.
7 I don't want to throw out readmissions as a
8 measure. I think that there's something here, but I think
9 we need to work on fixing the readmission measure.
10 Second, we need to fix the performance measure.
11 Once again, there's no need to account for both overall
12 improvement and performance. With proper risk adjustment,
13 we can focus just on performance.
14 But for the Commissioners, we hate payment cliffs
15 here in MedPAC. So we need to get rid of those cliffs and
16 get a more continuous payment methodology that doesn't have
17 those thresholds.
18 And then third -- and Dana did a nice job of
19 highlighting this -- we need more measures. I do think,
20 once again, readmissions is a good start when properly
21 constructed, but the challenge is finding other claims-
22 based measures. We often look towards mortality. That's

1 not a very good measure in the SNF context. There's not
2 much in the way of patient experience measures.
3 I do think we want to think about other claims-
4 based measures. I think we want to avoid MDS, minimum data
5 set-based measures due to the self-reporting bias there,
6 but I hope that we can think about additional measures that
7 might go alongside the readmissions measure.
8 Final point -- and I had a similar reaction to
9 Dana. One area where I would push Carol and the team is
10 around the size of the withholding is 2 percent and whether
11 that's too small, kind of the old pennies for performance
12 problem. This reminds me of the old joke from Annie Hall
13 where two older women are at a restaurant, and one of them
14 says, "Boy, the food at this place is terrible." The other
15 one says, "Yeah, I know, in such small portions."
16 I don't know why we want to make the SNF VBP
17 portions bigger until we really fix the quality of the
18 program. I think, Carol, I would be really reluctant to
19 sort of put more dollars on the table here until we're
20 certain we're just not paying based on noise.
21 I like what Dana suggested, pressing pause on
22 this program until we fix it, because I really don't like

1 the idea that we're taking dollars out of low kind of -- I
2 should say high-resource facilities that are carrying for a
3 low share of duals and giving them to facilities that are
4 basically caring for a more vulnerable population.
5 I hope we can fix this. I do have hope for it,
6 but I think it's a really poorly constructed program as it
7 currently stands.
8 Thank you.
9 MS. KELLEY: Mike, did you want to get in?
10 DR. CHERNEW: Yeah. So I think the queue is
11 building, and so I'm going to give people time to get in
12 the queue. But I want to say, first of all, Dana and
13 David, those were excellent comments and I'm completely on
14 board with the direction both of you are going.
15 But I'd like to get a sense from the rest of the
16 Commission is that there's a lot of flaws in this program,
17 which I think Carol laid out, and Dana and David
18 emphasized, I would lean toward the recommendation that
19 this program should be paused until we could actually get
20 the fixes in place. I worry sometimes that we spend a lot
21 of time doing minor tweaks, and this is in some ways an
22 anti-Robin Hood program. It robs from the ones we care

1 about and -- we care about everybody -- it robs from
2 potentially the ones serving the poor and gives to the
3 other places. I'm not completely sure that's true but I
4 suspect that that's true, given the analysis.
5 And so I'm leaning towards, back to Sue's earlier
6 comment, a bolder recommendation that this should just be
7 stopped until it's fixed. And then a bunch of constructive
8 comments about how to fix it, and I think Dana, your
9 comments were very well taken. I agree. Your expertise on
10 sample size and stuff is really important, and the number
11 of measures matters. David, I agree with your points as
12 well, how you said that.
13 But what I really need to think through as we go
14 forward is where the rest of you all are on that level of
15 approach. If you're a strong proponent of this proposal,
16 now is the time to speak up. Or if you fit where David and
17 Dana and, frankly, where I am, please say that. But that's
18 kind of what I'm trying to get out of the remaining parts
19 of the session, and anything else you want to say is
20 obviously welcome.
21 So Dana Kelley, I'm turning it back over to you
22 to manage the queue.

1 MS. KELLEY: Okay. It is now Paul's turn.
2 DR. PAUL GINSBURG: Thank you. This is really
3 well done, and to me, who is not an expert in post-acute
4 care, the big takeaway is could some value-based payment
5 models can be sufficiently flawed that they're not doing us
6 any good, and we need to really put as much work as
7 possible into developing the models well.
8 I support pausing this, but with a strong plan to
9 fix it and resume it. And one thing I was asking myself is
10 that this is a mandatory program. It followed a
11 demonstration. If we had continued as a demonstration, I'm
12 not sure that we would've actually found out how flawed it
13 was. And given the potential for fixing things, this has
14 not limited my interest in pursuing these programs in
15 mandatory designs.
16 One question that I was going to ask in Round 1
17 but decided it would be too sneaky in getting my big
18 picture things in is, as far as the fixes that were
19 recommended by staff or by Dana and/or David, how many of
20 these would require legislation versus regulations by CMS?
21 Because if some would require legislation, it just brought
22 in some of the pitfalls of Congress writing legislation

1 that's overly detailed and prescriptive about how to do
2 value-based payments. I've long felt that the ACO program
3 has suffered from some of the details in the 2010
4 legislation that established it.
5 I guess one other thought -- again, I think it's
6 a question for others -- is when the legislation that we've
7 been asked to look into was passed, to what extent did it
8 reflect the best thinking at the time? And, you know,
9 maybe that's just crying over spilled milk, but in a sense
10 it's relevant to this notion of to what degree should
11 Congress get into the details in value-based payments or
12 give much broader directions and constraints to CMS to
13 implement that, with the understanding that with experience
14 these things will be changed as we learn more. Thanks.
15 DR. CARTER: So if I can just jump in, I'll
16 address some of that. So a lot of the weaknesses of this
17 program are in statute. The minimum count is not. But the
18 single measure, the improvement and achievement, the
19 scoring cliff, and the size of the withhold are all in
20 statute. And so depending on -- it sounds like your
21 discussion is leaning towards a recommendation, and it
22 sounds like at least some of that is going to need to be

1 directed to the Congress.

2 MS. KELLEY: Okay. Amol?

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

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

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

22 One just really minor suggestion is I believe

1 Figure 1 in the paper had a histogram. I think virtually
2 because of the 40 percent eclipse it might actually be nice
3 to see that histogram in terms of percent of SNFs rather
4 than number of SNFs. That's easier to tell, actually,
5 where that cliff is impacting the distribution. Thanks.
6 MS. KELLEY: Larry.
7 DR. CASALINO: Well, I really got into the queue
8 to ask a question, which I'll ask in a minute. But just
9 responding to Mike's question about a pause, yeah, I would
10 support a pause. We want the pause to be as short as
11 possible, but of course, if a new program is going to
12 require legislation it's hard to say how long the pause
13 would be. So if we do wind up recommending that we would
14 want to put some urgency, I think, into the recommendation
15 that a new program be developed quickly.
16 And then just to point out that, again, I do
17 support a pause but supporting a pause of an undetermined
18 length we're essentially saying that the current program is
19 worse than no program. And I think I agree with that,
20 based on the staff's very lucid presentation. But just so
21 we're all clear that that's what we're saying, it's worse
22 than no program.

1 The question I wanted to ask, and this is for
2 David and Dana and anybody else, is to the count, to the
3 minimum necessary for readmissions measure, for example, to
4 be reliable. What are the alternatives? Dana, you not big
5 on multi-year. You mentioned multi-payer. A high count in
6 a single year, just Medicare, is going to exclude a lot of
7 homes, I guess, which might or might not be a bad thing.
8 Do either of you, or anybody else, have any ideas about
9 what to do with the count program, which is not unique to
10 this program? Because we can criticize it but we should
11 have a better alternative, in terms of the
12 count/reliability.
13 DR. SAFRAN: Yeah, I don't have a great idea, you
14 know, other than evaluating other measures where perhaps
15 the required sample sizes could be smaller. But, you know,
16 I'm not very knowledgeable about over the course of the
17 year roughly how many different Medicare beneficiaries does
18 a SNF typically have, and I imagine that's quite variable.
19 There are larger ones and smaller ones. But having that
20 information might help us think about, you know, are there
21 going to be any measures that are going to meet the kinds
22 of samples sizes that, let's say, 50 percent of SNFs or 60

1 percent of SNFs have over the course of a year.

2 One sort of wacky idea, but I'll just throw it

3 out there, is the kind of grouping of SNFs, if there's some

4 way that, you know, you want to have SNFs held jointly

5 accountable, and they want to identify others with whom

6 they want to partner so they have enough sample and then

7 partner on performance improvement concepts, you know,

8 that's one way to get to larger numbers. But I know it

9 would be quite unconventional.

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

11 DR. CHERNEW: I do, because I want to say, Larry,

12 yes, I believe this program is worse than no program. I

13 mean, I believe that very exclusively, based on my read of

14 the chapters and the presentation and the comments by David

15 and Dana, and I think we should not pursue value-based

16 purchasing for the sake of doing it, that we can actually

17 do more harm than good by taking -- I think this program

18 probably, for example, exacerbates disparities. Why we

19 would want to do that doesn't seem to make sense to me.

20 You could convince me otherwise and I'm all ears, if

21 someone wants to convince me otherwise, but my strong

22 sense, given the chapters were not getting better quality

1 or making disparities worse.

2 Again, I could be proven wrong but I do believe

3 that it's worse than nothing, and I think we should wait

4 until we get something that's better than nothing before we

5 do something. That's my personal view, just to respond to

6 your comment.

7 So I think, Dana, you might want to go back into

8 the queue.

9 MS. KELLEY: Brian?

10 DR. DeBUSK: Thank you. Thank you, Dana. Yeah,

11 you know, the one thing when I was reading this chapter,

12 what really stood out, with all the really quality work

13 that we've done over the last year or two on developing

14 that VBP template, like we used for the HVIP, like we used

15 for the MA bid, it seems like this is something if we could

16 go back to that same set of principles -- small set of core

17 measures, use peer grouping, no tournament models. I mean,

18 it seems like the template is really well-defined here, and

19 I'd love to see us use this as an opportunity to

20 standardize, yet again, the value-based purchasing program.

21 So, you know, Lydia and Carol, I was thinking,

22 you know, that would be a solid week's work to get this

1 thing recast into the SNF model. Correct?

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

3 October presentation.

4 DR. DeBUSK: All right. I was hoping that was in

5 the works when I read the chapter, because I think the work

6 that you guys have done building up to this is spectacular,

7 and this is the perfect -- it makes to just pour it right

8 into the template that you've already built. Thank you.

9 MS. KELLEY: Pat.

10 MS. WANG: I just want to respond to Michael's

11 request for feedback on the question of pause or not, and I

12 support pausing it. The analysis and the commentary here

13 make it pretty clear to me that this is worse than no

14 program at all, to answer Larry's question. I don't know

15 how complicated or easy that is to achieve, to just sort of

16 say time out. I don't know if CMS has any discretion over

17 that or whether that it's congressional. But I just wanted

18 to respond. Thank you.

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

20 Okay. Then Jon Perlin.

21 DR. PERLIN: Thanks. Let me thank the staff for

22 a very lucid presentation. I think the sentiment of the

1 group, I completely endorse. If we have a program that we
2 think is, marginal, at best, indifferent, that works
3 potentially worse than status quo, then just recommend it.
4 It also violates our expressed view on measures.
5 But I have two questions, really. One, it feels
6 a little bit like we're bidding against ourselves. I
7 thought the direction we were headed was related to this
8 concept of a unified post-acute prospective payment system,
9 or something that inherently builds in risk.
10 And second, related to that, I mean, a singular
11 measure can be so monodimensional and the measure that is
12 below a frequency event is inherently going to be
13 unreliable. And, you know, machinations to pick longer
14 times produce the predictive value in terms of trying to
15 make an assessment of whether that's a good environment.
16 And that would seem combining the notion that
17 there may be an opportunity to unify some of our thinking
18 with the broader program nothing that we've been espousing,
19 that we also ought to be thinking about unified suite of
20 measures that really create, if you will, a balanced
21 scorecard, that look at cost, that look at outcomes, look
22 at measures of experience, and structure. And I'm not a

1 big fan of structure, but, you know, does that environment
2 provide rehabilitative potential and certain skills? Does
3 it provide infection control resources, and some of the
4 things that have really been brought to light during COVID.
5 So those are my two points, one, you know, how do
6 we align this with our thinking about an overall unified
7 program, and two, across unified program, how do we think
8 about a suite of measures that are more reliable? Thanks.
9 DR. CARTER: So just as a point of clarification,
10 the measures that we're thinking about with an alternative
11 design were developed across the four settings, so you
12 could use those for other settings. We had explicitly in
13 mind.
14 DR. PERLIN: Exactly my point. Thanks.
15 MS. KELLEY: That's all I have in the queue,
16 Mike.
17 DR. CHERNEW: Great. So maybe we'll be way ahead
18 of schedule and that will be amazing. We'll see if anyone
19 else wants to add, although some of you haven't spoken and
20 I may call you out just to get your sense of where you are
21 in terms of a consensus or not. So I'm going to ramble for
22 one second while you ponder your thinking.

1 I have a related question. Would it be possible
2 -- this is almost a semantic question -- to create a
3 composite measure? In other worse, these multiple measures
4 create a composite measure from them, and then call that a
5 single measure and claim that CMS is now meeting its
6 single-measure criteria. In other words, if you built a
7 composite measure and judged based on that composite
8 measure, in some sense they're using a single measure. It
9 just is a really multifaceted one.
10 I realize that's semantic, but it strikes me as a
11 potential way out of this single-measure limitation that
12 Dana mentioned.
13 The other thing that's nice about composite
14 measures is you can deal with some of the sample size
15 issues in composite measures in ways that are harder if you
16 have a single measure, because you can bring in other
17 pieces of information.
18 And lastly, I would add, no one mentioned this
19 although it comes up in the chapter. There's this question
20 about going back to get data from earlier years, and
21 there's some hesitancy to do that. I share that hesitancy,
22 in some ways, but I think in the grand scheme of evils,

1 going back and expanding sample size by looking at earlier
2 years is a lesser evil than some of the sample size
3 problems, again, that Dana was speaking about.
4 So again, I think there's a lot of creative
5 things that CMS could do maybe with or without legislation
6 that we could think about, and that we can take offline.
7 But the current approach, again, remains particularly
8 troubling to me.
9 So how have I done in terms of getting more
10 people in the queue, Dana?
11 MS. KELLEY: Not that well, to be honest.
12 DR. CHERNEW: Oh my gosh. So let's see. I'm
13 going to go around the top. Karen, I've been trying to
14 keep track here. Karen, I haven't heard your thoughts
15 about -- you don't have to say much. Are you with us,
16 against us, or uncertain? Are you pro or do you want to
17 share?
18 DR. DeSALVO: Most everything's been raised that
19 were my concerns. Let me just say, first of all, I think
20 David's comment that if it takes that many slides or that
21 much text to point out the flaws in the program, that there
22 are more that we could get into, then we think it's

1 problematic. It's a highly vulnerable population, and it's
2 also sort of an area where we wouldn't want to exacerbate
3 disparities, as you raised, Michael. And I think it's not
4 only about disparities based upon income but other social
5 factors that are sometimes harder to gauge. We all know
6 clinically that sometimes people, you know, struggle to be
7 home because they're alone and they have transportation or
8 food security issues. There's a whole host of reasons why
9 some of the things that may make sense in other
10 environments won't here. So being able to adequate
11 incorporate that thinking into the measures and the
12 payment.
13 And I think the other point that was made is that
14 having value-based care models for the sake of doing that,
15 it isn't the goal. The goal is to really make sure that
16 we're being responsible with Medicare dollars and serving
17 the populations well.
18 So I'm excited to see what the team is going to
19 come back to us with. I like the foreshadowing. And I
20 really appreciate the attention to thinking through the
21 responsibility that we have here to do right by the
22 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.

1 It occurred to me after giving my remarks that one of the
2 things I recall with our global budget model at Blue Cross
3 Mass was that hospitals started to have criteria by which
4 they evaluated nursing homes to decide where were they
5 going to send their volume, because they wanted to be sure
6 they were good partners who weren't going to kill their
7 budget.
8 And so I do wonder, as part of the work ahead, as
9 we try to figure out what might some alternatives be,
10 whether we want to do some interviews with hospital leaders
11 about how they evaluate SNFs. That was just an idea to
12 throw out there.
13 DR. CHERNEW: Great. Well, the next person
14 around the screen that I see is Marge. You're up, Marge.
15 MS. MARJORIE GINSBURG: Okay. You can hear me?
16 DR. CHERNEW: I can hear you perfectly.
17 MS. MARJORIE GINSBURG: Thank you. So I concur
18 with everyone else about the pause. I confess I am
19 intrigued, Mike, with your statement about is there any way
20 that we can consolidate the issues being addressed in a way
21 that doesn't completely kill it.
22 So I guess my question is, is there any amount of

1 tweaking that could be done with the existing model that
2 moves it from the no-go to yeah, it's keep it going and
3 then do serious tweaking later? So we run the risk, if
4 anybody pays attention to what we have to say, about
5 killing it entirely, or is it easier, as I said, to try to
6 make a few changes that make it just barely doable? Is
7 that clear?
8 DR. MATHEWS: So this is Jim. I'm happy to try
9 and take that question. So given the analysis that we've
10 done over the last year or so, looking at the current VBP,
11 you know, I think the message has punched through, given
12 some of the commentary from the Commissioners thus far. We
13 do believe that the current SNF VBP is not really
14 salvageable in its present form, and given that some of the
15 flaws are attributable to certain statutory constraints,
16 that if you're going to change legislation it's probably
17 better to just sweep away the current system and change it
18 with something that is holistically better.
19 And as I'm listening to some of the commentary
20 here, I can tell that maybe we've been a little bit too coy
21 in alluding to what's coming in October, but our intention
22 is to be able to present to you, in a holistic way, what

1 the better thing is. So if Blue Cross, loud and clear,
2 paused, you know, this is worse than doing nothing, that is
3 something we can accommodate when we come back and regroup
4 after this meeting. But we will have something for you to
5 react to that would be a wholesale replacement of the
6 current SNF VBP.
7 MS. MARJORIE GINSBURG: Great. Okay. Thank you.
8 DR. CHERNEW: All right. Absent any other
9 volunteers I'm going to call, if I can, on Wayne. I feel
10 like I'm back in class.
11 DR. RILEY: Thank you, Chairman. No, I agree.
12 This program should be paused and re-tinkered. I do agree
13 with many of the comments, that I do worry about the health
14 disparity dimension to this, knowing that, again, many
15 seniors, African American seniors end up needing skilled
16 nursing care at significantly higher rates, particularly,
17 you know, in the southern part of the country, that we do
18 need to pause it but try to get it reactivated in some
19 better shape as soon as feasible, given the obvious
20 constraints.
21 DR. CHERNEW: Thanks, Wayne. So that would put
22 Jonathan up next on my screen.

1 DR. JAFFERY: Thanks, Mike. You meant me, right?
2 DR. CHERNEW: Yes. I meant you.
3 DR. JAFFERY: So thanks. Yes, I am supportive of
4 the direction. I'm glad to hear the comments that we can
5 expect in October to have something that's sort of moving
6 in this direction. I agree with the comment that Brian had
7 made also, that, you know, we've got a set of principles
8 that we've been moving towards, and it's nice to try and
9 align the various programs with that.
10 But just in general I guess I'm really glad to
11 hear us having some emphasis in our conversation today
12 about the idea that we really need to be promoting policies
13 that reduce equities and not exacerbate them. So I am
14 fully supportive of the conversation's direction today.
15 DR. CHERNEW: Great. Jonathan, thank you.
16 Bruce, you would be next on my list. If you've spoken, I
17 apologize. My list-keeping isn't that great, but I do have
18 a list.
19 MR. PYENSON: No need for apology, Mike.
20 DR. CHERNEW: I think, Susan, you're going to be
21 after Bruce, and then we can be ready for the
22 muting/unmuting part.

1 MR. PYENSON: Thank you, Mike. I was especially
2 glad Jonathan Perlin asked the question, are we arguing
3 against ourselves with respect to [inaudible - audio
4 difficulties]. I was happy to hear Carol's answer that a
5 unified approach is part of the solution. So I do support
6 the pause.
7 DR. CHERNEW: Thanks. Sue.
8 MS. THOMPSON: Absolutely. I too support the
9 pause, and I look forward to October.
10 DR. CHERNEW: Maybe I spoke too much. I asked
11 everyone to be concise, but that's terrific. Thank you,
12 Sue.
13 I think the last person for at least this round,
14 although you spoke earlier, would be Jaewon. If I have
15 missed anybody, again, my list-keeping isn't great, but I
16 think you were the last -- you'd be the last one, Jaewon,
17 to jump in on this. Dana Kelley, if I've missed anybody,
18 please let me know, or anybody else. If I've missed you,
19 again, I'm super sorry. I got chats in front of some of
20 your faces.
21 MS. KELLEY: No, I don't have anyone in the
22 queue. Oh, Jaewon.

1 DR. RYU: No, no. No worries. I concur as well.
2 I think everyone made great points. I think super
3 compelling. I do agree that it seems like a little bit of
4 an outlier or may be a lot of an outlier versus other VBP
5 programs we've evaluated or discussed.
6 It did dawn me, and I like Dana Safran's comment
7 around it would be interesting to see some of the feedback
8 or ideas on whether it's from hospitals, or I thought even
9 from nursing homes, SNFs that are out there. I just don't
10 know how well appreciated some of these flaws are, or what
11 is the perception of the operational folks who are on the
12 front lines in that realm? And maybe David or others who
13 are closer to this space know. But as I was listening to
14 the discussion, I think that's one thing that kept coming
15 up in my mind, is gee, do others feel this way too, and is
16 there broad recognition that this is how the program's
17 structured? You know, I just couldn't help but be curious.
18 DR. GRABOWSKI: I can quickly answer that, Mike.
19 I don't think the industry is a huge fan of the program
20 yet. As Carol mentioned, it's comparatively a small share
21 of dollars. They end up taking an overall haircut on it,
22 so I don't think they love it. They don't love the

1 measurement. But I don't know that it's been a huge area
2 of focus. I don't know, Carol, if you would disagree with
3 that. I would have expected more pushback, but I haven't
4 heard a lot of that. But it's not a beloved program by any
5 stretch of the imagination.
6 DR. CARTER: Yes. We've talked a little bit with
7 folks and my general sense is that the industry has not
8 been terribly focused on the program. They've had sort of
9 bigger fish to fry, in terms of a new payment case mix
10 system that came into play, that took a lot of their
11 attention over the last year and a half, and now, of
12 course, COVID. So I just think the folks, it's not that
13 they've focused on design features. They're not even
14 really focused on it.
15 And I guess the other thing I would say is the
16 program's really asking them to do things that they're
17 already focused on. To the extent that they can improve
18 it, they're being pressured by hospitals, ACOs, MA plans,
19 to lower rehospitalization rates. So it's not like this
20 program asks them to think about something in a different
21 direction. It just kind of reinforced whatever they were
22 doing already. But I think mostly they haven't

1 particularly focused on the program.
2 DR. CHERNEW: Terrific. Dana, were you going to
3 say something?
4 MS. KELLEY: I was going to say that Larry would
5 like to say something.
6 DR. CHERNEW: Okay. Larry, you're up.
7 DR. CASALINO: Yeah, this is the unique situation
8 in my time on the Commission that we actually have time, so
9 I want to ask a general question. One of our core
10 principles for value-based purchasing programs is that
11 there should be patient experience, patient, in this case,
12 maybe family experience. We always say that when we
13 summarize our principles. But I think we give a pretty
14 short shrift, generally speaking, when we're discussing
15 specific programs, and certainly we've done that today with
16 nursing homes. You know, my experience with nursing homes
17 is -- and this may be an illusion -- but in many cases you
18 can walk in the door and within three or four minutes you
19 have a pretty good sense of the place, if you're family.
20 So I guess I have a specific question and a
21 general question. Specific question is, for nursing homes,
22 or long-term care facilities, when we say we want patient

1 experience measure, what are we talking about, because we
2 also want things to be administratively simple and not
3 expensive, and those two may be in conflict. And then more
4 generally, how do we deal, in our recommendations, with the
5 conflict between wanting to get patient experience, family
6 experience, and wanting things to be administratively
7 simple, not burdensome, not expensive?
8 MS. TABOR: And those are great points,
9 particularly relevant, and again, thinking about October
10 presentation, that right now there are no national programs
11 for looking at patient experience in nursing homes, and
12 that is, you know, thinking about it from a traditional
13 sense of residents saying "how satisfied were you with your
14 care while you were there?" and another kind of general
15 question, that's a good marker of experiences, "Would you
16 recommend it to others?"
17 So there are some industry surveys out there that
18 CMS could adopt, and has thought about adopting for SNF
19 quality reporting programs, but has been halted. And I
20 think there are a lot of issues with this population, that
21 Dana mentioned, like, you know, use of proxies and how
22 balanced measures are with using proxies.

1 So I don't think that's something we can really
2 take off the shelf right away and apply a new value
3 incentive program, but I think the Commission, based on our
4 principles, could continue supporting CMS moving to develop
5 a program.
6 DR. CASALINO: Thanks.
7 MS. KELLEY: Pat?
8 MS. WANG: Yeah. Thank you. You may be
9 addressing this in October, but I had two questions about
10 measures. One has to do with hospital readmissions,
11 whether they're preventable, or cause, or what have you. I
12 guess the interest I have is whether there need to be
13 differences in the measures of hospital readmissions based
14 on whether it's coming from a nursing home or a different
15 setting. We talked about it as being such a core measure,
16 but I feel like every program has a slightly different
17 hospital readmission measure or definition. And, you know,
18 ideally, given the importance and centrality of avoidable
19 hospital readmissions, I hope that maybe you could at least
20 comment in October the similarity or differences in the
21 approach that you're taking to the inpatient program, to
22 the stars program, to other programs that are out there.

1 That's the first thing.

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

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

18 MS. KELLEY: That's all, Mike.

19 DR. CHERNEW: Okay. So we're in the fortunate
20 position of being above quality and under budget, setting
21 an example for broad efficiency in how we run all of this.
22 Don't take it as a hallmark of my time here, but I really

1 owe it to the staff, Carol, and Sam, and Ledia, you've done
2 an absolutely terrific job, and the comments were really
3 helpful. So a special thanks to all of you that weighed
4 in.
5 I think what we're going to do is we're going to
6 jump to the next session, and that's going to be Brian and
7 Carolyn talking about lab fee schedule. So again, we are
8 going to go with the Rounds 1 and 2 session. If you have a
9 clarifying question don't hesitate to jump in and let Dana
10 know. And with that I'm turning it over to, I think Brian
11 is going to kick us off.
12 MS. KELLEY: Brian, are you on with us?
13 MR. O'DONNELL: I am on, but I think Carolyn is
14 going to start us out.
15 MS. KELLEY: Okay.
16 MS. SAN SOUCIE: Can you hear me?
17 MS. KELLEY: Yes, we can.
18 MS. SAN SOUCIE: Okay. Good afternoon. In this
19 presentation, Brian and I will discuss our work towards
20 fulfilling a Congressionally mandated report. The report's
21 focus is on the Protecting Access to Medicare Act of 2014's
22 changes to the Medicare clinical laboratory fee schedule.

1 The audience can download a PDF version of these slides in
2 the handout section of the control panel on the right hand
3 of the screen.
4 The Congress mandated that the Commission
5 investigate changes made to the clinical lab fee schedule
6 by the Protecting Access to Medicare Act of 2014. One part
7 of the mandate requires the Commission to examine the
8 methodology that CMS used to set private payer-based rates
9 for laboratory tests paid under Medicare fee-for-service.
10 Another part of the mandate requires the
11 Commission to report on the least burdensome data
12 collection process that would result in a representative
13 and statistically valid data sample of private payer rates
14 from all laboratory market segments. The report is due in
15 June 2021.
16 We have four parts to our presentation today.
17 First, we'll provide some historical background on the
18 clinical laboratory fee schedule to set the stage for the
19 changes made to the CLFS under PAMA.
20 Clinical laboratory tests analyze specimens from
21 the body to diagnose health conditions and help guide
22 treatments. Under Part B, Medicare covers medically

1 reasonable and necessary laboratory tests when they are
2 provided in a CLIA-certified laboratory.
3 For laboratory tests that are not bundled in
4 institutional settings or paid under the physician fee
5 schedule, Medicare predominantly pays for tests under the
6 clinical laboratory fee schedule.
7 The CLFS contains a range of services covered by
8 more than 1,400 HCPCS codes. Some tests are relatively
9 routine and provided by a wide variety of laboratories,
10 such as simple chemistry tests and comprehensive metabolic
11 panels. Other tests are low volume and complex and are
12 often furnished by relatively few laboratories, such as
13 molecular pathology tests.
14 In 2019, Medicare spent about $7.5 billion on 428
15 million CLFS tests. These tests were almost entirely
16 furnished by three types of laboratories: independent
17 laboratories (including large chains such as Quest and
18 LabCorp), hospital laboratories, and physician office
19 laboratories.
20 Prior to 2018, Medicare's CLFS payment rates were
21 set based on local, historical laboratory charges, updated
22 for inflation, and capped at certain amounts. Each

1 Medicare claims processing contractor established its own
2 fee schedule based on local laboratory charges in 1984 and
3 1985. This resulted in 57 different fee schedules that
4 were collectively known as the CLFS.
5 CLFS payment rates were not adjusted to reflect
6 laboratories' improvements in efficiency, changes in
7 technology, or market conditions.
8 Because of how CLFS payment rates were set and
9 updated over time, research suggested that Medicare's
10 payment rates were excessive. A 2013 OIG report found that
11 Medicare paid between 18 and 30 percent more than other
12 insurers for 20 high-volume or high-expenditure laboratory
13 tests.
14 The Protecting Access to Medicare Act of 2014
15 made several changes to the clinical laboratory fee
16 schedule, which Brian and I will go into in detail.
17 PAMA required CMS to shift the basis for CLFS
18 payment rates from historical laboratory charges to current
19 private payer rates.
20 Laboratories must report the payment rates they
21 receive from private payers so that CMS can establish new
22 CLFS rates based on the volume-weighted median of the

1 private payer rates.

2 Among other requirements, laboratories are

3 required to report their private payer data only if they

4 exceed two thresholds. One is the majority of Medicare

5 revenues threshold, which requires laboratories to report

6 only if they receive more than 50 percent of their total

7 Medicare payments from the CLFS or the physician fee

8 schedule. Another requirement is the low expenditure

9 threshold, which requires laboratories to report if they

10 received more than $12,500 in CLFS payments during the data

11 reporting period. The second threshold was implemented to

12 reduce the reporting burden for small laboratories.

13 PAMA requires laboratories to report their

14 private payer rates every three years so CMS can

15 recalculate CLFS rates.

16 Based on the first round of data reporting, CMS

17 estimated that private payer-based CLFS payment rates would

18 reduce Medicare spending by about $670 million in calendar

19 year 2018, including reductions in premiums.

20 This is because private payer rates were expected

21 to be lower than Medicare's 2017 payment rates for a large

22 majority of laboratory tests. Indeed, GAO found that

1 private payer-based rates were lower than Medicare's 2017
2 payment rates for about 88 percent of laboratory tests.
3 PAMA established a long phase-in of payment
4 reductions to mitigate the impact on laboratories and to
5 allow them time to adjust their operations. CLFS payment
6 rates can decrease by no more than 10 percent per year for
7 the first three years under the new payment system and no
8 more than 15 percent per year in the next three years.
9 Because of a one-year delay in implementation and an
10 additional one-year delay in all payment reductions,
11 payment rate reductions resulting from private payer-based
12 rates are expected to be fully phased-in by 2025.
13 Now Brian will go over the results from the first
14 round of data reporting.
15 MR. O'DONNELL: During the first round of data
16 reporting, just under 2,000 laboratories reported the
17 private payer rates they received for 248 million
18 individual tests.
19 Looking at the entities that reported,
20 independent laboratories were overrepresented while
21 hospital and physician office laboratories were
22 underrepresented.

1 As an example, let's look at the first row of
2 data in the table on the screen. Independent laboratories
3 billed for 48 percent of all CLFS laboratory tests in 2016,
4 but accounted for 90 percent of the volume of tests
5 reported to CMS, meaning such laboratories were
6 overrepresented in the first round of data reporting.
7 Some stakeholders contend that hospital and
8 physician office laboratories receive higher private payer
9 rates than independent laboratories.
10 Therefore, they have suggested that the lack of
11 reporting from these types of laboratories lead to
12 artificially low Medicare payment rates.
13 However, CMS modeled the impact of various
14 reporting scenarios, and their analyses suggested payment
15 rates would increase only modestly with greater hospital
16 and physician office laboratory reporting. For example,
17 under one alternative scenario, CMS found that greater
18 reporting by hospital and physician office laboratories
19 would have increased Medicare spending by only a couple
20 percentage points.
21 Despite evidence suggesting the limited impact of
22 underreporting, CMS made two changes that are designed to

1 increase the number and variety of laboratories required to
2 report their private payer rates in the future.
3 Both changes are technical modifications to the
4 "majority of Medicare revenues threshold" so I'll briefly
5 describe them here and will be happy to go deeper on
6 question.
7 The first change, in the left-hand box, makes it
8 so that laboratories that predominantly furnish tests to
9 Medicare Advantage enrollees will more likely be required
10 to report in the future.
11 The second change, in the right-hand box, makes
12 it so that hospital outreach laboratories will more likely
13 be required to report. Outreach laboratories are hospital-
14 based laboratories that furnish tests to patients other
15 than admitted inpatients or outpatients.
16 This next section reviews trends in utilization
17 and spending before and after private payer-based rates
18 were implemented in 2018 as one part of the Commission's
19 review of CMS' rate-setting methodology.
20 Some stakeholders have suggested that
21 inappropriately low payment rates could lead to access
22 issues. If substantial access issues occurred, those

1 changes would be reflected in the utilization data.

2 In the first two years of setting Medicare

3 payment rates using private payer data, we found that

4 utilization was stable.

5 Overall, we found that utilization increased from

6 12.8 to 12.9 tests per beneficiary from 2017 to 2019.

7 These results suggest beneficiaries had stable

8 access to laboratory tests, but as we note in the mailing

9 materials, access trends should be monitored over a longer

10 period of time because payment rate reductions are being

11 phased in slowly.

12 Moving on to spending, we found that Medicare

13 spending actually increased from 2017 to 2019. The

14 increase was driven by technical changes under PAMA and

15 increased use of new, high-cost tests.

16 Looking at the figure on the slide, I use three

17 categories of tests to explain key trends that underlie the

18 aggregate growth in spending.

19 For the first category, chemistry tests, spending

20 decreased by 14 percent, largely in line with expectations

21 under PAMA.

22 For the second category, panel tests, expected

1 spending declines have not materialized because of
2 unbundling and a generous phase-in of payment rate
3 reductions under PAMA.
4 The large spending increase for the third
5 category, molecular pathology tests, is due to the
6 introduction and broader use of new, high-cost lab tests.
7 Breaking down utilization changes by type of
8 laboratory, we found that volume increased by 2.4 percent
9 for independent laboratories and decreased by about 1
10 percent for both hospital and physician office
11 laboratories. This shift is part of a longer-term trend of
12 large, independent laboratories growing their market
13 shares.
14 Looking at the figure, you can see that changes
15 in spending also varied by type of laboratory. Spending
16 grew by about 16 percent for independent laboratories,
17 driven by the use of new, high-cost tests that I spoke
18 about on the previous slide.
19 In contrast, spending declined for both hospital
20 and physician office laboratories because of small volume
21 declines and because these laboratories predominantly
22 furnish routine, low-cost tests for which spending has been

1 declining or flat under PAMA.

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

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

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

16 Finally, we'll analyze CMS' revised data
17 reporting requirements for the second round of data
18 reporting, although this analysis will be limited because
19 Congress delayed the second round of data reporting until
20 2022.

21 For the second part of our review, we plan to
22 report on the least burdensome data collection process that

1 would result in a representative sample of laboratories.
2 Just to reiterate what I've said before, some
3 stakeholders are concerned that currently collected data
4 are not representative of the full laboratory market.
5 However, increasing the number of laboratories
6 that are required to report increases administrative
7 burden.
8 One alternative that would collect representative
9 data without the added administrative burden is a survey.
10 Therefore, consistent with our congressional
11 mandate, we plan to study how private payer laboratory
12 rates could be collected through a survey. The study will
13 include a range of topics, including appropriate sampling
14 techniques and the sample sizes needed to generate valid
15 estimates.
16 So just to recap a few things that Carolyn and I
17 discussed.
18 As of 2018, Medicare relies on private payer data
19 to set CLFS rates. Given that Medicare had historically
20 paid far more than other payers for laboratory tests,
21 payment rates for many tests declined substantially.
22 Stakeholders are concerned that independent

1 laboratories were overrepresented in the first round of
2 private payer data collection. Because of that, they
3 contend that Medicare payment rates are too low, which
4 could lead to access issues.
5 We find no evidence of substantial changes in
6 access in the first two years after CMS implemented private
7 payer-based rates, but further monitoring is warranted
8 given the slow phase-in of payment rate reductions.
9 Over the same period, Medicare spending increased
10 unexpectedly due to PAMA-related changes and the secular
11 increase in the use of new, high-cost tests.
12 For future rounds of data collection, CMS has
13 changed the reporting requirements to include more
14 laboratories, but the effects won't be known until 2022.
15 We've laid out some plans to meet the
16 congressional mandate over the next cycle, including
17 exploring how to collect private payer rates through a
18 survey. The staff seeks feedback from the Commission on
19 these plans.
20 And with that, I look forward to the discussion,
21 and I'll turn it back to Mike
22 MS. KELLEY: Mike, I think you wanted me to go

1 ahead with Round 1?

2 DR. CHERNEW: Yeah, I think we should jump right

3 into Round 1. I know we have a little bit of a queue, so

4 go ahead, Dana.

5 MS. KELLEY: Bruce, you had a question?

6 MR. PYENSON: I have a question on page 8 and

7 another one after that. I think Slide 8 mentions the low

8 phase-in, the last bullet there, of reductions. Do you

9 have any visibility into what the reason for that is? Was

10 there concern that there would be access issues if rates

11 came down? It seems like there was a view that the rates

12 are too high, we should bring them down. So it seemed odd

13 to have a long phase-in to get the rates to the right

14 place. That's my first question.

15 And the second question is: I believe the

16 mandate asks for other recommendations as MedPAC sees fit.

17 Is there a plan for that?

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

19 DR. MATHEWS: Answer the factual question first,

20 Brian, and then I'll jump in.

21 MR. O'DONNELL: Right. So, you know, as far as

22 the phase-in goes, that's in the statute. So CMS is

1 largely following the statute on that. And I think, you
2 know, as I said in my mailing materials, they knew that a
3 lot of these tests were going to decline by very large
4 amounts in percentage terms. And so, you know, I think
5 folks thought that there could be access issues, and so
6 they kind of made this very slow kind of phase-in. Now,
7 whether that would have actually resulted had the phase-in
8 been shorter, I don't think we know.
9 DR. MATHEWS: Okay, and then with respect to
10 recommendations, you know, part of what we are doing in
11 this session is gauging the Commission's collective
12 interest in heading down that path. Clearly, if you have
13 specific things you would like us to work for that involve
14 analytic work, we need to build that into the work flow in
15 the upcoming months. And if we were to make bold-faced
16 recommendations that involved the Commission reviewing
17 policy options, draft recommendations, voting on a final
18 recommendation, that builds time into the calendar, and so
19 we need to know that now.
20 An alternative approach would be to have a
21 chapter that reflects a strong sense of the Commission with
22 respect to a consensus as to where this policy should go,

1 and we could do that without bold-faced recommendations.
2 But part of what we are doing here today is figuring out
3 what you collectively want to do.
4 MR. PYENSON: Thank you.
5 MS. KELLEY: Marge, do you have a question?
6 MS. MARJORIE GINSBURG: Great. Thank you.
7 Perhaps it says this in the report and I missed it. Is
8 this information based entirely on labs that are being used
9 through original Medicare and do not include labs that are
10 contracted through Medicare Advantage plans? I mean, I
11 know big systems like Kaiser do most of their labs in -- I
12 mean, they've created their own labs. But I think they're
13 unusual. And I'm very interested in knowing whether the
14 data include MA plans or exclude them, and if they exclude
15 them, is there a reason why they should not be brought into
16 the analysis?
17 Thank you.
18 MR. O'DONNELL: Right, and so just to clarify,
19 all the analytics that we did, obviously that's using kind
20 of data from original Medicare. In terms of the data
21 reporting, which I think you're referring to, you know, the
22 requirement is that a lab must receive at least half of its

1 total Medicare revenues from the CLFS and the physician fee
2 schedule. So let's say that you are a lab that
3 predominantly serves Medicare Advantage beneficiaries,
4 whether you're Kaiser or whether you're just located in,
5 you know, Allegheny County in Pennsylvania. And so, you
6 know, you were likely excluded in the first round of data
7 reporting because, you know, if you serve 50 percent MA
8 benes, you did not receive half of your revenue in all
9 likelihood from the CLFS, which is fee-for-service, and the
10 physician fee schedule, which is fee-for-service.
11 And so they were largely excluded if you served
12 mostly MA benes in the first round. In the second round of
13 data, CMS made a technical tweak to try to include more of
14 those labs, but we don't have a good sense for how many
15 labs, additional labs that will include because the data
16 reporting hasn't happened yet.
17 MS. MARJORIE GINSBURG: Okay. So just in terms
18 of -- and maybe this is a Round 2 comment, but I think more
19 needs to be done to bring -- I mean, MAs now comprise
20 almost 40 percent of Medicare beneficiaries, and it's time
21 we start collecting that data as well. Thank you.
22 MS. KELLEY: Pat?

1 MS. WANG: This is related to Marge's question.
2 Are MA payments to labs considered private payer or
3 Medicare fee-for-service?
4 MR. O'DONNELL: So --
5 MS. WANG: Yeah.
6 MR. O'DONNELL: Yeah, so under the definition,
7 when labs report their private payer rates to CMS, Medicare
8 Advantage plans are considered private payers.
9 MS. WANG: Okay. I think that's appropriate.
10 The other question I had was more -- slightly different,
11 because there's unit cost or unit payment, I guess, and
12 then there's number of units and the mix of units that are
13 provided. Can you remind us what, if anything -- or what
14 original Medicare does to monitor lab utilization short of
15 the big fraud cases, okay, because that's like really
16 extreme. But does original Medicare have tools to observe
17 lab utilization and detect what it might consider worrisome
18 or inappropriate or emerging trends of, you know,
19 utilization of certain kinds of labs, number of labs, that
20 kind of thing?
21 MR. O'DONNELL: Right, so that's a good question.
22 And, you know, other than folks like us and CMS and OIG, I

1 don't think there's things that are kind of built in, if
2 that's what you're referring to, in terms of model
3 relocation.
4 MS. WANG: Wow.
5 MS. KELLEY: Okay -- oh, sorry. Is that all,
6 Pat?
7 MS. WANG: Yeah. That's really disappointing to
8 hear.
9 DR. CHERNEW: Yeah. I --
10 MS. KELLEY: Okay.
11 DR. CHERNEW: Go on, Dana.
12 MS. KELLEY: Dana Safran?
13 DR. SAFRAN: Is it my turn?
14 MS. KELLEY: Yes.
15 DR. CHERNEW: We're still in Round 1, so I just
16 lost track of the --
17 DR. SAFRAN: This is a Round 1 question. Sorry,
18 the two Danas throws me off sometimes. I just have a
19 question related to the increase in the high-cost lab
20 tests. In the chapter, if I understood it right, you
21 indicated that this increase, which you show on Slide 13,
22 was occurring in Medicare but not in private payers, if I

1 understood that right. Or maybe that wasn't there. Maybe
2 I just wrote a note to myself wondering if we saw the same
3 increase. I think that's what it was. Excuse me.
4 So, yes, I was wondering whether we see this same
5 increase in high-cost tests occurring in Medicare Advantage
6 data as well as in private sector data, and also wondered
7 whether we have hypotheses about why we see this happening
8 in the independent labs but less so in physician or
9 hospital labs. It felt a bit like an income maintenance
10 effort in light of the cost decreases that labs are seeing.
11 So I was just trying to understand what we're seeing in
12 other venues.
13 MR. O'DONNELL: Right. So on the first point
14 about whether we have any sense of this trend happening
15 among private payers, I really don't think we have a good
16 line of sight on this. You know, our data are quite
17 limited, you know, in terms of private payer data. And I
18 would also note that a lot of these things are really quite
19 new, so, you know, this trend really kind of picked up
20 steam in the last five years. So it's quite a new trend.
21 But to answer your question directly, we don't have great
22 line of sight.

1 In terms of why are the kind of, you know, high-
2 cost tests focused in independent labs, you know, we did
3 note that the mix of tests that hospitals and physician
4 office labs tend to be kind of the lower-cost labs and that
5 these independent labs are the ones furnishing these high-
6 cost tests. And I think it could be a couple of things,
7 but I think, you know, within the independent lab kind of
8 bucket, I think you have, you know, at least three sub-
9 buckets, you know, one being kind of the Quests and the
10 LabCorps of the word, the second bucket being kind of like
11 smaller regional labs, but those labs tend to focus in
12 these kind of lower-cost tests as well. And then you have
13 this third tranche of labs, which really focus on doing
14 kind of these higher-cost molecular diagnostic type tests.
15 And so, you know, I think it's at least part of
16 the market segmentation that's going on. A lot of these
17 new tests are developed by labs, and they focus in those
18 types of tests.
19 DR. SAFRAN: That's very helpful. Thank you.
20 MS. KELLEY: Paul?
21 DR. PAUL GINSBURG: Sure. I've got two
22 questions. The first is when you were talking about the

1 potential of doing a survey to gather this data, were you
2 thinking of a survey of labs or a survey of -- could it be
3 a survey of literature and private insurers?
4 MR. O'DONNELL: Right, and, you know, as we've
5 gone out and kind of talked with folks in the industry, I
6 think that thought had come up a number of times, and in a
7 lot of ways it would be cleaner because, you know, they
8 know the discounts they're giving, and they kind of have
9 the systems built already.
10 I think one of the things that, you know, you
11 face when you think about that is what hook does the
12 Medicare program have to require private payers to report
13 their data. So probably MA, you could get them to report,
14 but I think sans that, I think that was the concern that I
15 heard when you talked about, you know, requiring private
16 payers to report, is that, you know, unlike labs, we're not
17 directly paying them money. So for labs, we have a hook,
18 right? We're saying, "We're paying you this money. You
19 report your private data to us."
20 And so we haven't gone deep on that front, Paul,
21 but that's just kind of what we've heard as we went out and
22 talked to folks.

1 DR. PAUL GINSBURG: Good. And my second question
2 is: I take it from reading the materials that these fee
3 schedules continue to be local, and if that's correct, you
4 know, should we potentially be talking about making them
5 broad or even national as far as the recommendations we
6 come up with?
7 MR. O'DONNELL: Sure. We can clarify this in the
8 paper. I think what happened, the situation was that they
9 used to be very local, but they are transitioning to a
10 national payment rate. So under the kind of private payer
11 paradigm, there is one national payment rate. So that's
12 what it will be kind of going forward.
13 DR. PAUL GINSBURG: Good. Okay.
14 MS. KELLEY: Jaewon.
15 DR. RYU: Thanks, Dana. I just had one question.
16 I think normally we are used to seeing within a type of
17 service either the private payer rates are higher or lower
18 than CMS, the one or the other. And here I was a little
19 bit confused as to how it could be higher for some
20 services, some lab services, and then lower for others. So
21 I think you mentioned that 88 percent of the tests out
22 there, the private payer rates are lower or less than CMS

1 rates, but then the other 12 percent it's higher.
2 I'm just curious how that happens. What exactly
3 -- is it part of some weird esoteric formula? You know,
4 how exactly does that come to be?
5 MR. O'DONNELL: Right, and I think that's a great
6 question, and, you know, I think one of our hypotheses is
7 that when you think about why private payers were able to
8 get lower payment rates than Medicare, I think one of the
9 leading hypotheses is that, you know, a lot of folks can
10 furnish these low-cost, low-complexity tests, so payers
11 were able to go and negotiate with these large
12 laboratories. So I think that constitutes most of the lab
13 tests you generally think about. But for the smaller
14 segment of tests, you know, they might be kind of newer
15 tests. They might be tests that are furnished by fewer
16 labs. And so private payers might have fewer totals to
17 negotiate.
18 So that's just a hypothesis, and I think what
19 we'll do for the next round of data, the next report that
20 you all receive from us, is we'll take those payment
21 changes, payment rate changes, and we'll stratify by the
22 type of service. And so if we see these clustering of

1 services, then we'll have probably a better answer for you.
2 But I think that's our leading thought.
3 MS. KELLEY: Sue, did you have a question?
4 MS. THOMPSON: I do. And, Brian, take me back,
5 and this is -- I'm just interested in how you're thinking
6 about this. I heard you describe three buckets, if you
7 would, in terms of defining the laboratories: the large
8 Quests, if you will, the smaller that provides services
9 more locally, and then the labs that are developing
10 services that are more high end and sophisticated.
11 Where would you put the hospital-based laboratory
12 that has substantial outreach? In what bucket are you
13 thinking about that one?
14 MR. O'DONNELL: Right, and let me just clarify.
15 So, you know, we put independent labs up there as one
16 category, and just when I was putting them into those three
17 buckets, I was admitting that within the independent
18 laboratory space, you know, there's gradations in at least
19 three buckets.
20 MS. THOMPSON: Okay.
21 MR. O'DONNELL: But, you know, as far as
22 comparable labs, when you look at the mix of services that

1 they furnish, it does tend to be the more routine kind of
2 common tests that they're performing. So, you know, the
3 indication I gave in the paper was that molecular pathology
4 tests, independent labs, 93 percent; hospital labs were 6
5 percent; and then physician office labs were only 1
6 percent. So you can see they do do some of these high-cost
7 tests, but they're really focused in more routine tests.
8 MS. THOMPSON: Thank you.
9 MS. KELLEY: And I think, Pat, you had a
10 question?
11 MS. WANG: It seems like, you know, things have
12 slowed down and the requirement for submission of private
13 payer data is in three-year increments, which is rather
14 long. But however it is achieved, so, you know, I assume
15 that the idea of doing a very slow phase-in of this new
16 methodology in order to prevent access issues assumes that
17 the labs needed to readjust their revenue mix to increase
18 private payer rates while Medicare rates perhaps were
19 coming down so that they could maintain their operation and
20 maintain access. I mean, that's the only thing that makes
21 sense to me in terms of such a long transition. I just
22 wonder whether it is part of anybody's analysis or capable

1 of not being known, whether, in fact, that is happening,
2 and as these changes to the fee schedule happen and the
3 Medicare fee-for-service rates come down, whether, in fact,
4 private payer rates are coming up or not, because I think
5 it might be informative about sort of the overall health of
6 the sector.
7 MR. O'DONNELL: Yeah, that's a good question, and
8 I think there's a couple things that complicate that. The
9 first is that obviously the lab sector this year has been
10 dealing with, you know, a tremendous drop in volumes on
11 most tests and then a tremendous increase in volumes on
12 COVID testing. I'm sure there's that. But, you know, as
13 you start to see kind of second and third round of data
14 reporting, I think you'll have a little bit greater insight
15 in terms of, you know, what's actually happening with
16 private payers.
17 But I have to say, you know, I see -- and this is
18 just anecdotal, but I do see private payers continuing to
19 be aggressive in terms of negotiating rates for lab tests.
20 So maybe those are just anecdotes and it's not
21 representative. That could be the case. But, you know,
22 that's something we'll have to watch going forward.

1 DR. CHERNEW: So let me jump in for a second. I
2 fear we're straying past Round 1, so I want to maintain our
3 discipline as to where we're going here, because some of
4 these things are a little less, "What did you mean on Slide
5 2?" and a lot more broader sort of dynamic questions. So
6 we can save them. Dana, I'm not sure if there's any more
7 Round 1 questions, but I am eager to get on to Round 2 when
8 we get through, and I will emphasize again, the clarifying
9 questions.
10 MS. KELLEY: We are all done with the Round 1
11 queue.
12 DR. CHERNEW: Great. So we're going to move. I
13 think Brian is going to kick us off on Round 2. Again,
14 please be disciplined in the length of your comments. I
15 will say, lacking discipline, that I've never heard
16 Allegheny County mentioned in a presentation before, and
17 since I'm from Allegheny County, a shout-out to Brian. But
18 now to Brian DeBusk.
19 DR. DeBUSK: Thank you, Michael.
20 First of all, really interesting chapter, really
21 well done. I'm going to try to follow the order of the
22 mandate. To address the least burdensome aspect, I think

1 it's pretty obvious that you'd want to do sampling there.
2 I think we would want to -- I mean, we may want to
3 recommend sampling just the larger labs. I noticed in the
4 mailing materials they're about 50 percent of the volume
5 anyway. And we already have the CMS study that showed that
6 incorporating physician offices and hospitals didn't seem
7 to change the rates that much. So, again, in the name of
8 less administrative burden, I hope we can focus on sampling
9 the larger laboratories.
10 The other question I would ask is let's say we
11 collect all this, you know, rural hospital data and all
12 these small physician group practices, you know, what would
13 we really want to do with the data anyway? I mean, this
14 feels like a site neutrality issue to me. We've talked
15 about this for years, about how Medicare should pay similar
16 rates for similar care. This seems like a great
17 opportunity to reintroduce and maintain our position
18 regarding site neutrality.
19 As far as the statistical methods, I think using
20 the median from a sample of larger, what we would presume
21 are fairly efficient suppliers would be the way to go. I
22 think if we were required to take in a sample of some of

1 the smaller operators, I think then you'd probably use
2 something below the 50 percent median. I mean, I think
3 there you maybe go to the 20th percentile or the 25th
4 percentile just, again, with site neutrality in mind.
5 Jim, you commented earlier about how far we
6 should go and how close should we stick to the mandate and
7 how much should we make additional recommendations. I do
8 hope that we'll attach some additional recommendations to
9 the report, and I just want to briefly comment on that.
10 I think collecting the prices in a reporting --
11 Pat, you alluded earlier to utilization of these tests, and
12 one of my concerns is let's say we collect the private
13 payer rates from a series of tests that have strict
14 utilization tools, lots of eligibility requirements. You
15 may see private payers willing to pay a higher rate when
16 coupled with good tools around eligibility. Well, I would
17 hate to export that rate into Medicare under a necessary
18 and beneficial standard. You're really comparing apples to
19 oranges there. So as we collect prices, it would also be,
20 I think, useful, especially on the higher-spend items, to
21 be looking at eligibility requirements and just to make
22 sure that we're comparing apples to apples when we look at

1 these prices.

2 The other thing that really jumped out from in

3 the mailing materials, there are three categories:

4 molecular pathology, multianalytic assays, and proprietary

5 lab analysis. In two years that went from 530 million to

6 1.4 billion. So those three categories had a 168 percent

7 increase in two years. They went from 7.4 percent of

8 spending to 18.6 percent of spending. If you project that

9 forward two more years, those three categories alone are

10 going to be over one-third of the entire spending in this

11 category.

12 So I think we really need to keep our eye on

13 molecular pathology, multianalytic assays, and proprietary

14 lab analysis, and I'm still learning about this, but I do

15 think there's a trend toward moving some of these higher-

16 end tests into hospitals.

17 I think there are companies that are packaging

18 the reagents along with the bioinformatics back end and

19 offering -- basically helping hospital systems to go up

20 market. And I think as long as that doesn't increase

21 program costs, I don't think that's a problem. But I

22 wouldn't be surprised to see these higher-end tests moving

1 inside the hospital over the next few years.
2 The other thing that I would mention, I think
3 allowing CMS to bundle the rates again I think would be
4 another feature that we should recommend. Unbundling these
5 tests I think is a little bit out of sync with the
6 direction these tests are going. I think a lot of these
7 assays, they go after more and more markers. And I think -
8 - and, again, I'm still learning about this, but there's
9 this concept of test stacking where I might have one assay
10 that looks for 400 markers; well, then the next version of
11 that assay looks for 410 markers. Well, what I'll do is go
12 in and actually redo the entire assay, so I start from
13 ground zero and do all -- look for all 410. I think we
14 just need to be careful. We need to make sure CMS has the
15 ability to unbundle -- or to combine some of those tests
16 because, again, by the next time we revisit this, I'll know
17 a lot more about test stacking.
18 Then the final thing I want to mention is
19 geographic adjustment. I think I'd be really careful with
20 that because some of these tests are so expensive. I mean,
21 you look at even a 3 percent geographic adjustment on a
22 $4,000 test. That's a $240 swing. That pays for a lot of

1 overnight shipping. And so I would be really careful
2 there, because if we do feel the need to introduce the
3 geographic adjustment, I think it would need to be very
4 small, and I think it would need to be decoupled from the
5 test price, because, again, even a modest adjustment could
6 get really out of hand there.
7 Those are my comments. Thank you.
8 MS. KELLEY: Okay. Jon Perlin.
9 DR. PERLIN: Okay. Well, thanks, Brian and
10 Carolyn, for really a superb presentation on what feels
11 like a very esoteric topic, but the reasons Brian just
12 mentioned about cost, one that's escalating quickly in
13 terms of importance.
14 When Mike asked me to be a responder on this, I
15 told him this is not my area of deep subject matter
16 expertise. He smiled and said, "It will be." And I think
17 I've learned more about lab testing, particularly from the
18 hospital aspect with respect to the clinical fee schedule,
19 than I ever expected to.
20 But I think these points about cost really take
21 us from what the statute requires -- balance between
22 representation of different lab types and the burden of

1 testing -- to really back into the larger question for
2 MedPAC, which is that is -- the balance between cost and
3 sustainability of the program with access to care and
4 services like laboratory.
5 So this molecular testing aspect is really the
6 driving force in cost escalation in the future. I fear
7 that frankly the emphasis, as they say, is on the wrong
8 syllable. We need to put it back on what's really going to
9 drive cost in the immediate future.
10 I went to our lab director and I found this out,
11 that there are over 3,500 general lab tests available to
12 physicians. Those are the just regular chemistry
13 diagnostic. There are now over 75,000 orderable genetic
14 tests and approximately ten new tests launched daily, and
15 this is growing about 10 to 15 percent per year in the area
16 of genetic and molecular testing.
17 The issue of bundling and not just stacking,
18 Brian, but reshuffling makes it extraordinarily confusing
19 and creates some problems in terms of interpretation. In
20 fact, surveys of clinicians indicate they don't know what
21 to do with the answers to the data that they get.
22 So I want to break this into a couple parts and

1 then come back to the larger cost driver, but let me talk
2 about the specific PAMA mandate for balance between burden
3 and representation.
4 My fear is this: If you start with the wrong
5 proposition, you get to wrong answers. And the burden
6 drives up the cost -- the burden of reporting here simply
7 drives up the cost of production for the smaller labs,
8 hospital and physician offices, without adding commensurate
9 value. It removes focus from, you know, a bigger issue
10 that I just mentioned.
11 I think the statute itself is still in conflict.
12 I know that on page 4 it talked about representation
13 aspect, but it also says very specifically that the
14 revenues from the clinical laboratory fee schedule on the
15 physician fee schedule need to constitute a majority of
16 Medicare revenues. And so obviously this excludes those
17 sorts of labs, or at least it would have that effect and
18 functionally hospital and physician offices don't.
19 I wanted to talk for a moment just about the
20 incentives in hospitals. Remember, in hospitals part of
21 the reason this isn't majority is that the services that
22 might be offered to a select number of outpatients or

1 service to a community are a fraction of the testing done
2 inpatient, and the utilization control is that those lab
3 tests are part of a bundle, which is really what -- the
4 intent was that there be judicious use of appropriate
5 tests.
6 I think intermediate guidance was given that
7 said, okay, it's really difficult to report, so hospitals
8 have got to use a very strange bill pay called a "14x
9 bill." And that's really an artifice that's created
10 because the data do not exist in the format the statute
11 requires reporting on. The data are not mapped to CPT or
12 HCPCS codes, and a great deal of manual labor goes into
13 this. I'll come back to that later. But it is as bizarre
14 as trying to get on the GoToMeeting call that we're on now
15 using Zoom. It just doesn't work. They're different
16 technologies, they're different standard sets, et cetera.
17 So these are incredible operational burdens in determining
18 which claims have reportable data, transferring this data
19 to CMS requirements, the fact that the data systems don't
20 return information at the CPT level, that they don't
21 include secondary insurance, that they don't necessarily
22 reconcile data that are supposed to be eliminated because

1 they're bundled, they don't match up payments that are made
2 on different dates or test or process in different batches.
3 And so all of those are sorts of things or complexities
4 that actually are more burdensome than doing the study of
5 the lab test itself. So that seems very ironic in terms of
6 taking a focus on really what the point is here, which is
7 cost sustainability and reducing burden.
8 Now, because something is difficult doesn't mean
9 it shouldn't be done, but because something doesn't add
10 commensurate value does. So I agree emphatically with
11 staff's recommendation to look at alternatives here, you
12 know, use of a survey, returning to the original NPI
13 definition, et cetera. I think those are the important
14 factors. And just in conclusion, the staff were absolutely
15 right when they said that utilization is decreasing, but
16 the increase in cost should be highlighted in the report to
17 Congress. This is really where the challenge is going to
18 be going forward.
19 I think there is a little bit of text about the
20 effect of the pandemic on the supply chain, and that should
21 be carefully considered when discussing changes to CLFS.
22 And then, finally, shifting independent labs from

1 physicians to hospitals, I know Brian just mentioned that
2 some of those labs may be seeking to go upscaling with in-
3 house certain reagents and package and information systems.
4 But the truth is these assays are now so incredibly
5 complex, so rarefied, and oftentimes so infrequent because
6 there are now so many that they have a limited number of
7 homes. And so the large independent labs serve as the
8 reference labs. And if you're sending your labs either to
9 very specialty independent labs or those very large
10 reference labs, then the idea of geographic adjustment is
11 really not rational because the locations of those labs
12 concentrate the bio for the test regardless of the
13 geography of those that would be using it.
14 So let me stop there. Again, I thank the staff
15 for great work, and I hope that we see our way to some very
16 concrete recommendations to add value and reduce burden.
17 Thanks.
18 DR. CHERNEW: Okay. Paul?
19 DR. PAUL GINSBURG: Thanks. You know, a lot of
20 good stuff has been -- well, first of all, it was a great
21 job on the slides and the chapter, and what Brian and Jon
22 said was very useful. I just wanted to emphasize a couple

1 of things.

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

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

1 private insurers handle some of these situations with
2 highly expensive and specialized tests and other
3 technology.
4 MS. KELLEY: Okay. Larry, you're next.
5 DR. CASALINO: I really didn't think I'd have
6 anything to say during this session, but it turns out to be
7 very interesting, and Brian and Jonathan's comments were
8 extraordinarily good on top of your presentation. But it
9 seems to me whether it's done by requiring all labs that
10 meet certain criteria to report or sampling, and using that
11 as a way to determine Medicare ordinarily pay, that's an
12 assumption that the prices being sampled are somehow based
13 on costs, right? And I think we've heard enough to assume
14 that that's true for most tests but may not be true for the
15 really expensive molecular diagnostic tests that are coming
16 along, where at this time at least there might be very
17 little competition.
18 So if a price is based on negotiated leverage and
19 has very little relation to the cost of doing the test, and
20 then Medicare winds up paying that price, you know, whether
21 we're using a median or not -- and the median might not
22 mean much if there's only two suppliers -- I think there's

1 a problem. So I don't have a solution, but I think that
2 the underlying assumption that Medicare has been acting on,
3 if you can just get people to tell you your prices, you'll
4 kind of know what the costs are with a little profit, and,
5 therefore, you can use that, that's probably true for most
6 tests, but not for the ones that are way more expensive and
7 not for the ones that, as Jonathan pointed out, are really
8 driving a lot of the spending growth.
9 MS. KELLEY: Mike, did you want to say something
10 here?
11 DR. CHERNEW: I wanted to react to Larry and a
12 few of the other comments before the other Commissioners
13 jumped in, because they may be able to react to some of the
14 things I'm going to say.
15 So, first of all, obviously, the presentation was
16 outstanding. The comments were terrific. A few things in
17 reaction to what Larry and others have said. The first one
18 is sort of a matter of principle. I'm not sure why we ever
19 want to put artificially high rates into the averages that
20 we pay. I'm not sure what "artificially" means. I
21 essentially mean market power-driven rates, and that puts
22 us somewhere where Paul was, which is maybe we'd pick a

1 lower percentile. So that's point one.

2 Point two -- and I'd love people's thoughts on

3 that. Point two is I think we -- just for everybody's

4 knowledge, at some point we're going to have to have to

5 deal with this issue of new technology and how new

6 technology affects Medicare when new things get put in and

7 there's launch prices and a slew of other issues. This

8 report is probably not the place to deal with that issue

9 generally, although it may certainly come up in that

10 report, and understanding the breadth of this report with

11 regards to that issue matters. I personally love the

12 issue. I'm worried because it is a real conundrum about

13 what to do in a whole variety of ways. Given we were asked

14 to do it, Jim and I will go back and forth about how broad

15 or not to make this particular report, but understand this

16 issue of new things, writ large, be they tests, drugs,

17 whatever, is very much on the agenda.

18 The third thing that I'd love people's reaction

19 to, it could be yours, Brian O'Donnell's, or anyone else's,

20 is if someone asked me to come up with getting the prices

21 for lab tests, I would start by getting a claims database,

22 of which there are many that might not be perfectly

1 representative, but might be good enough. There's
2 Marketscan. There's FAIR Health. There's HCCI. There's
3 Blue Health Intelligence. And I could see to some extent
4 what folks are paying.
5 This whole chapter reminds me of the pitfalls of
6 fee-for-service, right? The fee-for-service system drives
7 you batty when you realize all the combinations of
8 different things can be done, and that may challenge how
9 this shows up in some of these other data. It challenges
10 Medicare Advantage, which sort of Marge asked before, if
11 they're not paying in a fee-for-service way, it's hard to
12 know what the price was. Not everybody uses the same
13 codes. So we'll have to sort through that.
14 But I'd like to get people's reaction on
15 essentially for the main part as to how we should deal with
16 the data collection and then what we should do with the
17 data once collected, and if there's administratively
18 simpler ways of going about doing this.
19 And the last thing I'll say is I appreciate any
20 comments -- some of you have made them -- abut the
21 geographic adjustment, and those comments are very well
22 taken and very useful, so going forward, if people want to

1 add to that line of thinking, that will be another topic
2 that will be useful as we think about what to do with this.
3 So now on to the rest of Round 2. That was just
4 an interlude.
5 MS. KELLEY: Okay. Bruce, you're next.
6 MR. PYENSON: Thank you very much. I wanted to
7 talk a bit about what we should recommend. We've just gone
8 through an exercise with the value-based program for SNF
9 where we said we need to pause on that. I would suggest
10 the same on this situation with labs for several reasons.
11 It is dangerous to base Medicare fees on the private payer
12 fees. An analogy might be dialysis where, again, you have
13 a handful of large organizations, and, fortunately,
14 Medicare doesn't base its payment on private payers.
15 Private payers are paying way more than Medicare. And
16 there's enough potential for problems even understanding
17 what private payers are paying and what the real financial
18 arrangements are.
19 So I think it is not a good idea. We're seeing
20 the beginning of that perhaps with the very expensive tests
21 where there's only a few sources and there's emphatically
22 different mixes of codes. It's no secret that labs have

1 probably negotiated and agreed to very low test rates for
2 commodity tests and higher rates for non-commodity tests,
3 and that mix is likely to be different between Medicare and
4 commercial.
5 So we've got a whole series of fundamental
6 challenges in basing rates on private payers. In the past,
7 the analogy of a successful program was DME with
8 competitive bidding where Medicare was paying more, and
9 that's probably a lesson to be looked at.
10 More fundamentally, a commodity chemistry is a
11 case for deflation, and, frankly, that's happened even in
12 exotic labs. So, for example, the price of a human genome
13 test for a single individual has plummeted. So year after
14 year, we've seen PCR prices go down, down, down. So this
15 is a test case for deflation that I believe should be built
16 into Medicare's reimbursement as opposed to spending lots
17 of time looking at the minutiae of how you do sampling.
18 Let's create a program that's going to work and
19 solve the problem that we were talking about in the context
20 study and, frankly, lab -- when we think of the potential
21 money that's at lab, that's way more than the 2 percent
22 that was at stake, I believe, in the post-acute care for

1 SNF. So this is an important issue, but, Mike, I agree
2 with you on starting with claims databases. But I don't
3 think -- if we don't come up with a better program, we're
4 not fulfilling our commitment this morning in the context
5 session. And I see all sorts of problems with the way the
6 fees are being set, and I think this is an ideal case.
7 It's not huge. It's relatively constrained. The data is
8 understandable with the codes. So let's start here, and
9 let's get to something that will move in the right
10 direction rather than fixing the obvious technical
11 problems.
12 Thank you.
13 MS. KELLEY: Jaewon?
14 DR. RYU: Yeah. I don't have strong feelings on
15 the technical, in the recommendations, I should say. I
16 think what I find unsettling, and I get that this is a
17 little bit out of scope, is it feels like the way the
18 program is set up it's a problem that's only going to get
19 bigger, and maybe this is similar to what Bruce is saying.
20 Ideally, I'd love to say, for the 88 percent of the tests,
21 where the commercial raters and private payer rates are
22 less than CMS, it would be great there to index that to

1 private payer rates.

2 But the problem seems to be in the other 12

3 percent. And so I do think there's a danger, to Bruce's

4 point, in indexing to a private payer rate when that 12

5 percent of the time, or 12 percent of the tests you're

6 indexing to a higher rate, and it's a higher rate that

7 seems like it's just on the cusp of just growing.

8 In many ways this feels like specialty pharma

9 from six to eight years ago, with the emerging technology,

10 and it just overwhelmed the pharma spend, and with each

11 passing year it's sort of been exponential growth.

12 I would share Pat's reaction early on, when I

13 find it very concerning that there's really unfettered, no

14 filter around assessing for appropriateness in that high-

15 end molecular and other kinds of tests. You know, whether

16 it's a formulary or utilization management or bundling, I

17 think Jon Perlin mentioned some of the advantages, the

18 natural protections you have there. It feels like we would

19 miss out if we didn't make some mention to call attention

20 to that being the larger issue.

21 If you extract that, if I'm reading the materials

22 correctly, utilization relatively flat, spend relatively

1 flat. To the extent there's an increase it's being driven
2 off of that high-end molecular testing. I feel like we
3 have to make some mention around that and try to create the
4 alarm bell sooner so we don't land, five years from now,
5 dealing with a problem that resembles specialty pharma
6 today.
7 DR. CHERNEW: Yeah. So can I just jump in and
8 react to Jaewon and Bruce real quick? I appreciate both of
9 those comments, and as I said, the analogy of specialty
10 testing is reasonable and we will deal with that. How
11 would you feel -- again, I'm thinking about possible
12 recommendations. There are sort of the simple things one
13 could do. One could recommend that the price is the max of
14 the CMS price and the competitive price, and then you would
15 be able to focus where there are cost-savings opportunities
16 and you'd have a cap on the rest of it, in various ways.
17 You could have other relatively simple formulas to avoid
18 too much of an access problem, or you could set a floor if
19 you needed to, potentially.
20 So I guess my question for Bruce and Jaewon --
21 although I know Dana is next so I'm going to come back to
22 you after Dana Safran -- is are there relatively simple

1 formulaic fixes that would allow us to reduce some of the
2 overpayment that currently exists to address the fiscal
3 problems from a context chapter without creating a whole
4 other set of problems, where I view is a new complicated
5 set of important tests that are hard to get our heads
6 around. I'd like to be able to thread that needle as
7 opposed, because I'd rather not miss the opportunity to
8 become more efficient in places where we can.
9 So give that some thought. I think Dana Safran,
10 you're next in line.
11 DR. SAFRAN: Great. Thanks. Just very briefly,
12 you know, the comment I was going to make is just very
13 similar to something, Mike, that you said on your last
14 round, which is, to me the issue here, especially around
15 the high-cost labs, there's a really wonderful case in
16 point of the context chapter we talked about this morning,
17 and in particular, the challenges that we have to confront
18 around new innovations and how those get priced and how we
19 manage appropriate use.
20 And so, you know, I heard you say, Mike, that
21 probably we don't want to tackle that in this chapter, but
22 I wonder if we want like a text box or something that

1 really points us to this beautiful case in point. Because,
2 you know, the inflation rates that Brian cited for us, in
3 just this space, are pretty compelling. And so I just
4 wanted to make that point and tie it back to our morning
5 conversation.
6 And then the other thing I was going to say is I
7 haven't heard any other comments focused on this, so I
8 apologize if I missed it. But the issue that has created
9 the missing data from hospitals and physicians because of
10 the 50 percent rule in the NPI is something we just have to
11 go fix. It was illustrated on your Slide 9, I think, and
12 so apologies if that's already, you know, been hammered to
13 the ground. But I just was going to flag that issue as one
14 that seems just glaringly obvious. Thanks.
15 MS. KELLEY: Mike, that's the end of the queue.
16 DR. CHERNEW: Right. I just about to say, is
17 that the end of the queue, and now you've flustered me. So
18 I want to go back to you, Bruce, to have a little bit more
19 discussion. Everybody, please jump in when you want to
20 contribute to this discussion. I'm not going to call you
21 out because, as Jon Perlin noted, this is an area where to
22 get engaged there are a lot of things you have to

1 understand. And so I don't want to put anyone on the spot,
2 but jump in when you want to, if you want to.
3 But Bruce, you sort of raised this point about
4 where to do, and are trying to craft some sort of
5 intermediate position between the status quo, which I
6 really don't like for reasons that are clear in the
7 chapter, and this problem, I think, Dana, your idea about a
8 text box or some other thing to notice this, to call this
9 out, is actually a really good idea for this chapter, just
10 so everybody understands. Brian and I, and I think some of
11 the other staff, had an exchange prior to the meeting about
12 essentially the duality of this program, between these new,
13 complicated, high-tech, large test, and the sort of more
14 standard tests that some of this was motivated by.
15 So Bruce or Jaewon, if you want to expand on your
16 earlier Round 2 comments, I'm all ears. If not, anyone
17 else, or we can move on.
18 MR. PYENSON: I'm happy. Jaewon, is it okay if I
19 jump in? So in terms of a solution, I think the precedent
20 of the DME competitive bidding program is a good one. The
21 vast majority of lab tests are commodities, right, and we
22 have a scale with the ability to move samples around, you

1 know, the collection boxes and those sort of things. This
2 is an ideal circumstance where Medicare could consider a
3 competitive bidding program.
4 More fundamentally, we have a Moore's law kind of
5 situation here where the prices and the ability to produce
6 commodities just becomes cheaper and cheaper, and the
7 technology gets better and better. And some of that is
8 information technology and physical technology and that
9 sort of thing.
10 So I think it's time we recognize that, that
11 commodities in general should get cheaper over time. The
12 vast majority of labs are commodities. Now even we saw the
13 fancier tests, frankly, are commodities also. You think of
14 things that used to be exotic, like PCR and genome
15 sequencing. It's done very inexpensively today.
16 So a simple solution from that standpoint is to
17 pick a number, like 5 percent or 10 percent, and say
18 whatever this fee schedule is, is going to go down by 5
19 percent or 10 percent a year. And there's precedent for
20 that in other federal programs that we could talk about.
21 So those are two basic approaches that I'd suggest, either
22 competitive bidding -- and you could create a bundle; you

1 could include the fancy tests in that, bid it out on a PMPM
2 basis -- or here's the fee schedule and it's going to
3 deflate every year for the next 5 or 10 years, and we'll
4 look at it.
5 DR CHERNEW: Jaewon, do you want to add
6 something, or else I'm going to react.
7 DR. RYU: No, go ahead and react. I don't think
8 I have much to add.
9 DR. CHERNEW: So my concern, and again, I'm
10 watching the questions coming in, my concern, Bruce, is the
11 vast number of permutations that one can do in tests seems
12 to make this a little bit harder to competitive bid than
13 DME situational. I guess that also might end up driving
14 Brian and Carolyn crazy. But I do think that's a
15 reasonable thing to do. It would require creation of an
16 infrastructure, of a bidding process, which I know that are
17 done in parts of DME. If people are thinking about that,
18 that's valuable.
19 I guess I would weigh that against using, for a
20 subset of tests, using the data that we're seeing
21 privately, because that's sort of like an off-the-shelf
22 competitive bidding type thing.

1 MR. PYENSON: I agree. The capitation is being
2 done in the private sector. It's not all that widespread
3 but it's out there. So the other is permutations and
4 combinations, but it's all commodity. And so I think it's
5 an idea situation, and we do have the precedent for doing
6 that in the private sector, and, you know, competitive
7 bidding is a bit different in DME. It's not on a PMPM
8 basis.
9 So I think those are issues, but I think either
10 of them aren't that much of a stretch. My preference is
11 actually explicit deflation.
12 DR. MATHEWS: So can I jump in here, Bruce? As
13 we were developing the work for this meeting, over the last
14 several months, we did consider whether or not we should
15 talk about a competitive approach for clinical lab
16 services. And we internally ran into two separate issues
17 that at least for the present time took it off the table,
18 but we could obviously come back and revisit this. But I
19 would like, especially Bruce, to get your reaction here.
20 One with respect to the basic chemistry tests,
21 panels, things like that, that compose the vast majority of
22 the volume that we are talking about. And I agree

1 completely that those are commodity products. They are
2 widgets that are being produced. It's just that so much of
3 the volume is concentrated in, you know, two very large
4 entities here, and so the question would be, how much can
5 you squeeze out through a competitive process where they've
6 clearly got the volume to be able to produce rock-bottom
7 per-unit prices, and everyone else who is doing these
8 things -- hospital outreach labs, physician labs -- are
9 going to have a higher per-unit cost. That was one issue
10 that, you know, put the brakes on us.
11 The second is the opposite situation, where
12 you've got so many of these high-cost, proprietary lab
13 tests that are uniquely provided by a single laboratory.
14 And the question there is, you know, how much competition
15 are you going to be able to get where there is one producer
16 of a test and they are effectively a monopoly, if a payer
17 needs that test.
18 So could you talk a little bit more about both
19 facets of this question?
20 MR. PYENSON: Yeah, and perhaps it might be a bit
21 easier to talk about the first and then the second, for me.
22 And for sure further research is needed. But I believe

1 there are significant regional labs as well, so this might
2 be competitive bidding on a regional basis to allow
3 differences and other players to enter the markets.
4 But my impression is that the capital needed to
5 get into the lab business is probably not as dramatic as
6 some other kinds of businesses, you know, that we might
7 think about. And there's all sorts of other laboratories
8 in effect for other purposes. For example, veterinary labs
9 do the same stuff, right? It's the veterinary lab at
10 Cornell University that I understand is testing all their
11 students twice a week for COVID.
12 So I think it would be beneficial to look into
13 some of those issues a little bit further. I agree there
14 is a market domination of a couple of labs, at least on a
15 national basis.
16 I think on the more exotic tests, my impression
17 is that what you're testing for is not patentable, right?
18 There is a lawsuit on the BRCA gene, for example. And in
19 many cases I believe there's multiple ways to identify, to
20 diagnostics, and we see that with pretty fast competition
21 in some of the cancer genome tests, and even companion
22 diagnostics, where different companies will talk about why

1 their approach is better than someone else's approach for
2 the same condition.
3 Again, I'm by no means an expert in that, but I
4 think what I've heard says there might be opportunity there
5 worth exploring.
6 DR. CHERNEW: Okay. I think Betty had a
7 question.
8 DR. RAMBUR: I do. Thank you very much. I'm
9 working hard to try to wrap my brain around this area, and
10 I have a question, in terms of explicit deflation, in terms
11 of how you know where that floor starts, where does it go,
12 how fast, and all of that.
13 And I appreciate the idea of not continuing to
14 pay the price of what something used to cost versus what it
15 costs now. But my biggest concern, thinking about all of
16 this, are the new tests that really create micro-diagnoses,
17 or even identify variants of normal, that then have
18 downstream costs and effects that even cause harm.
19 So my question is, as a person sort of trying to
20 wrap my brain around this for the first time, how do we
21 prevent that from happening? What's the pricing strategy
22 that prevents that downstream explosion of additional

1 costs? And a number of you have talked about that, but I
2 can't understand how you set up the financing to minimize
3 that outcome.
4 DR. CHERNEW: Betty, that was a terrific point
5 and I think you may have stumped folks, so let's see. We
6 could do Rock, Paper, Scissors for who's going to respond.
7 Again, I think as I said in the beginning, some of this is
8 just an inherent problem with fee-for-service, when you can
9 move things around, and thinking about how to deal with
10 bundling things. This is one motivation for these in the
11 models. As Jon mentioned in his earlier comments, when
12 you're doing this as an inpatient, we don't have all these
13 problems because the tests are bundled in with a whole
14 bunch of other things, and that obviously works a lot
15 better than the complicated set of questions that we're
16 dealing with now.
17 But we have on the table what we have on the
18 table, so I don't have a great answer for you. I'm going
19 to look to Brian or Carolyn to see if they have an answer.
20 MR. O'DONNELL: I don't have the answer but I
21 have a comment. So I would just note that, you know, in
22 the Medicare space you can think about price or

1 utilization. When Betty said how can we get the right test
2 for the right person and now have these kinds of downstream
3 effects, to me that runs to more of a utilization question.
4 How do we get the utilization right?
5 And, you know, I think of it two ways, one being
6 kind of the ACO model, where there's kind of
7 rationalization within that larger bundle. But also, I
8 don't have a great sense for what private payers do in
9 terms of things like, you know, prior auth or cost-sharing.
10 So, you know, from the Medicare fee-for-service
11 perspective, there's no cost-sharing at all on clinical
12 labs, and obviously you have no prior auth-type mechanism.
13 And, you know, one of the things I was thinking about is
14 getting a little bit deeper in terms of what the private
15 payers are doing in that space.
16 DR. CHERNEW: So two things. The first one is I
17 agree that it is worth some broader thinking, and certainly
18 in the spirit of this report and the spirit of this policy,
19 which is trying to figure out what we can learn from the
20 private sector to inform what seems to be a pricing problem
21 in the public sector. So I do think that's useful.
22 The second point is, this has been an absolutely

1 terrific presentation and discussion. I was where Jon
2 Perlin was beforehand, not knowing a lot about labs. Now
3 Jon Perlin is twice the expert I am. But that being said,
4 what I think we will do to wrap this -- again, I'm looking
5 to see if anyone has other comments -- is we'll take some
6 of this discussion offline and figure out where to go.
7 There's a lot of possibilities on the table. There's the
8 competitive bidding version. There is the sort of baseline
9 deflation factor, if you will. There are versions that
10 might separate out by type of test. You could do things
11 differently, like type of test, and we're going to have to
12 be sensitive to which of these things are CMS things and
13 which of these things require legislative changes. So a
14 lot of institutional detail here that goes on.
15 I think Bruce's point, that this actually is a
16 big deal for a number of reasons, is true, and so I think
17 it deserves more attention. It is just a really
18 administratively complicated thing. What I would like to
19 avoid is building an ever-more-complicated administrative
20 system to managing the pricing of this over time. I think
21 we should, whenever possible, try to minimize the burden we
22 put on our providers in terms of providing data and doing a

1 bunch of things, and trying to figure out how to set the
2 prices as efficiently as we can otherwise. Obviously, we
3 do need more data in places. I think we can do better than
4 some of the other things.
5 But we will take some of that offline. This the
6 going once, going twice comment. What's next is going to
7 be another really interesting topic, so let me pause.
8 There you go. The slide changed, suggesting
9 that, you know, the gavel came down. So I should say this
10 to everybody that I can see, all the Commissioners and
11 staff, but also to the public. There are many, many ways
12 you can reach out to MedPAC to react to some of the
13 discussion we've had here today. This is certainly not the
14 only, and as Glenn Hackbarth, former chair, used to say
15 when I was on the committee, maybe not even the best way to
16 make all of your comments.
17 So please, to the public, we realize we're not in
18 person, but don't feel that we're trying to avoid comments.
19 And to the Commissioners, this is not the only time you get
20 to engage on these topics. So we will reach out as needed,
21 as we begin to grapple with all those things that were
22 said, but for now let's move on to Eric, Rachel, and Jeff,

1 to talk about another mandated -- actually, a congressional
2 request, that we do some stuff on private equity.
3 So I'm not sure who's going to kick it off. Eric
4 is first on the slide so I am going to say it's Eric, and
5 if it someone else, I am so sorry.
6 MR. ROLLINS: No. It's me, Mike. Can you hear
7 me?
8 DR. CHERNEW: Yes. I can hear you. Terrific.
9 MR. ROLLINS: Okay. Good afternoon. I'm going
10 to conclude today's presentations by talking about private
11 equity and the Medicare program. Before I begin, I'd like
12 to remind the audience that they can download a PDF version
13 of these slides in the handout section of the control panel
14 on the right-hand side of the screen.
15 The chairman of the House Committee on Ways and
16 Means has asked the Commission to look at the role that
17 private equity plays in Medicare. The request does not ask
18 the Commission to make any recommendations. We plan to
19 respond to the request with an informational chapter in our
20 June 2021 report to the Congress.
21 Today I'm going to summarize the request, provide
22 some background on the private equity industry, and outline

1 our proposed analytic work plan. After that, we'd like to
2 get your feedback and guidance on the work plan. We then
3 plan to come back to you in the spring to share our
4 findings.
5 The request asks the Commission to look at four
6 specific issues, to the extent feasible. First, we've been
7 asked to look at the current gaps in the data that CMS
8 collects on provider ownership that may make it difficult
9 to track private equity investments in Medicare providers.
10 Second, we've been asked to examine the business
11 models that PE firms use when they invest in the health
12 care sector and how those models vary across health care
13 settings.
14 Third, we've been asked to examine the effects
15 that PE investment has on Medicare costs, the beneficiary
16 experience, and the provider experience.
17 And fourth, we've been asked to assess the extent
18 to which PE firms have invested in companies that
19 participate in the Medicare Advantage program and whether
20 it is possible to evaluate the effect of those investments
21 on Medicare costs.
22 We plan to examine each issue in an objective

1 manner and will not take a position on the broader debate
2 about the merits of private equity.
3 Before we get into the background portion of the
4 presentation, we thought it would be helpful to specify
5 what we mean by "private equity." Broadly speaking, the
6 term refers to any situation where investors buy an
7 ownership stake in a company or other financial asset that
8 isn't publicly traded. The term generates confusion
9 because it covers a wide range of investment activities,
10 such as venture capital funds for startup companies, growth
11 capital funds for new companies that need money to expand
12 their operations, buyout funds that acquire established
13 companies, and hedge funds that invest in a wide range of
14 assets.
15 Within the health care sector, the growing
16 prominence of PE firms in recent years largely reflects the
17 actions of buyout funds. For example, some of the
18 physician staffing companies that have engaged in the
19 controversial practice of surprise billing have been owned
20 by these funds. As a result, we plan to focus on buyout
21 funds in responding to the congressional request and will
22 use the term "private equity" to refer to them unless noted

1 otherwise.

2 Turning now to slide 5, although private equity

3 has received a growing amount of attention, it's worth

4 keeping in mind that the amount of public equity, which is

5 stock in publicly traded companies, still dwarfs the amount

6 of private equity. Last year, total public market

7 capitalization in the U.S. was about $37 trillion, while

8 the total assets being managed across all types of private

9 equity in North America were about $3 trillion.

10 Having said that, investment in private equity

11 has been growing quickly, and several factors have

12 contributed to that growth.

13 First, PE firms often rely heavily on borrowed

14 money when they buy companies, and the corporate tax system

15 favors these so-called "leveraged buyouts" because interest

16 payments lower a company's tax liability.

17 Second, interest rates have been low for an

18 extended period, which makes it easier for PE firms to

19 borrow money.

20 Third, changes to accounting standards have

21 forced pension plans to recognize more of their unfunded

22 liabilities, and many of those plans have invested in

1 private equity in the hope of getting better returns.
2 PE firms vary greatly in size and in the types of
3 companies that they purchase, but their investment
4 activities follow a similar life cycle. That cycle begins
5 with a PE firm raising money from outside investors and
6 pooling it into an investment fund. Most of the money
7 raised for these funds come from what are known as
8 institutional investors such as pension funds, university
9 endowments, and foundations.
10 Each investment fund operates for a specific
11 period of time, which is usually around 10 years. The PE
12 firm usually serves as the fund's general partner and
13 controls its investment decisions. The outside investors
14 are passive investors and generally cannot withdraw their
15 money before the end of the fund's life span. Most PE
16 firms raise money for new investment funds every few years
17 and thus manage multiple funds.
18 Once an investment fund has been set up, the PE
19 firm that manages the fund will then buy a variety of
20 companies, which are referred to as "portfolio companies."
21 Most acquisitions take place during the first three to five
22 years of a fund's life span, called the "investment

1 period." PE firms rely heavily on borrowed money when
2 making these deals, with debt often accounting for more
3 than half of the cost of an acquisition.
4 PE firms favor the use of debt because it
5 magnifies the potential return on their investments, but
6 one controversial feature of these leveraged buyouts is
7 that the company being acquired, rather than the PE fund
8 itself, usually becomes responsible for repaying the debt.
9 The PE firm then tries to improve the financial
10 performance of its portfolio companies and increase their
11 overall value. Since the PE firm owns the companies, it
12 has a much greater degree of control than with other types
13 of investments and can make significant changes to the
14 company's business strategy and management team.
15 Since PE firms need to sell their companies
16 before the investment fund reaches the end of its life
17 span, a PE firm will usually own a portfolio company for
18 somewhere between three and seven years.
19 Once an investment fund enters the second half of
20 its life span, the PE firm shifts its attention from buying
21 portfolio companies to selling them for a profit. This
22 phase is sometimes known as the "liquidation period."

1 Private equity firms usually sell their companies
2 to a strategic acquirer, such as a competing company in the
3 same industry, another PE investment fund, or by taking the
4 company public through an IPO. The profits or losses from
5 the sale of an individual company will depend on the extent
6 to which the PE firm can improve the company's performance
7 and find an attractive buyer.
8 Investors have traditionally paid PE firms using
9 what's known as the "2 and 20 model." The PE firm receives
10 two types of payments under the model. The first is an
11 annual management fee that equals 2 percent of the total
12 amount that investors have committed to the fund. The
13 second is a performance fee equal to 20 percent of the
14 profits on the fund's investments. These fees are known as
15 "carried interest" and appear to account for most of the
16 revenue that PE firms receive.
17 There has been debate over whether PE investments
18 have performed better than investments in publicly traded
19 stocks. Some research has found that PE funds outperformed
20 public equity prior to 2006, but there is greater agreement
21 that PE returns have been similar to public equity returns
22 over the past decade. The decline in PE returns relative

1 to public equity should not be surprising, because overall
2 investment in PE funds has been growing, and this has
3 resulted in PE firms having to pay higher prices for
4 portfolio companies.
5 As those prices increase, the expected returns
6 should decrease relative to other investments. Although PE
7 returns have been similar to public equity returns in
8 recent years, it's worth noting that PE fund performance
9 varies widely, with funds in the top quartile performing
10 significantly better than the median or average fund.
11 While PE buyouts first became prominent in the
12 1980s, their role in health care only became more
13 noticeable over the past two decades.
14 One major PE firm estimated that in 2019, PE
15 buyout deals involving North American health care providers
16 totaled $47 billion, up from $30 billion the year before.
17 PE funds have been investing in a wide variety of
18 health care providers, but recently, there has been greater
19 interest in areas such as retail health, post-acute care,
20 and physician practices.
21 Private equity's interest in health care has been
22 driven by several factors, such as the aging of the U.S.

1 population, the predictable cash flow for many providers
2 due to the use of third-party insurance and fee-for-service
3 payment, at least prior to the pandemic, and the high
4 degree of fragmentation in many provider markets.
5 I'm now going to shift gears and give you an
6 overview of our proposed work plan, and I'll discuss each
7 of the four issues we've been asked to examine.
8 I'll start with the gaps in Medicare's data on
9 provider ownership. Providers submit ownership information
10 when they first enroll in Medicare, and they must update
11 that information when there is a change in ownership. CMS
12 stores this information in a database called the "Provider
13 Enrollment, Chain and Ownership System," or PECOS.
14 CMS has largely used this database to support
15 activities such as provider payment and fraud prevention,
16 rather than analysis.
17 The Office of the Inspector General and the
18 Government Accountability Office have both identified
19 problems with the PECOS data. For example, GAO found that
20 it was difficult to use PECOS to identify PE-owned nursing
21 homes and understand their often complex ownership
22 structures.

1 We plan to interview CMS officials, state
2 officials such as those who collect information on nursing
3 home ownership to administer the Medicaid program, and
4 outside experts to see if there are ways to improve the
5 accuracy and usability of the PECOS data. However,
6 collecting good data on PE ownership may be inherently
7 challenging because PE investments can involve multiple
8 limited liability corporations that may not have an obvious
9 relationship to the parent PE firm.
10 The next issue is examining the business models
11 that PE firms use when they invest in health care. As I
12 discussed earlier, PE firms try to buy undervalued
13 companies, improve their financial performance, and then
14 sell them at a substantial profit. However, the business
15 models that PE firms use to increase the value of their
16 acquisitions can vary, even within a given industry. This
17 variation may be especially true for health care since PE
18 firms have made investments in a wide range of companies.
19 To better understand these models, we plan to
20 focus on PE acquisitions of hospitals, nursing homes, and
21 physician practices. We've chosen to focus on these
22 providers because there has been significant PE activity in

1 each area, and they play major roles in caring for the
2 Medicare population.
3 We plan to conduct interviews with outside
4 experts such as representatives of PE firms, to the extent
5 that they are willing to be forthcoming with us, financial
6 analysts, and providers.
7 In our interviews, we hope to learn more about
8 issues such as the extent to which PE firms try to improve
9 a portfolio company's profitability by increasing its
10 revenues versus reducing its costs and the relative
11 importance of Medicare versus other parts of the health
12 care sector, such as commercial insurance.
13 Next slide, please.
14 The third issue that the Commission has been
15 asked to examine is the impact of PE ownership on Medicare
16 costs, beneficiaries, and providers. We explored the
17 feasibility of conducting some type of quantitative
18 analysis of these issues but have concluded that it would
19 be very challenging in the time we have available for
20 several reasons.
21 One requirement for such an analysis would be
22 good data on provider ownership, and as we discussed

1 earlier, the PECOS data that CMS collects can be inaccurate
2 and hard to use.
3 Some researchers have used commercial datasets to
4 identify PE-owned providers, but this approach would also
5 be difficult because none of the commercial datasets are
6 viewed as comprehensive, and it appears to be very labor-
7 intensive to generate a reasonably complete picture of PE
8 transactions, even for a specific provider type or
9 physician specialty.
10 And even if were able to get accurate ownership
11 data, we would need to link it to a variety of other data
12 sources, and Medicare's data on service use and quality has
13 its limitations that would make it difficult to assess the
14 effects of PE ownership, especially across multiple
15 sectors.
16 Given these challenges, we plan instead to review
17 and summarize the available research literature and to
18 discuss some of the challenges involved with using Medicare
19 data to assess the effects of PE ownership.
20 The last issue we've been asked to look at is PE
21 investment in companies that participate in the MA program.
22 We have begun examining the ownership information for MA

1 plan sponsors, and our initial exploration suggests that
2 very few sponsors are owned by PE firms.
3 The health insurance industry is highly
4 concentrated, and most MA enrollees are in for-profit plans
5 offered by publicly traded insurers or not-for-profit plans
6 offered by companies such as Blue Cross/Blue Shield
7 affiliates.
8 Even if some of the smaller sponsors that we have
9 not yet examined turn out to be owned by PE firms, there
10 appears to be relatively little PE activity at the plan
11 sponsor level.
12 Having said that, there have been some PE
13 provider acquisitions that appear to focus on the MA
14 population. In particular, Humana, which is the second-
15 largest MA sponsor, has recently launched several ventures
16 with PE firms to acquire home health agencies, hospices,
17 and primary care centers. We plan to learn more about PE
18 involvement with the MA program by interviewing a variety
19 of stakeholders, including representatives of PE firms, MA
20 plan sponsors, and providers. Through these interviews, we
21 hope to better understand how PE firms view the MA program
22 and which parts of the program are seen as better

1 investment opportunities. We are also interested in
2 learning about situations where plan sponsors themselves
3 make investments in other health care companies, such as
4 venture capital funding for startup companies.
5 That brings us to the discussion portion of our
6 session. We'd like to get your feedback on our proposed
7 work plan and any suggestions you might have for useful
8 data sources or relevant research on private equity
9 investment in health care.
10 That concludes our presentation. We will now be
11 happy to take your questions.
12 DR. CHERNEW: So if I understand correctly, there
13 are no Round 1 questions because that was so clear. What I
14 think might be useful as we go through the set of comments
15 is to get a sense of how you feel we should take this
16 chapter, generally speaking.
17 I will give my first comment and then see where
18 all of you go, and that is -- and I think it was John who
19 mentioned hair on fire, feet in ice, or hair and ice and
20 feet on fire, some version of that, but the point is I
21 think it's very tempting for people to try and take a
22 concept -- it could be private equity, it could be Medicare

1 Advantage, it could be labs -- and generalize and then try
2 and build your policy towards the average, and this strikes
3 me as an example where the average could be particularly
4 problematic. Some of the things that I think are most
5 troublesome and frankly motivated the request to us have
6 been associated with private equity, but on the other hand,
7 I do believe there's great potential in other places for
8 private equity.
9 So my takeaway -- again, I'm waiting to see -- I
10 know most of you will have one comment in a minute -- my
11 takeaway is if there's behavior you don't like, worry about
12 the behavior. Don't try and find some generalizable trait
13 of the organization who's behaving badly and then regulate
14 all like organizations, but that's a Chernew view. It's
15 not necessarily a view overall. So I think we'll go around
16 and get as many comments as we can, but if there are no
17 Round 1 questions, we'll jump into Round 2. And I think
18 Round 2 is going to kicked off by Larry, unless Marge, I
19 see -- is yours a Round 1 question, Marge?
20 DR. PAUL GINSBURG: Actually, after, Marge, I
21 have --
22 MS. MARJORIE GINSBURG: Yeah. I think this is

1 sort of a Round 1-ish question.

2 So my first reaction in reading this is this

3 seems like a really weird assignment to give us. Am I --

4 is it just me, or is this really kind of strange? It seems

5 to me there must be other federal agencies that do this

6 sort of thing rather than us. So perhaps Mike or Jim can

7 respond to whether this is really unusual or not.

8 And the only other comment I wanted to make was

9 on page 15. It says CMS is in the process of redesigning

10 PECOS with the goals of simplifying and speeding up the

11 enrollment process. Is that a goal that we have as well?

12 So those two are it. Thank you.

13 DR. MATHEWS: Okay. I'm going to take the first

14 part of the question, and I will defer to Eric or one of

15 the other members of the team for the second.

16 First and foremost, for our listening public, I

17 would not characterize the assignment as "weird."

18 It is atypical. It's not something that we have

19 worked with previously in any depth, and during the course

20 of the back-and-forth on the request, we made that clear to

21 the folks who are interested in us doing this work.

22 Nonetheless, they felt that we could make a contribution

1 here, even understanding the limitations that we are facing
2 that Eric walked through.
3 And given the fact that our value to the Congress
4 is being able to provide information, analysis, advice,
5 recommendations, at the end of the day, we took on the
6 assignment.
7 So it is different. I will admit that, but we're
8 going to try and do the best we can here.
9 Eric, do you want to take the other piece?
10 MR. ROLLINS: Sure.
11 Just to say real quickly, Marge, in terms of
12 whether or not the process for providers to enroll in
13 Medicare is burdensome or time consuming, I don't think
14 that's an area we've looked at very closely. I don't
15 remember any sort of Commission presentation sessions that
16 have been focused on it during our time -- during my time
17 here, which has been about five years. But that doesn't
18 mean anything. It could still very well be a priority for
19 CMS.
20 MS. MARJORIE GINSBURG: Great. Thank you.
21 DR. CHERNEW: Still on Round 1.
22 MS. KELLEY: Go ahead, Betty.

1 DR. RAMBUR: I have just a question, a Round 1
2 question.
3 So you had talked about the challenges with doing
4 a quantitative analysis of certain questions that were
5 asked like beneficiaries' experience, and so the thought
6 was to look at the literature. I was just curious. Is
7 there literature out there on this? I'm not really aware
8 of beneficiaries' experience in these type of models, or is
9 there some value, at least some qualitative data
10 collection?
11 MR. ROLLINS: So we're still sort of feeling our
12 way through the literature and getting a sense of what's
13 out there.
14 There have been some studies that look at private
15 equity ownership facilities such as hospitals or nursing
16 homes. To the extent that they've tried to see sort of
17 what has been the effect of private equity ownership, they
18 have usually looked at things like cost reports and things
19 like that to get a sense of sort of a provider's financial
20 performance, and to the extent that they get at quality or
21 beneficiary experience, it's a little more indirect by
22 looking at sort of how those providers may be done on CMS

1 Star Rating system.

2 My sense -- and Larry would know better -- is

3 that the research of PE activities for other types of

4 companies like physician practices were limited, and that

5 may be partly due to the fact that that's a newer area

6 where there's been a lot of PE investment. And less time

7 has gone by for sort of the research literature to really

8 build up.

9 DR. RAMBUR: It would seem that having some

10 understanding of the beneficiaries' experience might be

11 valuable. Just my two cents.

12 DR. CHERNEW: Thanks, Betty.

13 I think we're at Paul.

14 DR. PAUL GINSBURG: Sure. Yeah. The Round 1

15 question I had is that I noticed that private equity was

16 about a tenth the size of public equity throughout the

17 economy. I was wondering how much of that $3 trillion in

18 private equity used private equity commercial real estate.

19 The reason I ask that is that commercial real

20 estate, that is the dominant form of ownership in

21 commercial real estate, and that I suspect that how private

22 equity operates in real estate could be distracting from

1 how it might be operating in health care.
2 MR. ROLLINS: I don't know off the top of my
3 head, Paul, how much of that is commercial real estate.
4 My recollection is that buyout funds for most of
5 the activity in private equity is a majority of the dollars
6 that are being managed, but we can look into that and get
7 back to you.
8 MS. KELLEY: Wayne, did you have a Round 1
9 question?
10 DR. RILEY: Yeah. A quick question. In terms of
11 the genesis -- and maybe Dr. Mathews can answer this -- was
12 there some -- on the part of the congressional staff that
13 requested this, was there some concern about the private
14 equity and its role in some of the celebrated hospital
15 closures recently?
16 I can think of a former teaching hospital in
17 Philadelphia that closed and I believe had some private
18 equity ownership, and that was very disruptive to a number
19 of not only patients, but also young physicians in
20 training, of course, which Medicare pays for.
21 DR. MATHEWS: So I cannot recall off the top of
22 my head whether hospital closures was a factor or even one

1 of the factors motivating the original interest in this
2 topic.
3 What I can do is go back and review the
4 paperwork, the letter that resulted in us doing this work,
5 and I can loop back with you outside of this meeting.
6 DR. RILEY: Thank you.
7 MS. KELLEY: If there are no more Round 1
8 questions, we can move to Round 2. I think Larry was going
9 to go first-oh, wait. I see--
10 MS. WANG: I tried to put my name in, but maybe
11 it didn't go through. May I?
12 MS. KELLEY: Of course. Go ahead, Pat.
13 MS. WANG: Thank you.
14 Given the difficulty as Eric and the team have
15 noted of using large datasets and kind of doing some big
16 quantitative, qualitative analysis of this, it's just a
17 question, because there have been things written about
18 different transactions, and the information is kind of out
19 there.
20 Would it make sense or add value to the study to
21 pick a couple of companies and just go through the entire
22 case study life cycle before private equity, after private

1 equity, maybe transactions if there was additional private
2 -- or just sort of -- just to do something longitudinal to
3 follow, to pick from some of the publicly available
4 information and go a little bit deeper?
5 If that makes sense, I wonder whether it would be
6 feasible to add that, like the environmental analysis of
7 the things that MedPAC is actually really, really good of
8 doing of, you know, impact on costs in the community or,
9 you know -- I don't know how you measure beneficiary
10 access, but other features like that. I just wonder
11 whether that would add anything to the work plan.
12 MR. ROLLINS: That is one option that we
13 considered Pat, and like you highlighted, the pros would be
14 to sort of get more of a flavor of what's going on in a
15 particular sector.
16 I think the concerns that we have are that even
17 if you kind of focus on one or two sectors, it's still
18 going to be a pretty heavy lift analytically to put all the
19 data together to sort of kind of provide any kind of
20 analysis.
21 And then I think more broadly, our fundamental
22 concern was given the variation and PE activity, it just

1 seemed very hard, and I think we didn't want to be in a
2 position where we were making any sort of general
3 conclusions about what the effects of private equity
4 investment are. We were worried that by focusing just on
5 one or two sectors, we might provide a little more insight
6 as to what's going on in those sectors. But we wouldn't
7 have produced anything that you could really sort of stand
8 back and generalize from.
9 MS. WANG: Thank you.
10 MS. KELLEY: Okay. Shall we go to Larry then?
11 DR. CASALINO: Okay. Thanks.
12 So I'll try to be brief. I think actually the
13 chair of Ways and Means or Ways and Means -- actually, the
14 four questions they asked are really good ones, and so
15 someone understands some things to be able to put out those
16 questions.
17 And I'll also say that as usual, it's just
18 routine to say it, but it's true. The staff have produced
19 a really lucid and concise, informative document, I think.
20 Pretty much every month, when we get the staff
21 presentations and mailing materials, I think, gosh, I wish
22 we could hire for my group some of the MedPAC staff, but

1 then I realize no, no, we can't do that. And we'll never
2 try, never try.
3 DR. MATHEWS: Don't do that, Larry. Sorry.
4 DR. CASALINO: We'll never do it. Anyway, I
5 think that would be great, but it does cross my mind once a
6 month.
7 So Michael asked me to comment a little bit on
8 the tone of the paper, and I think -- and the presentation.
9 I think it's fine for now. I think after their interviews
10 and a bit more literature reviews are done, I think over
11 the next few months, some more quantitative articles are
12 going to probably come out about impact to private equity
13 purchase and the three sectors mentioned. The tone could
14 change if the findings change. I think we should keep that
15 in mind.
16 So I'm just going to run through the things that
17 I think could be changed in the written materials of the
18 presentation and a few other things I want to say.
19 I think that private equity has some very
20 significant advantages as an investor. It's not clear that
21 these are necessarily desirable for other stakeholders
22 besides private equity. Brian and Eric mentioned some of

1 these, the interest loophole, ability to finance purchases
2 with debt and then load that debt on to the acquired
3 entity. Not mentioned in the presentation, but in the
4 written materials, the ability to force the entity after
5 purchase, like the physician practice, to pay dividends to
6 the PE firm or to pay management and consulting fees that
7 may or may not be appropriate.
8 So the paper does a good job of describing these
9 advantages, if you want to call them that, but they're kind
10 of buried. The description is kind of buried in the middle
11 of the documents. They're in a logical place, but I
12 personally would also like to see these things made a bit
13 more visible by maybe just listing them in the executive
14 summary and also, I think, certainly in the section on why
15 PE has been growing because I think these are reasons why
16 PE in health care is able to grow.
17 One gap, I think, in the paper, Eric mentioned
18 briefly in the presentation, a little bit about in the
19 paper, is differentiating what the paper calls "physician
20 staffing companies," we call "physician management
21 companies." But these are companies that basically focus
22 on hospital-based physicians, especially anesthesiology,

1 emergency department, immunology, OB/GYN, and then they
2 sign contracts with hospitals to provide services in these
3 specialties. And they employ the physicians then to
4 provide the service.
5 A lot of these companies are huge, so TeamHealth,
6 MEDNAX, Envision, and they're either owned by private
7 equity now or had significant private equity involvement in
8 the past. And we're talking about big investors like
9 Blackstone and KKR.
10 So these, I think, need to be clearly
11 differentiated, I think, from the more midmarket or small
12 market private equity firms that are out there acquiring 10
13 physician dermatology practices and 2 physician dermatology
14 practices, for example. They're different beasts, and they
15 probably have different business plans and maybe a
16 different amount of time for how long they intend to be in
17 the business.
18 It's just worth saying these big physician
19 management companies or physician staffing companies,
20 they're quite involved in surprise billing and also in
21 providing the dark money to block the surprise billing
22 legislation last fall in Congress.

1 In terms of the business plans -- so these firms
2 promise annual returns of -- 20 percent return on
3 investment annually to their investors. How often they
4 meet that nowadays is a different question, but that's what
5 they like to claim they'll do. So thinking about physician
6 practices or nursing home or hospital -- but let's just
7 take physician practices. Are there many practices out
8 there that are really so badly run that you can generate 20
9 percent extra revenue from them every year without stinting
10 on something? I haven't heard a convincing case for that.
11 So how much of the 20 percent annually they can generate
12 from operations is a question, I think.
13 They can potentially generate money from real
14 estate, and I don't know in detail, but I think the
15 Hahnemann Hospital that Wayne was referring to in
16 Philadelphia was a real estate deal. Buy the hospital in a
17 potential fine area, let it go bankrupt, and then sell the
18 real estate to make a high-end condos.
19 So real estate can be a play. I think that may
20 be more true in the hospital or post-acute care industry
21 sectors than certainly in physician practices.
22 And then can they get some of the 20 percent from

1 these dividends, consulting management fees, I mentioned?
2 I think they expect to get a lot of the 20 percent annual.
3 So, in five years, this would be 100 percent, double your
4 money, from their sale.
5 And then the question is, who are they going to
6 sell it to? There's a nice discussion on this on page 12,
7 and I think that this would be a great thing through
8 interviews for the staff to explore in the next few months.
9 What is really happening with these sales,
10 especially in the physician practice area? Things are so
11 new that there haven't been many second sales yet, but who
12 is buying the practices, and are they really buying them
13 for a lot more than the original private equity firm paid
14 for them? Because if the private equity firm cannot sell
15 what they bought for a lot more than they bought it for,
16 they're probably not going to be able to give the returns
17 to investors anywhere near that they promised. And so this
18 could actually turn into an unintentional, I think, Ponzi
19 scheme.
20 Michael, I don't have too much more to say. I'll
21 just add a couple things.
22 Small point but I think significant is another

1 possible way to get to these high returns is if you buy a
2 12-physician dermatology practice, which is really big, you
3 might pay 12 or 14 percent, what's called EBITDA, and that
4 can be a lot of money, well over $1 million per
5 dermatologist.
6 But then if you start buying two or three
7 physician dermatology practices to add to this bigger
8 platform practice and you buy them for twice EBITDA maybe,
9 so you get them cheap and probably even more cheaply now
10 after what's happened with the pandemic, you add them to
11 the bigger practice. And the day that they're added --
12 they don't have to change their location or anything, but
13 now they're part of the bigger practice. Now they're worth
14 12 to 14 times EBITDA too because they're part of this
15 bigger entity.
16 Case studies, I think, is a good idea, especially
17 under the circumstances, maybe two of the three sectors if
18 the staff proposed a study, ideally to try to find the case
19 study of a firm that was doing a good job and one that
20 wasn't.
21 I agree with Mike that there's probably a lot of
22 heterogeneity. From what we've heard in a lot of

1 interviews, there probably really are PE firms that are
2 both capable and well intentioned and then firms that
3 aren't either capable -- or they're not capable and they're
4 not well intentioned either. And there might be some that
5 have one but not the other. So I think that's probably
6 true.
7 I would say, though, that average effects are
8 also important, and hopefully, we'll be able to get at that
9 quantitatively with a lot of labor -- or in this year.
10 I do wonder how if the high performers are truly
11 high performers or if it's just luck. So if they're in the
12 top quartile, how long do they stay there? It's been shown
13 in a lot of industries that genius stock pickers or genius
14 movie producers who pick hits, they look really good, but
15 actually, if you look at their track record over the years,
16 they turn out to be no better than anybody else. So one
17 wonders with the PE firms.
18 A few other ideas about who else to interview
19 besides who you mentioned in the paper. I think
20 consultants, attorneys, and also health insurance companies
21 and hospital executives, who are both very effective by PE
22 purchases of practices, for example, or of nursing homes,

1 so worth talking to hospital executives and insurance
2 executives as well as consultants and attorneys who work in
3 the industry.
4 And then the last point, it would be interesting
5 to -- I already mentioned it would be good to know who
6 actually makes the second buy after PE firm buys and now
7 selling, how often the entities they bought do in fact go
8 bankrupt, because I don't think we have a good idea of that
9 in the three sectors mentioned.
10 And in terms of working with trying to make PECOS
11 work better for identifying ownership by PE, for example, I
12 would -- this goes beyond private equity, and I think the
13 fact that it's very, very difficult to determine who owns
14 something in U.S. health care -- and let's just say who
15 owns a physician practice. Is it the physicians
16 themselves? Is it a private equity firm? Is it hospital?
17 Is it a health insurance company? Is it Optum? Very hard
18 to tell.
19 I would personally love to see MedPAC make
20 recommendations at some point about how CMS could
21 contribute to making ownership more transparent, and I
22 think in that regard, the statement on the bottom of page

1 17, quote, Commission staff will further examine what
2 change is under way for PECOS and whether those changes
3 might shed light on PE ownership, that's pretty weak in my
4 opinion, I would say. Whether now or at some other time, I
5 would love to see MedPAC try to get Medicare to make
6 ownership more transparent. Without that, I think it's
7 very, very hard to understand the impact of the major
8 organizational changes that are happening in the U.S.
9 health care system.
10 And that's it.
11 MS. KELLEY: Okay. I have Bruce next.
12 MR. PYENSON: I wanted to compliment Larry on his
13 comprehensive view within the organizations that Medicare
14 makes arrangements with. I think my perspective is similar
15 to Mike's and others that there's a huge variation in
16 what's going on, but I think this is an opportunity for
17 MedPAC to create something like a payment basics role of
18 private equity in health care. It's not quite payment but
19 really a cornerstone piece on this.
20 My perspective is that we have an opportunity in
21 looking at private equity to expand beyond the
22 organizations that the Medicare program writes checks to

1 and to look at the organizations that serve those
2 organizations and perhaps even control them.
3 As the paper pointed out, of course, the new
4 Medicare Advantage plans are dominated by huge
5 organizations. Huge organizations that are publicly traded
6 typically don't deal with private equity directly.
7 However, if we're going to think about more
8 competition in any of the spaces that we've been looking
9 at, private equity is likely to play a role. We were just
10 thinking about labs and what it would take to get a lab
11 going in a region. That's a role for perhaps private
12 equity.
13 But where I see -- what I see would be very
14 helpful is to look a layer deeper at the organizations that
15 are serving the providers or the MA plans that Medicare
16 contracts with directly or pays directly.
17 So there's all sorts of organizations that are
18 doing data analytics, that are doing billing, that are
19 doing risk adjustment, risk optimization, and distribution,
20 various other feeder organizations that are critically
21 important to the functioning of the health care system.
22 But they're not getting cut a check directly by Medicare,

1 and often it's those organizations that are involved with
2 private equity. And I think extending our view to those
3 other organizations would be of benefit to the work of
4 MedPAC in general because often the behaviors that we are
5 examining or are puzzled by are no longer the incentives or
6 the motivations of a physician in a physician office or a
7 hospital, but are driven by the other business entities
8 that are so important to their functioning. So I see that
9 as an important recognition in a report that we put out.
10 I like Pat's suggestion of a case study kind of
11 approach, but I don't think that has to be generalizable in
12 the extent this is good or bad, but more on a this is the
13 way private equity works, not the conclusions of it, but
14 here's how the money comes in, here's how it goes away,
15 here's the life span, here's a couple of cases of that. So
16 I think that kind of educational approach would be quite
17 useful.
18 In terms of some of the discussion and the
19 questions of why is private equity interested in health
20 care as opposed to car washes or as opposed to clothing
21 manufacturers, well, that's what we were talking about in
22 the context section. Health care is growing, and the

1 spend, more and more money is going into health care. So I
2 don't think it's any surprise that private equity is
3 interested in it. So I think that's a reflection of the
4 issues in the context chapter.
5 So, in summary, my recommendation is that we
6 recognize these other entities that are normally beyond the
7 purview of MedPAC as important to health care and important
8 to private equity, and I think I've suggested doing that in
9 other contexts as well. I think it's important to really
10 understand whether what we're suggesting is going to work
11 or not.
12 Thank you.
13 MS. KELLEY: Jon Perlin.
14 DR. PERLIN: Sorry. I'm not sure I was in the
15 queue on this one, but I'll make a comment, given that I've
16 been in an organization that went through the cycle.
17 I think our chair's comments were just absolutely
18 accurate. The mean may not belie the spurious on the
19 edges, having lived through an LBO and come out of it
20 again.
21 In our organization, it was simply a capital
22 structure, and the capitalization was very different from

1 the operationalization.

2 It's interesting. There was a recent paper in

3 JAMA that talks about a relative improvement in PE-owned

4 entities relative to others. Truth be known, someone sent

5 it to me, and I begin reading it. I said, "Oh, the story

6 is largely based on my organization."

7 Now, I'm proud of the fact that we outperform and

8 lifted what appears to be an entire sector, but the truth

9 of the matter is that die was cast even well before the LBO

10 in terms of commitment to changing quality and performance.

11 So, you know, it is very interesting. I think

12 the reasons private equity in part has been interested in

13 health care is not only because it's a large sector,

14 roughly a fifth of the economy, but because prior to COVID,

15 all the other activity, there was very little place to

16 invest.

17 I think Bruce and Larry raised some very

18 important points that there are a panoply of approaches to

19 what gets invested in from direct care provision to the

20 fiscal spaces that support health care, et cetera.

21 I would just encourage the evidence-informed

22 approach of this topic that MedPAC and staff take so

1 thoughtfully to all topics, not rely too much on anecdotes,
2 especially, you know, get a number of outside experts that
3 would give varying views, but just simply recount the
4 facts, that I think the larger issue is obviously how
5 ownership influences -- how do ownership interests
6 influence such things as utilization and clinical outcomes.
7 Thanks.
8 DR. CHERNEW: So let me jump in before we get to
9 the Round 2. I'm not sure how deep the Round 2 queue is,
10 Dana. If you could let me know.
11 But just to give some context, first of all, the
12 author of the paper that Jon is talking about, one of the
13 authors is a colleague of mine, Zirui Song. I happen to
14 know by text, he's been listening to you.
15 As an aside, although this might be somewhat a
16 typical request, I do think per what Bruce said, this will
17 be an interesting area for MedPAC to learn about even more
18 broadly. Given staff time, I'm not sure how far we're
19 going to be able to go down that route for this activity.
20 That's the sort of discussions that I'll have with Jim.
21 I will say that for this report, I'm not leaning
22 towards any recommendations, per se. Again, if anyone has

1 recommendations they're interested in making, this would be
2 a time to get them out on the table we could discuss.
3 I do think we could have some conclusions. The
4 conclusion I am leaning towards -- and again, I say this to
5 get pro or con reactions from all of you -- is something
6 like private equity can be good or bad. They are likely to
7 be an important source of efficient funding to have
8 efficiency increasing disruptions, but they also can do
9 some things that -- they exploit loopholes, if the
10 loopholes exist, and that we -- and they're not alone in
11 that behavior, and that we should focus policy on leaving
12 the opportunities for negative exploitation and increasing
13 incentives for positive efficiency enhancing disruption.
14 And when we see bad behavior, we should go after the
15 behavior and not the capital structure of those that are
16 behaving badly.
17 So that wasn't very eloquent, but since we're
18 earlier in this process and I'm an economist, I don't feel
19 bound to be eloquent.
20 So, with that, I'm interested in comments
21 basically about are there strong recommendations you think
22 we should go after, are there conclusions you think we

1 should make, or do you want to make comments on the process
2 by which we get there, given the limited time and the data
3 complexities that we're going to inevitably face?
4 So, Dana, how does the Round 2 queue look?
5 MS. KELLEY: Our next person is Marge.
6 MS. MARJORIE GINSBURG: That must have been a
7 previous one. I don't have a comment right now.
8 MS. KELLEY: All right. I'm sorry.
9 Karen?
10 DR. DeSALVO: Thank you.
11 I guess sort of sticking with the congressional
12 expectation that we don't need to make a recommendation, I
13 think the elucidation is helpful because it's a very active
14 area of work in the industry for reasons that have been
15 outlined. It's a growing industry.
16 And I just wanted to provide a couple of
17 reflections and then maybe a very concrete couple of
18 suggestions.
19 The reflection is that thinking about primary
20 care, when you want to innovate primary care practice in
21 the U.S. context, you have to get special money to do it
22 because it's really not quite possible to innovate within

1 the confines of the typical traditional Medicare construct.
2 I said that as nicely as I could.
3 And my first experience with that was after
4 Katrina when we got resources from HHS to reinvent primary
5 care for our city, which we did successfully in the vein of
6 the patient-centered medical home, and that experience was
7 punctuated by an ending of that grant funding that caused
8 us to have to go back to a fee-for-service model, which
9 caused us to have to start letting go of our team members,
10 community health workers, navigators, mental health
11 professionals, because there wasn't a fee-for-service fee
12 schedule weighted to pay for their services.
13 Over time, the system has started to level out
14 with Medicaid advancements because most of those are FQHCs,
15 federally qualified health centers. They've been able to
16 retain some of the component parts of medical homes, but
17 you see this story replay over and over and over again,
18 whether it's a CMMI model or a special grant program that's
19 funded by the private sector payer.
20 And I share all that to just remind all of us
21 that sometimes innovation needs an extra infusion of
22 flexible resources.

1 In fact, CMMI is basically a really big PE firm,
2 and it's been trying to infuse capital in a way that can
3 drive innovation into the ecosystem.
4 Wearing the hat of an MA plan, it's a similar
5 kind of challenge. What you want is primary care practices
6 with aligned incentives about prevention and meeting people
7 where they are in whatever environment that makes the most
8 sense digitally, at home, in the communities' site. A lot
9 of the current constructs of the Medicare program aren't as
10 flexible to support it. We're seeing that happen every
11 day, including even in areas like telehealth, which we'll
12 discuss tomorrow.
13 So some of the impetus, just because this came up
14 in the presentation, I'm just kind of answering the
15 question as a former board member of Humana. But the
16 interest is how can there be a way to try to innovate a
17 better model of primary care, one that doctors want to
18 practice, is team oriented, that consumers love, that gets
19 you to the kind of outcomes that you want, because whatever
20 we've been doing in the current construct, doctors don't
21 love, patients don't love, the system doesn't love.
22 There's no secret sauce here. I think it's less

1 about the financial. It's more about just trying to get to
2 a better model, and I think the more that you talk with
3 executives, I think you might be hearing more of that
4 story.
5 The two more things I just want to mention before
6 I got off of that, the why, is don't forget to think about
7 venture capital as a smaller portion of this perhaps that's
8 thinking about some of the digital innovations or some of
9 the companies that start to really grow quickly, and Rock
10 Health always keeps a really nice inventory of what's
11 happening in the field across the spectrum of investments.
12 That could be a place where you might want to have a
13 conversation with them and think about if they have ideas
14 of other data sources that would be useful.
15 And I just want to end by saying I really think
16 talking to the beneficiaries would be so helpful. I really
17 don't think there's a lot of data about if people notice a
18 difference. People did the concierge model years ago,
19 which is essentially what a lot of these new primary care
20 models are predicated on is this idea of a concierge access
21 anytime without the same kinds of constraints. We know a
22 little bit about how consumers felt about it, but those

1 models weren't designed particularly around reaching
2 populations equitably and doing it with technology in hand.
3 So I think getting the voice of the consumer in this just
4 to inform the field would be useful for everybody involved
5 and I think especially useful for the Commission to have.
6 MS. KELLEY: Okay. Thanks.
7 Paul?
8 DR. PAUL GINSBURG: Sure. It's been a great
9 discussion so far.
10 There's one perspective I want to put out, and
11 I'm not quite sure how we can follow it, is that in much
12 PE, the model is acquire an organization and run it
13 differently to make more money than it was making before.
14 I think physician practice is probably a prime opportunity
15 because physicians historically have been very well paid in
16 this country, at least in specialties, procedural
17 specialties. There likely are opportunities to manage more
18 aggressively on either the revenue or the expense side.
19 But my concern is really about managing
20 aggressively on the revenue side and how much of this is
21 exploiting the vulnerabilities of all fee-for-service
22 payments. I think in some areas, it's probably more

1 vulnerable than others, and that's often where you see PE
2 or other for-profit going. So, in a sense, it's a bit of a
3 wake-up call for Medicare that you need to put more energy
4 into shoring up your loopholes and maybe even increase the
5 urgency of getting away from fee-for-service because the
6 system -- and I think that's what attracts PE to health
7 care. The system is so much more vulnerable than car
8 washes as far as more aggressive management, making a lot
9 of money, without delivering commensurate value to its
10 customers.
11 MS. KELLEY: David?
12 DR. GRABOWSKI: Great. Thanks.
13 Let me start by saying that I'm really pleased
14 that we're looking at this issue around private equity. I
15 believe it was a really important request from Ways and
16 Means.
17 As Eric said, nursing homes have a relatively
18 longer history with private equity as compared to other
19 sectors like physician groups. As one example, one major
20 nursing home chain is actually on their third private
21 equity owners. So we've seen two sales, private equity to
22 private equity, to get to this third owner.

1 To Larry's point, real estate has been a big part
2 of these nursing home deals. Indeed, one thing to unpack
3 for Eric and the team is just all the permutations of these
4 nursing home deals. How do nursing home private equity
5 deals differ, if at all, from some of the big purchases by
6 real estate investment trusts and other entities? This is
7 a really complicated space.
8 In terms of how complicated it is, I love Larry's
9 comment about the challenges of determining ownership in
10 the U.S. health care system.
11 Let me even go further than Larry to say I don't
12 think this is an accident. We need greater transparency.
13 It's really hard to understand, even scrutinize these
14 deals, if we can't even identify them.
15 The PECOS data came out of the Affordable Care
16 Act with exactly the idea of allowing greater broker
17 oversight over an increasingly complex ownership structures
18 in the U.S. health care system. It's been incredibly
19 frustrating to me and others that have worked with these
20 data that they haven't been up to the task in terms of
21 either accuracy or usability. It seems that all we've
22 ended up with really is a complex database.

1 Anything we can do to improve these data -- and
2 I'm really looking forward, Eric, to your discussion with
3 the team at CMS about how we can improve these data. Mike,
4 you asked for what could be a focus of these chapters. I
5 think if we increase the transparency, the accuracy, and
6 the usability of the PECOS, those would be tremendous
7 outcomes from this. Those data right now just really have
8 some shortcomings.
9 As Eric noted, because of those shortcomings,
10 researchers and analysts have had to rely on commercial
11 databases to identify private equity ownership. Eric's
12 point about the completeness of these commercial databases
13 hit home with me.
14 I did a 2008 paper with my colleague, David
15 Stevenson, on the first generation of private equity deals
16 in nursing homes. We obtained a list of the largest deals
17 from an investment bank. We lived in constant fear that
18 someone was going to come up with a deal that we missed in
19 that analysis. In fact, we kept couching our analyses that
20 these are only for the biggest private equity deals at the
21 time to give us wiggle room.
22 We should have been able -- and the PECOS data

1 were one of the outgrowths, as I said, of the ACA, which
2 came after our analysis, but the hope had been the next
3 generation of studies could really leverage the PECOS. And
4 they haven't been able to do that.
5 Two other quick comments. I'm wondering. We
6 spoke a lot in the last cycle on MedPAC about market
7 consolidation. I've wondered how private equity
8 contributes to market consolidation. We did an analysis
9 with the PECOS where we found lots of joint investment
10 across hospitals and post-acute sites, including hospice.
11 How does private equity figure into that? Our analysis was
12 broader than just PE, but I'm curious whether there is kind
13 of broader investment that's helped to consolidate those
14 markets.
15 The final point -- and we talked about COVID this
16 morning, and I think COVID has magnified kind of private
17 equity investment, at least in nursing homes. In good
18 times, it may be fine to separate ownership and operation
19 of a nursing home. In these really challenging times
20 during the pandemic, I'm not certain of the wisdom of
21 having operations and ownership separate. I know a lot of
22 operators right now are struggling to pay their lease. We

1 saw some of the revenue numbers this morning. But I do
2 think it's worth scrutinizing just the stability of these
3 arrangements in a pandemic. I realize these are
4 extraordinary times, but it's not clear to me that these
5 kinds of ownership operation models are well built to
6 withstand these kinds of times.
7 So I'll stop there, and once again, I'm glad
8 we're looking into this and look forward to everything the
9 team is going to learn from CMS and others about how to
10 improve the data infrastructure and how we can understand
11 these deals going forward.
12 Thanks.
13 MS. KELLEY: Okay. Brian?
14 DR. DeBUSK: Well, thank you, and I will echo
15 some of the other comments. I do think this is a great
16 question on the part of Congress.
17 My comments are going to closely align with
18 Paul's, Michael's, and Larry's.
19 First of all, I just want to point out the
20 obvious limitations. I mean, you guys have already talked
21 about the limitations of PECOS and the change of ownership
22 process. I think the other thing we have to face is that

1 private equity firms don't like to be transparent. They
2 don't like to be measured. So, I mean, I think that's the
3 other thing that we're up against. We have incomplete
4 data, and we have a group of people that don't want to be
5 measured in the first place.
6 I think in a report, I hope we can recommend that
7 it's probably best to use some indirect methods to gage the
8 impact of private equity and health care. As Michael said,
9 I think they're a combination of good and bad things, but
10 regardless of how we feel about private equity, they're
11 here in health care. I mean, they've arrived, and they're
12 making moves. These are very financially savvy people.
13 They have access to capital, and they love to scale
14 programs. And they like to scale them relatively quickly.
15 I think we need to focus -- and I think Bruce
16 mentioned this. We needs to focus on where private equity
17 migrates. Look at the mechanism that they're using for
18 their transactions because you have to assume they're going
19 to find a viable business model, build a template, and then
20 try to scale that template geographically. I mean, that's
21 their mechanism of action.
22 I think this really puts a lot of pressure on

1 fee-for-service. Paul, I agree with your comments. I
2 mean, these guys are great at finding arbitrage and taking
3 advantage of it. If it's arbitrage that's good for
4 beneficiaries and for taxpayers and for providers, I think
5 that's great. I don't think any of us would complain if a
6 private equity firm was buying up physician practices in an
7 area and building a population health front end so that
8 they can engage with Medicare Advantage plans and
9 alternative payment models and make money off of shared
10 savings and capitated payments. I don't think we'd have a
11 problem with that.
12 But I think if the same firm were buying these
13 physician practices, aggressively renegotiating rates,
14 sending out-of-network billing skyrocketing, and just
15 slashing costs, I think we would have a problem with it.
16 So I think as policymakers, the real pressure here on us is
17 what opportunities have we left. Where are those arbitrage
18 opportunities in the system? Because I think it's safe to
19 assume with PE being here, I don't think they're just going
20 to go away. And the arbitrage that we may have left in the
21 past, they're going to capitalize on. So, if anything, I
22 think this creates pressure for us to make sure that we

1 have the incentives correct.

2 Thank you. Those are my comments.

3 DR. CHERNEW: Can I just jump in? I know we have

4 a few people --

5 MS. KELLEY: Oh, of course.

6 DR. CHERNEW: Dana?

7 MS. KELLEY: Go ahead, Mike. I'm sorry.

8 DR. CHERNEW: I'm sorry. I just wanted to jump

9 in because it will help, I think, see where people will go

10 next. I know we have -- Pat, you're going to be after me,

11 then Amol, Jonathan, and I guess Larry again.

12 First of all, I'm exactly where Brian is in much

13 of what he said. We want to make sure that you make a

14 profit from doing good as opposed to making a profit from

15 doing bad, and the better we can set up the systems to

16 enable that, the better the world will be.

17 I wanted to talk about actually where Larry and

18 David were about the PECOS. As one of the researchers

19 that's constantly frustrated by PECOS, my concern, which

20 you triggered, Brian, is we could spend a lot of time

21 trying to get better sense of corporate ownership in ways

22 that pe who actually do corporate ownership will be able to

1 obscure. So I think what we will have to sort going
2 forward is how much time and effort we should spend or CMS
3 should spend trying to sort that because I'm afraid they
4 will inevitably fail, given the potential complexities of
5 the way in which people can build corporate ownerships and
6 the definitional issues.
7 But we'll sort that out later, and I think now we
8 should probably go to Pat and then move through the queue.
9 MS. WANG: Okay. Thank you.
10 DR. DeBUSK: Michael, on that one point -- I'm
11 sorry to interrupt. On that one point, I do think if we
12 could in our discussions with Congress, if we could shift
13 the emphasis toward the mechanism of action and perhaps
14 away from this perpetual cat-and-mouse game, I think there
15 would be some benefit there.
16 MS. WANG: Okay. You know, just picking up on
17 the important discussion on PECOS and transparency, I think
18 that the call for transparency is always more powerful if
19 you can say why you want to know and that you have
20 information to suggest that greater transparency is
21 relevant as opposed to we're just we just kind of want to
22 know because we always like to know what's going on.

1 In that regard, I think Karen's comments earlier
2 were really striking to me, particularly when she talked
3 about PE funding as being a source of flexible capital for
4 primary care, et cetera. It's really, really an important
5 function.
6 The difference between PE firms and CMMI, which I
7 think you said something like they're trying a PE kind of
8 function, is the need for the return, the high financial
9 return from PE. CMMI doesn't require that.
10 So just as we always want to evaluate the impact
11 and the success of the CMMI investments for lasting and
12 sustainable improvement in the health care system, I think
13 that's the question around PE that supports the call for
14 greater transparency and maybe the extreme efforts that
15 would have to be made to improve PECOS.
16 The reason that I sort of was raising the idea of
17 case studies before is I feel like what's missing from the
18 discussion is a longitudinal understanding of the impact of
19 PE. In the short term, funding innovation, creating new
20 models of care that are not constrained by the typical way
21 that we do business is really, really valuable.
22 But the question is what then happens to that

1 investment in a physician practice. What's the next step?
2 Because there is this cycle of transactions that kind of
3 flows from an initial PE investment. I think that's kind
4 of what it's about.
5 So my interest would be knowing, longitudinally,
6 what are the impacts on consolidation in the system. If
7 you buy a physician practice or an urgent care center, do
8 you then kind of, the law of economics, make it an
9 imperative to acquire more and bundle them so you can
10 achieve those scales? What is the impact of consolidation
11 on the market in terms of cost to payers? I mean, there's
12 more clout. There's more bargaining. Costs should go down
13 in some respects, but maybe they go up in other respects.
14 What's the impact on quality? What's the impact on
15 existing parts of the delivery system, particularly those
16 that have been there for a long time and are expected to
17 serve those whose payer source may not pay very much, if
18 anything?
19 Those are the kinds of questions that I don't
20 know how to get at that, but that's why I was suggesting a
21 longitudinal case study, just so that at least I, along
22 Bruce's sort of concept of payment basics, can understand

1 the life cycle of something that has had PE investment and
2 kind of where it goes. Does it eventually get acquired by
3 publicly traded companies? Are there entities that started
4 as not-for-profit who wind up publicly traded? Are there
5 small entities that wind up gigantic? Are there
6 innovations that create a lasting impact in how to take
7 care of the elderly at home? It's that kind of thing.
8 I don't have the specific suggestion other than
9 trying to pick areas to do case studies that would
10 illustrate at least longitudinally the sort of life cycle
11 of an entity that has had this kind of investment in it.
12 Thank you.
13 MS. KELLEY: Amol?
14 DR. NAVATHE: Clearly a very important topic.
15 I'm very struck by what seems like the heterogeneity of
16 opinion and emotion from folks around this question and its
17 impact on health care, even just across the Commission.
18 I think I largely agree with the view, Michael,
19 that you've been putting forth, which is there are clearly
20 some publicized bad examples, if you will, of how private
21 equity has affected health care, but I think we want to be
22 careful from taking a view of sort of an indictment of the

1 entire investment vehicle and the entire investment
2 community with respect to private equity.
3 So that being said, I think what I am struck by
4 is that from the way that we as MedPAC tend to approach
5 understanding health care, we clearly don't really
6 understand some of the very basics of what the scope and
7 scale of private equity's influence is. I think to the
8 extent that we can work with academic groups that have
9 tried to do that -- I think there's at least a few of them
10 that I'm aware of -- and try to kind of stand on their
11 shoulders, if you will, as well as access some of the other
12 resources, even if it's an incomplete view.
13 David, to your point, maybe it's not going to be
14 a 100 percent view, but it will be a view. And at least we
15 will have a floor for how big and how wide and how deep
16 this issue runs.
17 I think there's a couple of pieces that are
18 particularly interesting and I think, to some extent, Pat,
19 to your point, are great calls for transparency or at least
20 a push and perhaps itself is something that we could get
21 back to answering the Ways and Means request is to what
22 extent is the regulated aspect of health care and a vehicle

1 for -- or an opportunity for arbitrage that private equity
2 is interested in, because one aspect of clearly what MedPAC
3 has an opinion on and influence over and sort of within our
4 four walls, if you will, is the regulatory aspect of health
5 care between Medicare. So I think that makes this sort of
6 squarely important for MedPAC to understand.

7 To the extent that through our qualitative work
8 and perhaps through other quantitative work we can get
9 there, I think that would be particularly important.

10 The other piece is that examples like Heinemann
11 exist. So I think while we don't want to cast the entire
12 PE industry, if you will, as bad actors, there's clearly
13 been an impact, and I think some would argue a negative
14 impact, on beneficiaries, on trainees, on physicians, on
15 others who are impacted by decisions made seemingly more
16 based on profit motive rather than social welfare.

17 And if we can use the case study template here
18 for a second to put a personal view on what the impact can
19 be when the profit motivate exceeds the social welfare
20 motive, to some extent, then maybe we can actually be
21 successful in driving towards greater transparency.

22 I would at least submit that do-gooders are

1 probably not quite as scared of transparency relative to
2 the minority perhaps of bad actors. So if an outcome of
3 this allowed the PECOS conversation that we have had is we
4 can circle back basically, quantify to some extent first
5 principles of how big, wide, and deep this problem or issue
6 is, not necessarily the problem in the negative sense, and
7 then articulate a reason, even if it's in a few examples
8 with a personal face on it, why this actually can touch
9 people in potentially a negative way that interacts with
10 the regulatory aspect of Medicare, then I think that that
11 is a pretty powerful case to say we would pursue trying to
12 get more information and using perhaps congressional
13 authority and other avenues to try to understand this more
14 deeply.
15 The last point I have is while I agree that
16 there's not a lot of reliable data, from what I understand,
17 to do deep quantitative analyses, it seems to me that part
18 of what the congressional request to us is to try to
19 elucidate what we would need to be able to do that.
20 There are, again, academic groups who are
21 starting down that path. So if we can complement our
22 qualitative work, talking to beneficiaries and the private

1 equity firms and MA plans, et cetera, et cetera, with at
2 least an approach of what we would need and how we would
3 execute those analyses, which hopefully will be less time
4 consuming, Eric and team, than actually having to conduct
5 all those analyses and collect all that data, then I think
6 we can at least paint a picture of all the different
7 components that would be needed to more comprehensively be
8 able to sell you this and recognize the limitations in,
9 again, a very concrete way, if possible.
10 So those are sort of some reflections of mine in
11 terms of how perhaps we can try to look under the hood a
12 little bit more, and largely speaking, I agree with a lot
13 of the statements that other Commissioners have said.
14 Thanks.
15 MS. KELLEY: Jonathan Jaffery?
16 DR. JAFFERY: Thanks, Dana.
17 So, like others, I thought this chapter was
18 great, and this discussion has been phenomenal really. And
19 I'm learning a ton.
20 I would say that, like others, I do think that
21 there is definitely some opportunity to think about both
22 negatives and positives in this space. I do wonder if the

1 stated need to have 20 percent annual return ends up
2 creating some inherent conflict with the ability to get
3 enough efficiencies that will also return some of those
4 efficiencies or some of those positive benefits back to the
5 Medicare program and beneficiaries in terms of access,
6 quality, and cost savings, but I don't want to dismiss that
7 possibility out of hand.
8 So to balance that, one of the things that I'm
9 thinking about in terms of innovation here that I'm not
10 sure we've talked about, although there's been some hints,
11 been some comments that Karen and Brian in particular have
12 made, is thinking about, first of all, the idea of infusing
13 cash into practices, physician practices, and maybe
14 particularly primary care practices, to be able to create a
15 team-based model of care.
16 One of the things that strikes me -- because
17 there are some health systems that could conceivably do
18 that and have to a certain degree, but one of the barriers
19 to making that sustainable that we've talked about beyond
20 what Karen mentioned in terms of grant funding that goes
21 away is that health system leaders are often stuck in a
22 mode of thinking about their finances and the analytics

1 about the finances based on their traditional models. And
2 it's hard for them to parse out things beyond the fee-for-
3 service, and I think evidence of that is -- I don't know
4 how many years now we've heard people constantly talk about
5 having a foot in two canoes. But it's been many, many
6 years now.

7 So it strikes me that folks who are running PE
8 firms are not going to be burdened by having that legacy
9 model of thinking about financing, and if there's an
10 opportunity to make a sustainable model through the various
11 population health program approaches that Brian was talking
12 about in ACOs and whatnot, they will be wide open to
13 innovating that way.

14 So that's a long-term assessment. We're not
15 going to understand that in the next paper, but it's
16 something to think about. It's an opportunity, and maybe
17 in this work plan, as you do stakeholder discussions and
18 interviews, maybe there's an opportunity to probe on those
19 things a little bit.

20 Thank you.

21 MS. KELLEY: Larry, did you want to say something
22 again?

1 DR. CASALINO: Yeah. Two quick points and then a
2 specific recommendation.
3 The first point is I think we're not here to
4 prejudge, any of us, the impact of private equity. I don't
5 think any of us know on the provider side in health care.
6 So, hopefully, in the next six months or whatever time
7 there is, the staff can come up with a bit more information
8 through case studies and review of the grant. I think
9 there will be more peer-reviewed literature by then as
10 well. Then we may have more informed conclusions, although
11 I don't think we'll have definitive conclusions.
12 The second point is I think we should be clear,
13 at least on the physician practice side -- and I think this
14 is true with nursing homes and hospitals as well. There
15 isn't a lot of private equity money that's interested in
16 value-based purchasing. The incentives aren't strong
17 enough, and the returns are not only meager but uncertain.
18 So most of the private equity money that I'm aware of in
19 the physician practice world is going to the kind of
20 practices that you can make as much money as possible from
21 straight fee-for-service, orthopedics, dermatology,
22 gastroenterology, not to value-based models or primary

1 care.

2 Now, there are exceptions. There are private

3 equity investments in primary care groups that want to take

4 the sickest patients they can get and get Medicare

5 Advantage contracts to do well with those patients and take

6 a lot of risk, and that is probably a very positive thing.

7 But that's not where most of the private equity

8 money is doing into practice purchase right now because

9 that's not really where the incentives are, the way the

10 system is set up as a way to make money. So those are the

11 first two points.

12 Then in terms of the recommendation, someone

13 asked a very good question. If we're going to make a

14 recommendation about knowing who owns what, we need to have

15 reasons. Well, why do we want to know that? I think

16 that's a good question.

17 I think there's a couple of things, reasons why

18 we want to know who owns what or who owns practices or who

19 owns nursing homes. One is if we don't know who owns what,

20 we really don't know what the effects of private equity

21 ownership are beyond anecdotes or case studies. We just

22 don't.

1 We also don't know what the effects of hospital
2 ownership of practices are and so on. In fact, through
3 very labor-intensive work, some research teams have got
4 some data on effects of hospital ownership of practices,
5 and it's pretty bad, right? Generally cost, prices go up,
6 quality doesn't change. That would be a summary of the
7 literature, I think.
8 The ACO world, at least the shared savings world,
9 hospital-based ACOs do quite a bit worse than physician-led
10 ACOs.
11 So this goes beyond private equity, I think.
12 We're seeing massive and very rapid and probably
13 irrevocable changes in the structure of the delivery system
14 by consolidation of hospitals, consolidation of physicians,
15 and a vertical integration between hospitals and
16 physicians, and then that private equity ownership effect,
17 nursing homes and hospitals as well.
18 Massive change is happening very fast with very
19 little evidence on the effects. So we're never going to
20 have evidence on the effects if we don't know who owns
21 what.
22 I agree that it could be very, very difficult for

1 Medicare to set up a process that's helpful with that, but
2 I think it could be a lot better than it is. It's kind of
3 utopian. This is something that I've been advocating for
4 years, and it seemed extremely utopian. This is a
5 potential opportunity. Ways and Means has asked MedPAC to
6 comment on how PECOS might be used to identify ownership
7 better, and in this case, talk about PE, but I would just
8 expand it to say we want to know about who owns practices,
9 period, not just PE, but hospitals and so on, their own
10 physicians and so on, and here's some ways we could do it.
11 So I would recommend talking to as many experts in that, in
12 how ownership could potentially be identified in PECOS data
13 if we could have it just the way we want it and try to use
14 this opportunity to do something about that.
15 Otherwise, we're still going to have research
16 teams spend enormous amounts of money to make incomplete
17 databases, and it's a slow painstaking process. We should
18 be able to do better than that as a country.
19 MS. KELLEY: Mike, did you want to --
20 DR. CHERNEW: Yeah, yeah. I just wanted to react
21 to two things. The first one is I don't know enough to
22 know where private equity is focused, but I do know of some

1 big examples of private equity or at least for-profit
2 companies in the value-based purchasing space, Halliday,
3 Caravan, Signify, and Remedy, so -- Archway. There's a
4 number of private equity firms that have been moving into
5 the space to support organizations trying to do delivery
6 system transformation.
7 And I would add, although not by private equity,
8 there's a ton of other consulting firms that are quite for-
9 profit oriented to try to support that system
10 transformation.
11 I'm not arguing one way or the other about where
12 focus is. I'm just trying to point to it.
13 To the extent that there are models that people
14 can make money off of it, it is not the case that private
15 equity is sort of ignoring that.
16 The other thing, I actually think it's easy to
17 make the case about why we would want to know about
18 ownership and private equity. I don't find that a hard
19 case to make. Certainly, we were asked this because people
20 felt it was important.
21 What I think we will have to explore -- and I'll
22 have to talk to Jim and his staff about how we can do this

1 -- is is that actually a doable thing.
2 One of the things as we've -- you should know,
3 actually, we have a grant to look at private equity and try
4 to understand what's going on, and one of the big
5 challenges -- and so it would be great for me to do that.
6 One of the big challenges that we've faced is the
7 word "ownership" is quite complicated. I used to think
8 you'd kind of own something or you don't. It turns out
9 there's a lot of contractual forms in which you're kind of
10 like an owner, but you're not really an owner until someone
11 else is the owner but you own, somebody's private equity
12 deals, they own the real estate but not the company. They
13 own the company but not the real estate. They own the
14 profits but not the actual company. So the ability of
15 lawyers and others to get around with simple words like
16 "ownership" means is quite complicated in my mind.
17 What I'm really trying to do actually, Larry, is
18 support what you said, but it might not sound that by my
19 town. But I am actually trying to be supportive.
20 I do think it is worth exploring how we can make
21 things like PECOS better, and it's always good to have
22 utopians on the Commission. I think that is a really

1 valuable thing to do, but I don't think we should be under
2 any illusions that it will be an easy thing to do,
3 particularly as Brian said earlier, when people don't want
4 to know that, they may have to figure out how they can
5 structure their contracts to not be owners when in fact
6 they're the ones that keep the profits if in fact you do
7 bad behavior type of things.
8 The same was true for a whole bunch of other
9 referral pattern issues. You can't refer something you
10 own, but what does "own" mean? That came up with sort of a
11 pay-to-click kind of -- you know, there's so many ways
12 around these things. We have to be really careful about
13 what path we're going down.
14 But that being said, I share your aspirations,
15 and I absolutely agree that if it is doable, the world will
16 be a better place if it were done.
17 So, again, I didn't mean to editorialize. I
18 think Jon Perlin is next in the queue, if I understand
19 where we are.
20 MS. KELLEY: Mike, I think Larry and Brian both
21 wanted to get in on this particular point.
22 DR. CHERNEW: Okay. Jon, we'll let Larry and

1 Brian in on this particular point.
2 DR. CASALINO: Brian, why don't you go ahead.
3 DR. DeBUSK: Okay. Thank you, Larry.
4 First of all, I wanted to completely agree with
5 your previous comment. I don't think a lot of private
6 equity right now that's focused at group practices is
7 focused on value-based payments. I think they're focused
8 on optimizing revenue, all the things we've already
9 discussed.
10 But I did want to throw this out. I mean, this
11 is a somewhat awkward and sensitive question.
12 When you look at our opportunities for arbitrage
13 -- and these people are experts are arbitrage -- what keeps
14 a private equity firm from building a template where they
15 move into a market, buy up a few key practices, including a
16 primary care practice and orthopedics practices, form a
17 multigroup specialty practice, contract with MA, form their
18 own next-gen ACO, and do all the standard things? I mean,
19 you'll rationalize PAC. You'll do sort of the December
20 wellness visits, all that.
21 But what if on top of that, they move all the
22 outpatient procedures that they can to their own ACSs, they

1 move all the ED visits to their own urgent care? You talk
2 about an opportunity for arbitrage. It's almost a can't-
3 fail model, where private equity and convenors or
4 consulting groups could move into a geography and take
5 advantage of the arbitrage and capitated payments and in
6 APMs. You know, how would we feel about something like
7 that? It's guaranteed savings. It's accelerating the
8 adoption of value-based payments, albeit at the expense of
9 hospitals.
10 DR. CASALINO: Well, I agree that if private
11 equity money going into value-based purchasing, that's a
12 good example, you gave, and some others. I think one goal
13 for the next six months actually could be on the physician
14 practice side to get a sense of how much private equity
15 money is going into VBP deals and trying to get Medicare
16 Advantage contracts and do good things with them as opposed
17 to just scooping up fee-for-service specialties and making
18 as much revenue as you can. They get relative amounts of
19 that.
20 I also agree with you, Michael, identifying
21 ownership is likely to be hell in part because corporate
22 practice and medicine laws, right? I mean, there's a lot

1 of states in which a hospital can't really employ
2 physicians in a practice or owner practice, same with
3 private equity and so on. So there are all kinds of ways
4 to get around this, and I agree that I don't know enough to
5 know if people that really understand these things could
6 come up with some kind of scheme that would be at least
7 much better than what PECOS has now in giving you a shot at
8 identifying ownership.
9 So that could be something also that one could
10 try to find out, I think, over the next 6 months.
11 DR. CHERNEW: Great.
12 Now I think we're to Jon.
13 MS. KELLEY: I think that's right.
14 DR. CASALINO: Michael, I'm sorry. There's one
15 other recommendation from the report and what you said made
16 me think of this. The differentiation between growth
17 capital and buyout capital, in fact, I think there is a
18 fair amount of growth capital on the physician practice
19 side.
20 So if I'm not mistaken, Healthcare Partners was
21 able to expand much more rapidly than it could have done
22 otherwise and then sell itself for $4.4 billion to a

1 dialysis company. It was using private equity money. That
2 was growth capital, not buyout capital. I think quite a
3 few other places have done that as well. I think Austin
4 Regional Clinic has received private equity money to grow
5 and do some good things and try to do some value-based
6 purchasing. I think they think that's very valuable, and I
7 think there's probably a fair amount of that going on,
8 growth capital private equity investing in pretty large
9 physician groups so they can grow faster, possibly hospital
10 chains, nursing home chains as well.
11 That's something that I wouldn't just forget
12 about the growth capital side of things.
13 DR. CHERNEW: And now?
14 DR. PERLIN: All right. Well, I'm going to make
15 what's going to seem like an extraordinary link between our
16 earlier conversation about the clinical lab fee schedule
17 and private equity.
18 Really behind our discussion is how certain
19 mechanisms of capital affect incentives, and so the focus
20 of our discussion has really been on the incentives of the
21 investor or acquirer, to your point, Michael, or whatever
22 acquisition means.

1 Let's flip that around and look at the incentives
2 of the individual or the entity that's being acquired.
3 Back to clinical laboratory fee schedule, think about the
4 complexity that was inherent in our discussion. Think
5 about what we're asking hospitals, but perhaps even more
6 so, physician practices who might happen to have a lab to
7 do.
8 When you think about that, I think you have to
9 think about how that's driving a push toward
10 industrialization to solve these sort of existential
11 problems of life and this very complex world.
12 The point is that really some of our contemporary
13 complexity means that we are, I think, driving the push
14 toward consolidation, and that consolidation is really
15 associated with seeking new mechanisms to solve operational
16 challenges through data, through technology, through
17 different management structures, and ultimately through the
18 promise of investment.
19 So I just wanted to not let that go unsaid
20 because I know over the past few years, we've had
21 conversations about whether or not our policy drives a
22 certain degree of consolidation, but I actually draw this

1 linkage to the management structures, the investment, et
2 cetera.
3 Thanks.
4 MS. KELLEY: Mike, I think that's it.
5 DR. CHERNEW: Okay. So everybody take a deep
6 breath. I don't have a ton of wrap-up. I will give a very
7 brief wrap-up of where I think we were.
8 First, let me thank you all for the comments that
9 you said, and let me thank you all for the comments that
10 you didn't say. I think the right mix of what you say and
11 what you don't is what makes the meeting good. So we are
12 going to come in with what I at least believe was a
13 remarkably good substantive discussion and under time.
14 If you feel like you didn't get a chance to say
15 your piece, I am really sorry. Let me know, but I think
16 we've done pretty well in that regard.
17 I just want to make one sentence about where I
18 think we are for each of the afternoon sessions so you can
19 ruminate on them, and we'll go from there.
20 With regards to the SNF session, my takeaway is
21 that the current SNF value-based purchasing process is
22 worse than none, and it should be paused. And we should

1 work aggressively and expeditiously to improve the program,
2 and hopefully, MedPAC will have some example of what that
3 might look like in sessions soon to be presented.
4 With regards to the lab session, I think the key
5 question is, Is there any information of value and private
6 prices? If so, how do we officially get at it and use it,
7 and if not, how can we set payment models to capture
8 growing efficiencies in the production of lab services? I
9 think I will take this back to Jim and the staff and ponder
10 those questions.
11 With regards to private equity, my general sense
12 is that "private equity" is too broad of a term. It can be
13 both good and bad, and something that Paul said resonates
14 with me. We have to really emphasize to CMS that they need
15 to get as much a handle on their loopholes as possible
16 because, per Brian, they will arbitrage that.
17 But there are also examples where they might do
18 quite good things, and so we are going to have to make the
19 chapter both recognize that heterogeneity, and then
20 somewhere in there will be a call for more and better
21 information about ownership and behavior per what Larry was
22 saying. And when we figure out more about what that

1 entails, we'll be able to figure out how to craft that
2 portion of the chapter.
3 So the to-do is emphasize heterogeneity, call for
4 more information, and emphasize focusing policy on bad
5 behavior as much as capital structure.
6 So that's my summary of where we were. I say
7 that to give folks a chance to react and send messages if I
8 got anything wrong. Other than that, I'm going to pause
9 for a second.
10 Again, thank the staff for amazing work. As
11 always, you did a terrific job. I know it's been hard for
12 everybody. I think technology worked better than I feared.
13 So anyone want the last word? I'm pausing for a
14 second.
15 [No response.]
16 DR. CHERNEW: Okay. We --
17 DR. PERLIN: Hey, Mike?
18 DR. CHERNEW: Jon?
19 DR. PERLIN: On behalf of fellow Commissioners,
20 we just shouldn't let the moment pass without saying what a
21 spectacular job you did. So thank you.
22 DR. CHERNEW: Thank you.

1 So now we are about to have for the Commissioners
2 and the staff -- we're going to have a virtually, socially
3 distanced happy hour. For the public, thank you for your
4 patience and listening. I wish I could see you all, not
5 really all of you -- that's too many for me to process, but
6 in any case, I am glad that we were able to read all who we
7 did, and we will be starting again on a really important
8 topic at 9:30 tomorrow morning, telemedicine. Don't miss
9 it. It's the hot ticket in town.
10 So thanks all, and we'll reconvene in a bit and
11 then tomorrow morning.
12 Jim, Dana, anything else you want to add?
13 MS. KELLEY: Nothing from me. Jim?
14 DR. MATHEWS: Nope. All good here.
15 MS. KELLEY: All right.
16 DR. MATHEWS: Thank you, everyone.
17 MS. KELLEY: Thanks, everyone.
18 DR. CHERNEW: Thanks, everybody.
19 [Whereupon, at 5:11 p.m., the meeting was
20 recessed, to reconvene at 9:30 a.m., Friday, September 4,
21 2020.]
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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
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
SUSAN THOMPSON, MS, BSN
PAT WANG, JD

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29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

AGENDA PAGE

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Medicare coverage for vaccines
- Rachel Schmidt, Shinobu Suzuki, Kim Neuman..........80

1 P R O C E E D I N G S

2 [9:30 a.m.]

3 DR. CHERNEW: Hello, everybody, and welcome to
4 day two of the September MedPAC meeting. It's probably
5 fitting that our first topic is telehealth, which we will
6 discuss remotely. I won't say much more except this is
7 probably in the top two topics that people on the Hill and
8 others have reached out to us to discuss, and I think we
9 have some interesting material to present, and I'm really
10 looking forward to all of your feedback. So, again, thank
11 you to the public for joining and the Commissioners for
12 attending and the staff for doing all of the work.

13 With that, I'm going to turn it over to Ariel and
14 Ledia.

15 MS. TABOR: Good morning. The audience can
16 download a PDF version of these slides in the handout
17 section of the control panel on the right hand of the
18 screen.

19 We would like to thank Bhavya Sukhavasi and
20 Rachel Burton for their input into this work.

21 Since the COVID-19 pandemic started, telehealth
22 has received a lot of attention. Telehealth has played a

1 key role in delivering health care to patients during the
2 pandemic, which has raised many questions about its future
3 role in the health care system after the pandemic. This is
4 an opportune time for the Commission to shape the policy
5 discussion around potential expansion of telehealth in
6 Medicare. Therefore, we expect to devote a significant
7 amount of time to this issue during the coming cycle.
8 The Commission previously examined telehealth in
9 the June 2016 and March 2018 reports to the Congress.
10 Today we'll broadly review the physician fee
11 schedule telehealth policies prior to the public health
12 emergency. We are focusing the discussion on the physician
13 fee schedule because it accounts for the majority of the
14 telehealth expansions that directly impact a payment
15 system.
16 We'll also discuss corresponding expansions of
17 telehealth under the public health emergency.
18 Then we'll explore some potential options for
19 making telehealth expansions permanent. Building off the
20 Commission's prior work from the 2018 report to the
21 Congress, Medicare could allow most telehealth expansions
22 to continue for clinicians participating in advanced

1 alternative payment models. For other clinicians in fee-
2 for-service Medicare, Medicare could revert back to the
3 pre-PHE health rules or allow some expansions with
4 additional safeguards.
5 Throughout the discussion we assume that Medicare
6 would continue the current telehealth expansions for the
7 remainder of the public health emergency.
8 Prior to the public health emergency, the
9 physician fee schedule covered a limited number of
10 telehealth services. Direct-to-consumer telehealth
11 services could only be provided to beneficiaries at an
12 originating site in a rural area. There were some
13 exceptions to the rural requirement for other telehealth
14 services like remote physiological monitoring.
15 Medicare utilization of telehealth services had
16 been increasing, but remained very low with only 0.3
17 percent of Part B beneficiaries receiving telehealth
18 services in 2016. As presented in our March 2018 report to
19 the Congress, commercial insurers also reported low
20 utilization of telehealth services.
21 Due to the public health emergency, Congress gave
22 CMS the authority to temporarily put in place flexibilities

1 to allow providers to furnish telehealth services to ensure
2 that beneficiaries continue to have access to care and to
3 avoid exposure risks to the community.
4 First, which patients? Under the PHE, clinicians
5 may provide direct-to-consumer telehealth services to
6 beneficiaries located outside of rural areas and with
7 patients in their homes.
8 Second, which services? CMS has added over 80
9 services that can be delivered via telehealth like
10 emergency department visits. Also, Medicare previously did
11 not cover audio-only telephone evaluation and management
12 visits, but under the public health emergency, clinicians
13 can now bill for them.
14 Third, which clinicians can provide them? Prior
15 to the PHE, physicians and other clinicians could provide
16 telehealth services. During the PHE, physical/occupational
17 therapists and speech language pathologists are now also
18 eligible. All clinicians are allowed to furnish telehealth
19 services to beneficiaries located in other states, but
20 state licensing laws apply.
21 Fourth, how much are services paid? Prior to the
22 PHE, Medicare paid the physician fee schedule facility-

1 based payment rate which is less than the nonfacilty rate
2 for telehealth services. During the PHE, Medicare pays
3 clinicians the rate for telehealth services as if the
4 service were furnished in person so the facility or
5 nonfacility rate. Medicare also pays the rate for audio-
6 only visits as if the services were provided in person.
7 CMS made decisions on how to pay for telehealth services to
8 eliminate potential financial deterrents to the use of
9 telehealth.
10 Fifth, which technology can be used? HHS
11 announced that it will not impose penalties against covered
12 health care providers for noncompliance with HIPAA
13 regulatory requirements in connection with the good-faith
14 provision of telehealth during the PHE. Therefore, a
15 provider can use any non public-facing remote communication
16 product, such as FaceTime or Zoom, to provide telehealth
17 during the PHE.
18 Finally, what are the costs to beneficiaries?
19 During the PHE, clinicians are permitted to reduce or waive
20 any cost-sharing obligations for telehealth services.
21 The Congress and CMS are under pressure to make
22 the telehealth expansions permanent after the PHE, and both

1 are considering making some of those changes permanent.
2 We know from several sources that physicians and
3 other providers have responded to the PHE and the
4 telehealth expansions by rapidly adopting telehealth to
5 provide continued access to medical care for their
6 patients.
7 Even before the COVID-19 pandemic, there was
8 growing interest in expanding Medicare telehealth coverage.
9 Advocates assert that telehealth can expand access to care
10 and reduce costs relative to in-person care.
11 However, others contend that telehealth services
12 may have the potential to increase use and spending under a
13 fee-for-service payment system. Telehealth companies were
14 recently involved in several large fraud cases related to
15 the ordering of durable medical equipment and cancer
16 genetic tests, resulting in a total of $3.3 billion of
17 losses for Medicare.
18 Current evidence on how telehealth services
19 impact quality of care is limited and mixed. A key issue
20 is how to achieve the benefits of telehealth while limiting
21 the risks.
22 Under the Quality Payment Program, CMS designates

1 A-APM models which include ACOs, episode-based payment
2 models, and primary care-focused models.
3 Most A-APMs assume financial risk for total
4 Medicare spending and are held accountable for the quality
5 of care for their assigned patients. This creates
6 incentives for those providers in A-APMs to improve quality
7 while controlling cost growth. Therefore, the concern that
8 an expansion of telehealth could lead to additional
9 Medicare spending is countered by the incentive for A-APMs
10 to constrain spending. In our 2018 report to the Congress,
11 the Commission also said that MA plans and risk-bearing
12 ACOs could be granted greater flexibility to use of
13 telehealth services.
14 Also, the Commission has long supported the
15 movement of Medicare payment policy from fee-for-service to
16 value-based payment such as A-APMs. Allowing clinicians
17 who participate in A-APMs more flexibility to provide
18 telehealth services could be another incentive for more
19 clinicians to move into these models.
20 With regards to other clinicians in fee-for-
21 service Medicare, we'll focus on what expansions Medicare
22 may want to keep for clinicians not in A-APMs, as well as

1 additional safeguards to prevent misuse.
2 I'll now turn it over to Ariel to discuss the
3 policy issues that would need to be addressed for each of
4 the options.
5 MR. WINTER: In the following slides, we
6 illustrate different choices you could make for clinicians
7 in A-APMs and for other clinicians. These choices are
8 meant to be illustrative and are open for discussion.
9 The first question is: Which beneficiaries
10 should be able to receive telehealth services after the
11 PHE?
12 Medicare could allow clinicians participating in
13 A-APMs to continue providing telehealth services to
14 patients outside of rural areas and to patients in their
15 homes. But giving the same flexibility to clinicians who
16 do not participate in an A-APM poses a risk of overuse.
17 However, we are going to discuss some guardrails that could
18 reduce this risk in a few minutes.
19 Next, which types of telehealth services should
20 Medicare pay for after the PHE?
21 For clinicians in A-APMs, Medicare could continue
22 covering most of the telehealth services that were covered

1 during the PHE.

2 For clinicians who are not in A-APMs, however,
3 Medicare could cover a more limited set of telehealth
4 services.

5 In our March 2018 report, we said that CMS should
6 pay for telehealth services that balance the principles of
7 access, cost, and quality.

8 CMS could use these principles to decide which
9 telehealth services provided by non A-APM clinicians should
10 be covered after the PHE.

11 For example, Medicare could cover telehealth for
12 mental health services because some beneficiaries have
13 problems accessing mental health providers.

14 A related question is whether Medicare should
15 continue to cover audio-only services after the PHE.
16 Because clinicians are unable to visually examine patients
17 during audio-only visits, it is possible that they will
18 lead to new services instead of substituting for existing
19 ones and, therefore, could increase program spending.

20 Therefore, policymakers might want to consider
21 not covering audio-only services after the PHE, even when
22 provided by clinicians who are in A-APMs.

1 The third question is: Should Medicare continue
2 to pay the higher nonfacility rates for telehealth services
3 provided by office-based providers after the PHE?
4 Prior to the PHE, CMS paid for telehealth
5 services at the lower, facility-based payment rate in all
6 cases. But during the PHE, CMS pays the higher,
7 nonfacility rate to clinicians who typically practice in
8 offices.
9 The issue is that services delivered via
10 telehealth probably do not have the same practice costs as
11 services provided in a physical office.
12 Therefore, continuing to set rates for telehealth
13 services that are the same as rates for in-office services
14 could distort prices and could lead clinicians to favor
15 telehealth over comparable in-person services.
16 In this illustration, Medicare would no longer
17 pay the nonfacility rate for telehealth.
18 Next, should telehealth technology and services
19 be required to comply with HIPAA after the PHE?
20 We are proposing that the answer would be yes for
21 both type of clinicians because enforcing HIPAA would help
22 protect patient privacy and reduce the risk of identity

1 theft.

2 Next, what would be the costs for beneficiaries?

3 Should clinicians continue to be allowed to waive cost

4 sharing for telehealth services after the PHE?

5 Because A-APMs have a financial incentive to

6 control spending, allowing them to waive cost sharing may

7 not lead to higher use. But clinicians who are not in an

8 A-APM don't have this incentive, so reinstating cost

9 sharing for services provided by these clinicians could

10 reduce the risk of overuse.

11 A related issue is that most fee-for-service

12 beneficiaries have supplemental coverage, which means that

13 they are shielded from most cost sharing.

14 Therefore, we looked into whether the Congress or

15 CMS could prohibit employer-sponsored supplemental coverage

16 and Medigap plans from covering cost sharing for telehealth

17 services.

18 We found that it would be difficult to do this,

19 as we describe in detail in your paper.

20 There are other safeguards you might want to

21 consider. Here we focus on safeguards to protect against

22 unnecessary spending for telehealth services provided by

1 clinicians who are not in an A-APM, and we describe two
2 options:
3 The first is to impose a limit on how frequently
4 specific types of telehealth services could be billed by a
5 clinician for a given beneficiary; for example, a limit on
6 the number of virtual check-ins that could be billed per
7 beneficiary per month. To implement this policy, CMS would
8 likely need to analyze claims data for telehealth services
9 provided after the PHE to identify services that are
10 growing rapidly or that are frequently provided to a single
11 beneficiary.
12 The second option is to require clinicians to
13 provide a face-to-face visit with a beneficiary to order
14 DME or lab tests above a certain dollar amount. As Ledia
15 mentioned earlier, telehealth companies have recently been
16 implicated in very large fraud cases involving DME and lab
17 tests. And there is a risk that such schemes could become
18 more common if Medicare expands telehealth coverage.
19 This option would essentially prohibit clinicians
20 from using telehealth visits to order expensive DME or lab
21 tests for beneficiaries.
22 So for your discussion, we'd like to get your

1 feedback on the options we discussed as well as any
2 additional information you'd like us to provide.
3 This concludes our presentation, and we'd be
4 happy to take any questions.
5 DR. CHERNEW: Thank you. That was terrific.
6 I'm watching to see if there are any Round 1
7 questions, but while I wait, I'm going to kick off with a
8 Round 1 question. It really had to do with Slide 7. I
9 think it's Slide 7. The question -- maybe I have my slide
10 wrong -- is: There's this issue about which providers
11 could provide telehealth services. My understanding is
12 everybody can provide telehealth services. This is really
13 about what gets paid for. So could you talk a little bit
14 about the distinction between what is payable and what is
15 providable? Or is it all really just about how folks get
16 paid?
17 MS. TABOR: I would say that it's more about how
18 folks get paid. That's the biggest change under the public
19 health emergency, that now physical therapists and
20 occupational therapists could now bill for services that
21 they're providing.
22 DR. CHERNEW: So as --

1 MS. TABOR: Go ahead.
2 DR. CHERNEW: No. You go. Keep going, Ledia.
3 MS. TABOR: So physicians and other clinicians
4 could bill for all services that were covered under the
5 list of available telehealth services, and now physical
6 therapists and other types of therapists have been added to
7 that list.
8 DR. CHERNEW: Yeah, so just to be clear I
9 understand, it was really Slide 8. It says, "Which
10 Medicare beneficiaries could receive telehealth services?"
11 You really mean which providers get paid when they give
12 certain Medicare benefits. Because anyone can receive
13 Medicare benefits no matter what we say -- could receive
14 tele-services; it's just that providers wouldn't be paid.
15 MR. WINTER: What we're talking about here on
16 this slide is the geographic restrictions that applied
17 before the PHE, which limited telehealth services to
18 beneficiaries who were in rural areas and who receive them
19 in certain originating sites, like hospitals and
20 clinicians' offices.
21 DR. CHERNEW: What I'm trying to figure out is if
22 it was limited to telehealth service provision or limited

1 it to telehealth service payment. So an urban patient
2 could get a telehealth service before the PHE. They just
3 couldn't get paid for it.
4 MR. WINTER: That's correct. So the clinician
5 could not get paid for it. That's true.
6 DR. CHERNEW: Okay. I understand.
7 MR. WINTER: So a hospital, if a patient was in a
8 hospital for an inpatient admission, the hospital could
9 provide a telehealth service, including -- but the
10 clinician could not bill for that service. The hospital
11 would get paid for it as part of their IPPS payment, but
12 the clinician could not bill for it unless it met these
13 geographic requirements.
14 DR. CHERNEW: Okay. Thank you. There's a few
15 other Round 1 questions, but Betty wants to say something
16 and set me straight on this point, so, Betty?
17 DR. RAMBUR: No, I -- your point is exactly
18 right. I just wanted to give another illustration.
19 Registered nurses provide telehealth services, care
20 coordination, et cetera, but even under the public health
21 emergency they are not allowed to charge for that or be
22 reimbursed for it. So I think that's the point you were

1 trying to make, correct, Michael? Service delivery versus
2 who is billing.
3 DR. CHERNEW: I just wanted to make sure that
4 there weren't licensing or other restrictions about who
5 could receive it versus just how the payment works. And I
6 think I understand now, so thank you, Ledia, and thank you,
7 Ariel. Betty, I'm sure you have a lot of firsthand
8 knowledge with these things. But I think now, Dana, we
9 should just go through the queue, which is I spoke long
10 enough to allow the queue to form, which is good. Sue was
11 jumping in during the presentation, and then we'll know,
12 but for now, Dana, work through the queue.
13 MS. KELLEY: Okay. Larry, I think you're first
14 with Round 1.
15 DR. CASALINO: Very nice job, Ariel, Ledia.
16 There's so many specific issues which you've listed very
17 well. It will be very interesting to see how
18 Commissioners' opinions on these evolve over the next few
19 meetings.
20 I have a specific question about the -- it's on
21 page 8 of the mailing materials, and this is in
22 relationship to the so-called communication technology-

1 based services, which you say that prior to the public
2 health emergency, CMS was paying for although didn't
3 consider them to meet the statutory definition of
4 telehealth.
5 So one, for example, is so-called virtual check-
6 ins, and I'm just quoting the paper, in which a patient
7 checks in briefly with the clinician via phone or other
8 telecommunications device to decide whether an office visit
9 is needed. And then a related one is remote monitoring and
10 interpretation of physiological data, like blood pressure
11 digitally stored and transmitted.
12 So my question is: One potentially very common
13 use of telehealth which could be done by video, could be
14 done by phone, and for that matter it actually can be done
15 through portals or emails, is dealing with chronic
16 diseases. So if you have a patient who you know can
17 accurately check their blood pressure, you've had them
18 bring their device into the office and check it, or they
19 can accurately check their blood sugars and record that,
20 those kind of things, traditionally physicians have had
21 patients come back into the office, most physicians, to
22 discuss their pressure or their diabetes results and maybe

1 make changes in their regimen. And with patients you know,
2 that is probably a waste of a lot of patients' time, half a
3 day of their time, and also -- well, let's just leave it at
4 that. So patients love to do that kind of thing over the
5 phone in many cases.
6 My question is: For virtual check-ins, it's the
7 phrase "to decide whether an office visit is needed,"
8 that's tripping me up. If you wanted to check a patient's
9 blood -- talk about a patient's blood pressure over the
10 phone that isn't transmitted to you digitally, they're just
11 saying, "Yeah, Doc, my pressure's a little high, it's about
12 150/95," is that considered one of these communication
13 technology-based services or would that fall under
14 telehealth and, therefore, under the issues that you're
15 raising?
16 MR. WINTER: That's a good question.
17 The way CMS defines the virtual check-in codes,
18 which they created, began paying for in 2019, the purpose
19 is to decide whether office visit -- whether the patient
20 needs to come in and see the clinician in person.
21 They don't talk about the scenario you describe
22 where they just want to get a check on some feedback on

1 whether their blood pressure is too high and what they
2 should do to adjust it. That's really a question -- I'll
3 look into that some more. Maybe they have some FAQs that
4 address that specifically.
5 But it does not seem to meet their definition of
6 this type of service.
7 DR. CASALINO: That's interesting because this is
8 potentially usual in visits and also an area in which
9 there's a lot of variation. Some physicians will say,
10 "Come back in six months, and we'll check your pressure
11 again." Others will say, "Come back in two weeks and we'll
12 check your pressure again," with the identical patient.
13 Then my other question about these communication
14 technology-based services, prior to the PHE, what was CMS
15 paying for?
16 MR. WINTER: In terms of these communication
17 technology-based services?
18 DR. CASALINO: Yeah, the ones that weren't
19 defined to -- CMS was paying --
20 MR. WINTER: Right.
21 DR. CASALINO: -- but were paying the same as
22 for telehealth or less or --

1 MR. WINTER: These were specific codes with
2 specific rates that were set by CMS, and so because they
3 were only provided -- these are only virtual services.
4 They are never done in person. There's only one rate for
5 these codes that applies to when it's done virtually, and
6 the difference between pre-PHE and where we are now is that
7 before the PHE, CMS would only pay for these codes, for
8 most of them anyway, for established patients. So the
9 clinician had to have already established -- have an
10 established relationship with a patient as demonstrated by
11 providing a prior in-person service event.
12 But during the PHE, CMS has loosened those rules
13 and allowed clinicians to provide these types of services
14 to even new patients, ones they've never seen before.
15 DR. CASALINO: So for these virtual check-ins,
16 for example, has CMS been paying a rate comparable to what
17 they pay for a telehealth visit, or it's less? And if so,
18 can you give a sense of how much less?
19 MR. WINTER: It is. It's much less, I believe
20 it's about between $10 and $15. I'll look up the exact
21 amount. Whereas, an E&M is in the range -- when it's done
22 in an office is in the range of $70, maybe $75. We'll get

1 you exact numbers.

2 DR. CASALINO: That's very helpful. Thank you.

3 MS. KELLEY: Pat?

4 MS. WANG: Hi, Ariel. Just to continue what you

5 were just talking about; can you say if the regular

6 physician fee schedule rate for an E&M visit in person is

7 around $75? Prior to the public health emergency, what was

8 the facility-only rate? As a percentage of that overall?

9 I don't have a sense of proportion, but before what CMS

10 allowed and during the public health emergency.

11 MR. WINTER: So the facility rate, which would be

12 paid when the E&M visit is done in a hospital setting, for

13 example, it's about $50, but I'll have to look up the exact

14 number and get back to you on that.

15 MS. WANG: Okay, okay. But in that specific

16 example, since about two-thirds of the rate that was

17 allowed during the public health emergency. Okay. That's

18 really helpful.

19 The other question I had was can you talk a

20 little more -- this idea of liberalizing what A-APMs can do

21 in telehealth, can you talk a little bit more about the

22 tools that an A-APM would have to control payment for

1 telehealth services? Because that's the implication, and I
2 just am not familiar. Like with an ACO, what kind of
3 control would they exercise to make sure that telehealth
4 services were being appropriately used or what have you?
5 MR. WINTER: So I think that they could rely on -
6 - it would be the same techniques and tools they would use
7 to control utilization generally, and if they're trying to
8 reduce hospital admissions, for example, or readmissions,
9 they might encourage their clinicians to use telehealth to
10 keep checking on patients, to get them out of the hospital.
11 And if they find that their clinicians are using telehealth
12 inappropriately or there's not much clinical benefit, then
13 because they're part of the same organization, they could
14 presumably -- they have, you know -- if they employ them,
15 they can tell them to stop doing that, or if they're just
16 affiliated with the ACO, they could say, "Look, if you
17 don't shape up, we're going to kick you out of our ACO next
18 year." So it's kind of the same incentives and tools they
19 have to monitor -- to manage utilization generally.
20 DR. CHERNEW: I want to jump in quickly on this
21 point. This is actually a very complicated topic. I'd
22 like to push it around too so we can get through quickly

1 Round 1 with just clarifying questions.
2 But the reason I say that is there's an issue
3 about what we mean by -- is it A-APM providers? A-APM
4 providers providing care to A-APM patients or A-APM
5 patients that could actually get care outside of the A-APM?
6 The A-APM doesn't have the same tools that, say, a Medicare
7 Advantage plan would have. So there's a lot of nuances.
8 In fact, if the attribution is retrospective, you
9 might not even know who the A-APM patient is at the time
10 the service is being received. So there's a lot of
11 complexities that I think fit under the A-APM bucket that
12 are probably more like Round 2 than Round 1 discussion
13 topics. So we should go on to the next Round 1 --
14 MS. WANG: That's fine. I'm finished with my
15 question. Thank you.
16 DR. CHERNEW: Thank you, Pat, and that's useful.
17 And this is a really challenging and very unclear topic to
18 me.
19 Dana?
20 MS. KELLEY: Jaewon, did you want to jump in on
21 this?
22 DR. RYU: Yeah. My question -- and it is a

1 clarifying question, but we could defer it to Round 2. But
2 it's really around this notion of if you're an A-APM
3 clinician who participates but not all of your patients are
4 in the A-APM model, my question was just, is it possible
5 for them to know which of their patients are in, which of
6 their patients are out? I don't know if we've looked at
7 that, and I think it gets to the attribution rules and
8 complexities around that. But that was my question.
9 DR. CHERNEW: Yeah. So that's the same point
10 that I was making. I think we should have that discussion
11 if we need to about how it would work in Round 2. I think
12 it's complicated, unless Ariel has a quick answer.
13 MR. WINTER: I think the quick answer is for this
14 iteration, just for illustrative purposes, we assume that
15 it would be the flexibilities would apply to the A-APM
16 clinician. So at the beginning of the year, the A-APM --
17 well, let's say it's an ACO -- would send a list of the
18 TINs for its participating clinicians, and if a telehealth
19 service were billed a clinician in one of those TINs, then
20 Medicare would apply the looser -- whatever the looser
21 rules are that we decide should apply.
22 So if an A-APM clinician saw -- whether they saw

1 an A-APM -- whether they saw a patient attributed to the A-
2 APM or not, they would be able to provide telehealth
3 services under these looser standards. That's what we
4 thought about just for -- you know, for the simplest -- we
5 thought it would be the easiest to implement policy, but
6 you could think about other ways of doing it. But it gets
7 more complicated if you start talking about retrospective
8 attribution, where you don't know at the time whether the
9 patient is going to be attributed to your ACO or not.
10 DR. CHERNEW: So let's save that when we discuss
11 these processes because it's challenging for a bunch of
12 ways. But that was a good clarification.
13 MS. KELLEY: Okay. Marge, I think you're next.
14 MS. MARJORIE GINSBURG: I'll pass because my
15 question and comment also was about A-APM. So I'll wait on
16 that.
17 DR. CHERNEW: Double thank you.
18 MS. KELLEY: Jaewon, I have you next. Did you
19 have a different question?
20 DR. RYU: No. That was my question.
21 MS. KELLEY: Okay. Then Dana.
22 DR. SAFRAN: Thank you.

1 What do we know about what it would cost for
2 providers to go from the current technology to virtual
3 technology that would be HIPAA compliant, assuming that
4 after the public health emergency, if it continues, if
5 telehealth is going to have to be under stricter HIPAA
6 compliance rules? What do we know about what that would
7 cost to amp up the technology in the practices and systems?
8 MS. TABOR: I don't have any exact numbers to
9 give, but I can give you some qualitative information that
10 we've gathered in our physician focus groups from this
11 summer as well as some conversations we've had with health
12 systems, and I think it would vary.
13 There are a number of HIPAA-compliant telehealth
14 services that are free, and we did hear from physicians
15 that they were using those. And there's others that are
16 very low cost, less than $100 per year kind of thing. But
17 we also did hear from health systems that they're taking a
18 broader approach to thinking about how to really up their
19 game, I guess, on telehealth and integrate it into the HR
20 as well as kind of operate in various different services.
21 So I would imagine that that would be a more costly
22 investment.

1 MR. PYENSON: Thank you. Great work.
2 My question is on the Medigap issue, and as you
3 point out, the Medigap policies are guaranteed renewable.
4 They are under the jurisdiction of state insurance
5 commissioners and may be influenced by the National
6 Association of Insurance Commissioners.
7 However, did you look at the contract between CMS
8 and the Medigap insurers? Because the vast majority of
9 claim processing is a direct link that's defined by a
10 potential, perhaps government-to-business contract, and if
11 the claims do not get -- if telehealth claims or other
12 claims don't flow through that process, that's a way to
13 perhaps avoid the automatic process of cost sharing
14 coverage.
15 So my question is I've read what you wrote, but
16 how far did you get into some of the weeds of that?
17 MR. WINTER: We did not look into the specific
18 contracts that CMS has with the Medigap plans to determine
19 how they cover cost sharing or how they deal with cost
20 sharing that's covered by the Medigap plans, but my
21 assumption would be that those contracts are subject to the
22 terms of the plan's coverage. So if the Medigap plan

1 covers, let's say, 100 percent of Part B coinsurance, then
2 that's what -- then the MAC would, I assume, build a
3 Medigap plan instead of the beneficiary.
4 So even if -- I don't see how you could change --
5 I don't see how you could change whether or not the
6 beneficiary would be liable for coinsurance for telehealth
7 services just based on changing that -- how the claims are
8 processed. My assumption would be you would need to change
9 the actual plan policy, but this is not an area where I
10 have a lot of expertise. So we can look into it more.
11 MR. PYENSON: Okay. Thank you.
12 MS. KELLEY: Betty, did you have a Round 1
13 question?
14 DR. RAMBUR: I do.
15 Briefly, I have a question about the two accesses
16 that were in the audio only, and my question relates to
17 issues related to the socioeconomic gap and technology
18 acquisition as well as the age-related gap and also the
19 rural areas, places that are not actually rural by
20 designation but still have poor broadband. So I was just a
21 little -- and very -- you know, I understand the concern
22 about additive services, but I was just a little curious

1 about those disadvantaged populations.
2 MS. TABOR: I think that is a concern that not
3 all Medicare beneficiaries have access to smartphones or
4 other technology in order to do telehealth visits. So one
5 concern with not covering audio-only visits would be that
6 some people would be at a disadvantage. So I guess we'd
7 encourage other kind of federal agencies to continue to
8 offer financial support to increase broadband connectivity
9 and also just general access to technology. But, yes, I
10 think we acknowledge that that is a concern.
11 DR. RAMBUR: Thank you.
12 MS. KELLEY: Paul, did you have a response?
13 DR. PAUL GINSBURG: It was on the Medigap
14 question. If I'm correct, legislation specifies a limited
15 number of benefit designs that Medigap plans can have. So
16 I would think that saying that they should not cover cost
17 sharing for telehealth would really require making a
18 legislative change rather than just dealing with it in a
19 claims processing way.
20 MR. WINTER: That's my understanding.
21 MS. KELLEY: Okay. I think that's all with the
22 Round 1 questions. I can move to Round 2.

1 Mike, did you want to start off, or shall I just
2 go to Karen?
3 DR. CHERNEW: I thought Jonathan and Brian might
4 have had Round 1 questions. Did I miss that, Jonathan and
5 Brian? Brian, no?
6 DR. JAFFERY: Mine is a Round 2.
7 DR. CHERNEW: Okay, good. Then we're moving to
8 Round 2, and we'll start off with the kickoff folks.
9 Karen, just so people can get a sense of the --
10 it was going to be Karen and then Wayne and then Sue, and
11 then I think we're loosely going to have a free-for-all, so
12 that's terrific. So, Karen?
13 DR. DeSALVO: Wow. I have about 20,000 pages of
14 things that I want to say, so I'm going to try to be a
15 little limited because we have some deep things to
16 consider.
17 As we've talked about, COVID has been an
18 accelerated use case for telehealth, and so I think if we
19 had any question about whether it could be done, we know
20 that it can. Now the question is, where will it settle out
21 in terms of use and desirability for the beneficiaries and
22 for the health systems, and what's the right way to have a

1 principled approach so that we're protecting the Medicare
2 program and protecting beneficiaries with an eye on equity
3 and access and making sure there's good outcomes?
4 Maybe we'll take a couple of broad comments and
5 then kind of get to some of the questions that were asked.
6 I guess as we're thinking about where telehealth
7 is going, as Bruce said, it's part of a -- or maybe this
8 was you, Larry. It's part of this broader movement towards
9 digital health, which the Commission occasionally touches
10 on, though I think we're going to have to probably be more
11 intentional about considering what it means to meet people
12 where they are using technology and using digital services,
13 because telehealth is but one platform, one version, and
14 even within that, there are multiple categories.
15 So I think that on the good, this causes us to
16 move into the 21st century and begin to consider it's more
17 about outcomes than about place and about the expectations
18 that beneficiaries are going to travel to a brick-and-
19 mortar facility. We're seeing some of this is technology
20 evolves in areas like end stage renal disease and dialysis
21 but also on the other end of the spectrum for even just
22 management of chronic disease.

1 What we've seen in telehealth in this rapid fire
2 in the few months is that the use cases around acute
3 illness, chronic illness management, mental health
4 services, specialty consultation, that there are a number
5 of ways that the health care system and beneficiaries have
6 been interested in leveraging just the telehealth
7 component. So, clearly, I think we have to sort out what's
8 the right way to continue to make it available in a way
9 that's more flexible than we've had heretofore.
10 I think what I might do is just say from a
11 principled standpoint, I like the way that the staff has
12 laid out, that maybe if you're in an alternative payment
13 model that tips the scales towards additional
14 flexibilities, because that's certainly what we want to be
15 able to do is allow providers and accountable entities to
16 have the kind of flexibilities to think about outcomes, to
17 think about moving upstream and doing prevention, to think
18 about wraparound and holistic services, and really have a
19 partnership over time with the beneficiary.
20 It sounds a little lofty for telehealth, but I
21 think telehealth is one of the tools in the toolbox that
22 alternative payment model-type systems, especially ones

1 that are more global budgeted, have as an opportunity, and
2 then the focus is less on the nuances of the fee schedule,
3 which are important, I understand, for those beneficiaries
4 and providers that rely mostly on traditional Medicare, but
5 I do like the pathway of trying to push people more towards
6 value-based care models.
7 I think in terms of payment, I'd want to just
8 broadly -- I hope that as we're developing this, we think
9 about the fact that though there are unscrupulous actors
10 who are going to try to abuse the system, I think we see
11 that in all areas of Medicare. I do want to try to stay
12 focused on the fact that for beneficiaries and their
13 primary care physicians, this can be augmented and
14 supplemental part of the care continuum, not just for the
15 docs, but for all of the team members that care for them.
16 Also, thinking about how to emphasize the
17 importance of this as a continuity of care relationship
18 augmentation and a way to give people access to services
19 like mental health that may not be so readily available or
20 that may be more acceptable even virtually because people
21 feel more comfortable doing that in that environment.
22 There's some data to show it.

1 We don't have to go entirely back to where we
2 are, and I don't think it has to be the same for every
3 category. Just as I'm asking for a principle of
4 simplicity, I'm asking for a little complexity as we think
5 about which providers we want to pay.
6 I'll just say quickly about your question about
7 should we expect HIPAA compliance, the answer is yes. And
8 there's probably no need to discuss that anymore. We want
9 to protect privacy for beneficiaries. So it seems that we
10 would stay within that frame.
11 Here's my last thing, which I bet you it's going
12 to come up in the next commenters, but I want to just call
13 out that even though CMS's early data shows that
14 beneficiaries irrespective of the color of their skin or
15 their geography were making use of telehealth services,
16 there's other data that indicate that this digital
17 availability may exacerbate a digital divide in all kinds
18 of ways.
19 Kenneth Lam has done some work, recently
20 published in JAMA Network, that shows that as much as
21 almost 80 percent, 78 percent of beneficiaries over the age
22 of 85 have barriers to telehealth or even telephone

1 services, and that may be a third or more of beneficiaries
2 across the board would have a challenge in accessing
3 telehealth or even telephone services. Sometimes it's
4 because they don't have the technology. Sometimes it's
5 because they're hearing impaired. Sometimes they have
6 cognitive impairment. Sometimes they don't trust the
7 system. There are an array of reasons that they outline in
8 this one paper, but I think there's other evidence and
9 certainly anecdotal evidence that we've all heard, that we
10 just want to play close attention to making sure that by
11 pushing this technology out and not thinking about what's
12 going to -- if the beneficiaries can receive, much less are
13 interested and ready to receive. I wouldn't want us to
14 exacerbate any of the digital or health divide that already
15 exists.
16 So thank you to the staff for kind of getting our
17 head around this really giant and highly charged issue.
18 It's a part of 21st century health care. It's a tool that
19 we should make sure is well used to the goal of improving
20 beneficiary health and doing that increasingly in the
21 context of global payments are accountable and entities
22 that are part of alternative payment models but not just in

1 A-APM but really thinking globally about accountability for
2 someone's health. But do that with an eye on the fact that
3 unscrupulous entities and individuals will try to take
4 advantage of the system, so we have to have some safeguards
5 in place, and most importantly I want to make sure we're
6 keeping a close eye on the fact that not all beneficiaries
7 are able to participate, and we wouldn't want them to have
8 a negative impact in this. Thanks.
9 MS. KELLEY: Okay. Wayne, you're next.
10 DR. RILEY: Yes. Good morning, all. Great
11 discussion. A salute to Ariel and Ledia for really framing
12 it superbly in the written paper and also in the slides.
13 You know, this topic is obviously "ripped from
14 the headlines," in a sense, and like most things in health
15 policy it's a Rubik's cube of risk and reward. And I want
16 to go back first to what Larry said, as a primary care
17 internist, and I know we have some primary care nurses and
18 clinicians among the Commissioners in addition to myself.
19 But chronic disease management is where I really think that
20 telehealth can play a significant adjunctive role, as Karen
21 just said, as a fellow internist.
22 For example, in taking care of diabetics, the

1 standard that we've always operated on, we'd like to see
2 our diabetic patients a minimum of four times a year, if
3 possible. If they're sort of out of control it may be six
4 to eight times a year to try to manage their glucose. It
5 strikes me that that's where telehealth, again going back
6 to Larry's point, the ability to reach out to your patients
7 via telehealth, whether it by telephone or by video, can be
8 a great tool in the hands of primary care clinicians, but
9 physicians and non-physician clinicians, to help really
10 address chronic disease management.
11 And this is particularly important, as we now
12 know, in minority communities, which have been impacted
13 severely by COVID, because of preexisting conditions, many
14 of which are indeed chronic. And we know that diabetes and
15 hypertension have been among the top four or five
16 preexisting comorbidities that really contributed to high
17 levels of morbidity and mortality with COVID in certain
18 populations. So as a physician I love the idea of chronic
19 disease management, that this is a tool that could be used
20 for that.
21 In terms of I think the data in the paper that
22 was laid out, that yeah, folks embraced it during the

1 pandemic, but as soon as quote/unquote, their doctor's
2 offices and their nurses and their nurse practitioners and
3 their PAs became available they went back to them. So, to
4 me, that is a clear indication that given a preference
5 between the two, they still prefer to see their provider,
6 which I think is gratifying in some ways. And again, it
7 underscores that telehealth is an adjunctive tool in the
8 larger scheme of things. So I'm glad that there wasn't
9 this overall rush to do it all digitally, that some of us
10 feared.
11 Now even here in central Brooklyn, where we have
12 a high population of Medicaid, a lot of dual eligibles.
13 You know, I've worked very closely with Pat Wang and her
14 great organization in covering some of her members. We
15 were surprised at how many of our patients embraced
16 telehealth. Now my suspicion is that it was because their
17 family members or their caregivers were helpful and
18 assistive to them accessing us during this pandemic,
19 because of the obvious reasons. We didn't want them coming
20 to the hospital, they were fearful to get on the subway,
21 they were fearful to venture outside, et cetera, et cetera.
22 So, you know, again, this is the risk-reward of this whole

1 discussion, in terms of telehealth.
2 Its impact on the fee schedule, obviously, you
3 know, this is important to the Congress, and it's important
4 to the Commission. And, you know, in terms of the
5 guardrails, you know, as a physician, I could accept
6 guardrails around particularly DME. I think that's a
7 reasonable reform to discuss and debate. And again, you
8 know, that's the risk-reward. The risk part of this
9 equation is any permanency that we recommend to the
10 Congress around this program has to have some sort of
11 guardrails so that it doesn't sort of fall victim to some
12 of the fraud and abuse and waste conditions that sometimes
13 befall some of these programs.
14 Again, you know, just to wrap up and turn it back
15 to all of you, it strikes me that the Commission's approach
16 avoidance about this historically was right at that time.
17 In this time it probably needs to be adjusted to somewhat
18 of a warmer embrace with obviously a lot of thought and
19 analysis in program design.
20 So I'll turn it back to you.
21 MS. KELLEY: Thanks. I have Sue next.
22 MS. THOMPSON: Thank you, Dana, and thank you

1 Ledia and Ariel. I suspect the two of you have job
2 security for the next many months as you navigate through
3 this discussion, so thank you for your good and hard work
4 here. And thank you for the opportunity to talk on a topic
5 that you all know that I have a great deal of passion
6 about.
7 Industries across our country have been focused
8 on consumers and understand the need to build strong
9 digital strategies. Health care currently lags in this
10 area and struggles to keep up to date with consumer
11 expectations. Telehealth is a core digital strategy for
12 health care that, as a result of this pandemic, has become
13 an expectation of our patients going forward.
14 It turns out patients and their families value
15 their time, and they don't necessarily like sitting in our
16 waiting areas with other contagious patients. The service
17 that they're seeking can be delivered by telehealth. And
18 they truly appreciate not having to leave their home for
19 two to four hours to go to the doctor or to see their
20 mental health professional.
21 During this pandemic I've heard it said by many
22 of the providers I work with that we advanced telehealth

1 work more in six weeks than we had done in the previous six
2 years, and clearly this was enabled by the relaxation of
3 payers to reimburse services provided by telehealth.
4 But to be more specific, in the month of April,
5 31 percent of all professionally billed services at Unity
6 Point Health, my employer, were delivered by telehealth.
7 In the Quad Cities region, one of our larger markets, 51
8 percent of professional services were delivered by
9 telehealth. Pandora's box is open.
10 Telehealth is a core digital strategy for health
11 care that will be an expectation from our beneficiaries
12 going forward. So how does MedPAC respond to this
13 watershed moment? I strongly recommend we embrace it as an
14 opportunity to more deeply engage with our Medicare
15 beneficiaries in managing chronic illness, to improve
16 engagement that will result in improved outcomes, and
17 reducing our costs.
18 Telehealth is a tool. It's not a service, and
19 let's not confuse the two. Declining to reimburse services
20 delivered by telehealth intentionally delays our
21 opportunity to more deeply engage with our beneficiaries,
22 and it ignores the opportunity to take advantage of

1 improving access.

2 There are three core risks in the chapter around

3 telehealth. Number one, increasing volumes will drive

4 increased cost. Number two, concerns for integrity,

5 worrying about inappropriate telehealth practices. And

6 last but not least, large-scale fraud. I fear we have

7 become so constipated in our fear about rampant increase in

8 utilization that we're no longer thinking about what's

9 right to do for our beneficiaries. We profess our

10 commitment to keeping the beneficiary at the center of our

11 policy discussion, and I believe that includes access to

12 health care. And telehealth is a tool to improve access

13 and engagement, while an opportunity to reduce cost.

14 The worry here then is that the cost impact to

15 increasing patients' access to health care, for as long as

16 I have been in health care, and frankly, as long as I've

17 been a MedPAC commissioner, there's been a constant goal to

18 improve patient access. We worry about availability of

19 primary care. If we believe this, then let's take the

20 opportunity to engage with patients with greater intensity

21 by telehealth.

22 It's interesting. With the telehealth

1 reimbursement discussion, concerns are raised in the other
2 direction. Now we're saying that if we improve access and
3 convenience too much, we may see patients make
4 inappropriate visits and raise health care costs. Do we
5 seriously and intentionally want to make health care less
6 accessible for the Medicare beneficiary to keep costs down?
7 I agree, there is risk of abuse by patients and
8 providers. As with any new technology, there is that risk.
9 So let's think about telehealth as a tool to gain access
10 and not a service in and of itself, and apply the same
11 protections of monetary fraud and abuse to the services
12 afforded by telehealth that we do to the in-person
13 services. Whether we're reviewing severity of illness and
14 intensity of service codes or E&M codes on the ambulatory
15 setting, services provided by telehealth require the same
16 coding standards, including CPT coding, and require the
17 same oversight as those services that are delivered in
18 person. Let's take the leap into what may be a key to
19 improving beneficiary engagement, improving quality,
20 improving our outcomes, and reducing our costs.
21 During this pandemic, our industry has been
22 transformed. The utilization of telehealth to maintain

1 access during this pandemic is part of that transformation.
2 Let's embrace telehealth as an enabler to support the
3 triple aim in service to our Medicare beneficiaries, and do
4 the work to embrace this enabler. Thank you.
5 DR. CHERNEW: So let me jump in. We're about to
6 go through the queue. We have roughly a half an hour, a
7 little bit more, and virtually everybody is in the queue.
8 So before you talk look at your watch. When you're done
9 talking look at your watch. If there's more than two and a
10 half or two minutes gone, you've talked too long. I
11 apologize for that. There's other ways to repeat. But I
12 hate to sit next to Jim. He was always looking at his
13 stopwatch.
14 So with that Dana's going to run through, and
15 thanks for your commentary.
16 MS. KELLEY: Okay. Brian.
17 DR. DeBUSK: First of all, thank you, and Sue, I
18 really enjoyed your comments and I really agree with a lot
19 of the things you said. This is a valuable, beneficial
20 tool, and I do think it should be expanded.
21 I mentioned this yesterday. This entire
22 telemedicine adventure is a great example of provider

1 resilience. If you look at how they ramped up in three
2 weeks, it's astounding to me. You know, we have a program
3 that we manage over decades, and programs that we phase in
4 over five- and six-year periods. This was three weeks. So
5 I hope we take note of that as we think about phase-ins in
6 the future.
7 I really enjoyed, in the presentation and the
8 materials, the distinction between A-APMs versus fee-for-
9 service, and trying to treat telehealth differently. I
10 think that's a really valuable distinction that we need to
11 preserve throughout our work.
12 I will make the comment, though, that that
13 distinction works both ways. When you expand telehealth,
14 your opportunities to manage and manipulate attribution
15 increase geometrically. You're going to have some
16 incredible opportunities. I mean, I don't mean to sound
17 cynical, but imagine a bank of people dialing for
18 attribution, starting about December 8 of each year. You
19 know, I think we've presented some chapters before about
20 these wellness visits that seem to occur disproportionately
21 in the latter half of the year. So I do think we need to
22 look at how telehealth could affect or otherwise skew

1 attribution.

2 The other thing that I think we've mentioned in

3 the past, and we haven't mentioned this much in the

4 session, we really need to take a look at how telehealth

5 could affect risk scores. I think in the MA enrollee

6 population you do have an outstanding risk that expansion

7 of telehealth is going to create an avenue for additional

8 visits, incremental visits that could be used not

9 necessarily primarily but at least secondarily for the

10 purposes of collecting and driving risk scores.

11 So there are two things there, both in the A-APM

12 world and the MA world, where we could have some

13 undesirable effects or some unintended consequences with

14 the expansion of telehealth. So I hope we look through

15 that in both areas.

16 As far as the presentation and the options and

17 the recommendations presented, you know, I think there are

18 a few areas that I really agreed with. I think that moving

19 back the facility rate for sure, I think we do that in

20 telehealth. And I also echo, Wayne, your comments about

21 doing some face-to-face requirements for DME and for lab

22 tests. I think that is absolutely essential. I strongly,

1 strongly agree and advocate that DME should have face-to-
2 face requirements when they're involved in telehealth.
3 The areas that the staff presented questions in
4 the presentation, the idea of extending it to non-rural, I
5 like the idea of extending it to non-rural areas. I think
6 that's a little bit of an artificial distinction. I mean,
7 transportation and accessibility isn't just a rural
8 problem. I could see myself in a heavily concentrated
9 metropolitan area having some of the same issues. I also
10 think we're seeing it at home. I think that's a good
11 policy to expand and allow beneficiaries to receive these
12 services at home.
13 And I do favor limiting the frequency, or at
14 least the ratio of telehealth to in-person visits. Let's
15 say someone wants to do something through telehealth.
16 There's nothing wrong with periodically requiring an in-
17 person visit. So we can start looking at some ratios or
18 some ways to manage that.
19 The only other thing that I would mention is I
20 think we said no, or the recommendation was leaning toward
21 no toward audio-only visits. I'm not sure how I feel about
22 that. I mean, I think there's some socioeconomic issues

1 there in limiting audio or not accepting audio-only visits.
2 And I hope we'll revisit that, because I don't know that we
3 always need a talking head to deliver care. I do think
4 voice will suffice sometimes.
5 And those are my comments. Thank you.
6 MS. KELLEY: Thank you. Okay, Bruce, you're
7 next.
8 MR. PYENSON: Got to start my stopwatch.
9 I've had a view that at least some, or perhaps
10 most of the telehealth that was delivered during the public
11 health emergency could have been delivered in the 1960s. I
12 have an image of a physician sitting at their desk with a
13 landline and a dial-up phone, before pagers even, and some
14 paper and pencil, and that was the public health emergency.
15 I believe the telehealth of the next several years is going
16 to be dramatically different from that.
17 So I think that the discussion of what we're
18 setting in place now is going to be used by a very
19 different industry that does things like scoops up the data
20 from the Blue Button, scoops up other information such as
21 the internet phenom of socioeconomic determinants of an
22 individual, and feeds that through a triage process before

1 getting to a physician. And that's the world of the next
2 several years. It's happening in some startup companies
3 now.
4 So my concern is that what we're setting in place
5 is dictated by the current structure and the current
6 experience, but the funding and the development for these
7 other technologies are zooming ahead. So I think it's
8 really important that what we set up now addresses that
9 future.
10 The way to do it, I think, is to realize that
11 that system is going to be very much less expensive and
12 should be reimbursed at a much lower rate than the current
13 telehealth services, and my apologies for running over two
14 minutes.
15 MS. KELLEY: Thank you, Bruce. Betty, you're
16 next.
17 DR. RAMBUR: Thank you. Briefly, from my
18 perspective, fee-for-service and first dollar coverage is
19 just the absolutely worst option, and the greater financial
20 risk, the more flexibility there should be. And full risk-
21 bearing organizations or providers should have the
22 flexibility to use all the tools available to them,

1 including deciding obviously telehealth and audio-only, I
2 would add, and cost-sharing models that they think make
3 sense.
4 I agree with what's been said about chronic
5 condition management, and my experience has been a little
6 bit different than Wayne's. My experience, and maybe this
7 varies by part of the country, is at least a third of
8 patients are so delighted to not have to go somewhere. I
9 mean, maybe people just don't like to drive in this part of
10 the world, or can't.
11 I'll save my other comments to just get to one
12 final point. I'm wondering if, in more traditional fee-
13 for-service, if there should be some special recognition,
14 policy recognition, for high-risk, low-mobility patients
15 who are sort of a little bit of a different category and
16 could really perhaps benefit from some differential
17 policies. Thank you.
18 MS. KELLEY: Thanks, Betty. Paul, you're next.
19 DR. PAUL GINSBURG: Oh, thanks. Well, I'm going
20 to speak mostly about the A-APM distinction. I like the
21 idea of flexibility in the more managed sector, and that
22 may support giving additional incentives to be in an A-APM

1 and for the delivery system to move in that direction. But
2 I'm really concerned about many A-APM -- there just is not
3 enough control over the physicians that participate in
4 them, and I would like to raise the possibility of making
5 the additional flexibility for A-APMs contingent on the
6 organization actually asking for it, so it governed the
7 relationship with the physicians that are in their
8 organization. You know, if they want all the flexibility
9 that can be offered, they can have it; but if they don't,
10 they can hold it back until they're ready for it.
11 Two other points. I think it's very important
12 when we discuss fraud and abuse to avoid no-cost-sharing
13 situations, because a very important tool -- it's not
14 adequate often. An important tool in managing abuse is the
15 patient, and the more aware the patient is that they might
16 have to pay something, that's a real asset.
17 And the final thing I want to mention is that I
18 don't recall any discussion of MA, and I didn't know
19 whether that means that MA's current policy should continue
20 or they have flexibility to use telehealth as they decide
21 or whether the policies that we're talking about for fee-
22 for-service would directly apply to MA and, thus, we'd

1 restrict their flexibility and make them conform to that.
2 I'd rather not do that. I'd rather leave the flexibility
3 to them as to how they want to use telehealth.
4 Thanks.
5 MS. KELLEY: Dana?
6 DR. SAFRAN: Thank you. So, you know, I want to
7 underscore my agreement that, you know, the move to virtual
8 care and the rapidity of that in this time period may be
9 one of the only gifts that COVID has given us. It's
10 something that, you know, many have hoped would take shape
11 in the delivery system, especially with the evolution of A-
12 APMs, and it just hasn't and suddenly now it has. So I
13 would love to use this moment to signal to the delivery
14 system that this is not only a good development but an
15 expectation ultimately at some point for ability to
16 participate in Medicare.
17 I think that we should consider how we can
18 ultimately leverage the lower infrastructure costs
19 associated with telehealth to begin to lower the costs of
20 care overall without -- you know, with lower reliance on
21 bricks and mortar, we can get there.
22 I would say that I am certainly among those who

1 worry about this as a potential burden on our efforts to
2 control the budget and budget growth. But I do think that
3 participation in A-APMs should be a ticket to the ability
4 to continue to use virtual care in whatever forms and
5 functions so long as they are HIPAA compliant and fully
6 secure.
7 I would say that I feel less comfortable with the
8 idea of a blank ticket for their use in a fee-for-service
9 system. I do wonder whether, if we begin to allow members
10 or beneficiaries to have a lower cost share if they
11 themselves are attributed to an A-APM, will that create a
12 virtuous cycle where we've got beneficiaries who want it
13 not only because they like the convenience but also because
14 they appreciate the lower cost sharing of those visits
15 without the threat of overuse because they're in a system
16 that's going to help manage that.
17 I know that creates complexities that we have to
18 work through about -- that Michael brought up earlier of,
19 you know, do practices know which patients are in the A-
20 APM, do the beneficiaries themselves know and so forth.
21 But I think, you know, broad lens, that a way to encourage
22 provider participation in these models can be to have

1 patients continuing to demand access to this, and part of
2 how we can do that is having it be lower cost sharing.
3 A final point I'll make is that I think that we
4 haven't mentioned the importance of studying its impact as
5 we go, but I think that should be a really clear and
6 important thing that MedPAC articulates. For example, we
7 know very little right now about once it's easily possible
8 to go back to in-person care, will those who have had a
9 virtual visit, especially in the Medicare population, kind
10 of seek out an in-person visit to sort of validate what
11 they've heard because they've lacked that laying on of
12 hands that they've associated, or not? We have questions
13 about quality, et cetera. So I think on the quality and
14 overall utilization, we should be studying the impacts,
15 especially after the public health emergency is over.
16 Thank you.
17 MS. KELLEY: Thank you. Jonathan Jaffery, you're
18 next.
19 DR. JAFFERY: Thank you. I will sort of echo a
20 lot of what people said, but not get too detailed on them
21 in the interest of time, although, Mike, I stopped wearing
22 a watch a long time ago, so I'll just have to trust how

1 much time it takes.

2 So, you know, I would agree that we need to allow

3 telehealth services to continue. I think, you know, we've

4 been very focused on people avoiding contact in the clinics

5 during COVID, and hopefully that will fade away before too

6 long, but we shouldn't underestimate the fact that we've

7 got a lot of older beneficiaries who we probably don't want

8 to just routinely come into clinic during flu season if

9 it's avoidable. So there are reasons to continue that.

10 I'm very supportive of limiting this to the

11 advanced APM models as well, and I guess the one thing I

12 want to emphasize -- or I guess the two things, I would

13 also very much support including audio-only. The reading

14 material indicated that over two-thirds of Medicare

15 beneficiaries have used audio-only relative to the video

16 visits. Our experience, UW Health has been consistent with

17 that as well, and personally I've found that to be actually

18 very useful and have not needed video capabilities for a

19 lot of these visits, particularly the chronic diseases as

20 Wayne and others have said.

21 The last thing I want to comment on, and I won't

22 reiterate what others have said too much, but this issue

1 had started to come up in Round 1, which was around whether
2 or not the capabilities are going to be focused on
3 providers in advanced APMs or are they going to be matched
4 to beneficiaries. And what I heard from Ariel was that,
5 for practical purposes, at least to start with, we would
6 probably limit it or start off with the provider. But I
7 think that's going to be a really important thing for us to
8 grapple with and think about what the implications are in
9 both ways.

10 As a specialist who's in an advanced APM through
11 Next Gen and an academic medical center, a lot of my
12 patients come from far away, and there's not really a
13 simple way to guarantee or have those individuals be part
14 of our advanced APM, be part of our Next Gen. And yet
15 those are the folks who may be getting a lot of benefit
16 from increased access to the specialty care and not have to
17 drive very long distances and take off half a day of work
18 or have their family members take off half a day of work
19 for something like that.

20 So I think we do want to preserve that
21 capability, and, you know, in the last cycle we talked a
22 lot about how do we -- or we started to talk, at least,

1 about how do we think about models for specialists in
2 advanced APMs and how do those align with some of our other
3 models and the ones that are more logically aligned with
4 primary care. And so I think that's a -- there's a line of
5 thinking that we may want to bring into some of our broader
6 advanced APM and ACO discussions going forward.
7 So I'll leave it at that. Thank you.
8 MS. KELLEY: Okay. Marge, you're next.
9 MS. MARJORIE GINSBURG: So I admit I'm a Luddite.
10 I'll get that up front. The arguments many of you have
11 given, particularly you, Sue, have been very persuasive
12 about the importance of it, but I'll tell you, this raises
13 so many red flags for me. I am inherently -- well, let me
14 back up a second.
15 Our first discussion yesterday was all about how
16 the Medicare budget was going to hell in a hand basket. I
17 am really concerned that just opening this up as a new way
18 for doctors and patients to relate without a whole lot of
19 safeguards means we are going to be looking at extensive
20 increases in the burden to taxpayers and ultimately the
21 burden to patients.
22 So cutting to the chase, I think the next step

1 has got to be a very carefully designed study of a certain
2 number of A-APMs who are participating, very closely
3 monitored for two or three years, and to see whether what
4 we are getting is greater benefit to patients and lower
5 costs to the system.
6 Thank you.
7 MS. KELLEY: Amol.
8 DR. NAVATHE: Thank you. I'm going to try to be
9 as brief as possible, picking up on many people's comments.
10 First, Ariel and Ledia, great work as usual.
11 Second, I definitely agree, in general support of
12 trying to support providers and beneficiaries in receiving
13 telehealth, as Karen said very passionately and others have
14 already spoken about. I think to pick up on just one thing
15 that Marge said, we have to be mindful about the
16 responsibility. So I support many of those things.
17 I'm trying to divide my comments into access,
18 payment, and monitoring. So in the context of access, I
19 think generally speaking, to the extent that we can follow
20 something like a targeted strategy -- I think Betty brought
21 up a couple of these points, and then the chapter does,
22 too, actually -- around focusing on those people who -- the

1 beneficiaries who may disproportionately benefit from this,
2 from an access perspective, those with disabilities, those
3 with neurological impairments, those with mental illness,
4 those people where the impact can be just substantially,
5 you know, disproportionate, clinically speaking.
6 So I think some sort of targeted strategy may get
7 us to a balance between the risk that Marge is worried
8 about, and I think the excitement a lot of us also hold
9 given the progress that we've made, whether it's six years
10 or from the 1960s, as the brief said.
11 So another couple points. The one thing -- I've
12 broadly supported -- I think if you look at how MA has done
13 it, at least a little bit of the details that we do have,
14 clearly there is value in telehealth and the whole cost of
15 care management, and there are cost efficiencies there.
16 And so in that sense, I'm excited and supportive of the
17 idea of, you know, giving A-APM participants even more
18 flexibility in the concept of telehealth. I think that
19 make sense.
20 The one piece that I think gives me pause is if
21 we look at A-APM participation, it has not been uniform
22 across the country based on community characteristics.

1 Participants who -- or beneficiaries that live in
2 communities with a disproportionate number of duals, for
3 example, has much less access to ACOs or bundled payment
4 participants. This is actually true even in CJR, which is
5 a mandatory program, because of the way that -- the
6 formulas that Medicare had to use to come up with who
7 participated in the candidate pool of MSAs.
8 So I think we have to be mindful about that
9 because, otherwise, you know, this digital divide concept
10 and disparities in general, we could unwittingly actually
11 support a divergence in how we allow access. Then as we
12 cross that with Betty's points about targeting the
13 beneficiaries, we could actually do a lot of harm rather
14 than a lot of good. And so I think we have to be mindful
15 about that disparity rather than sort of putting blinders
16 on and saying A-APMs are the solution to trying to get
17 telehealth out there.
18 There's some points in the chapter, in the paper,
19 that talk about new patients versus existing patients, and
20 I wondered in the context of access challenges, again, sort
21 of certain types of specialty care that are less accessible
22 if we should actually explore how to make that perhaps more

1 available to new patients rather than established patients.
2 Another point on the payment side, in particular
3 I think there was some discussion in the paper about how to
4 pay or whether to pay for -- and sort of design the
5 payment, if you will. So I think because we know adoption
6 of anything, even if it's free technology, requires a
7 little bit more effort, a little bit more work reorg, et
8 cetera, I think we could explore some concept of a tiered
9 payment there, so thinking about a slightly higher payment
10 for the initial set of visits, if you will, and then
11 subsequently could drop that.
12 Then another thing I wanted to -- the last piece
13 on this sort of monitoring responsibility piece that I
14 wanted to submit is I know the Commission holds very
15 strongly these principles of how we measure quality and how
16 we think about the quality and monitoring aspect of
17 programs and a common set of metrics, a set of metrics that
18 are outcomes-based. I wonder in this case if we actually
19 need to be making an exception to this rule. We may need
20 to be a little bit more targeted about trying to focus on
21 soliciting inputs from beneficiaries specifically about
22 telehealth, about monitoring access and quality of

1 telehealth services in particular, because of all of the
2 unicorn reasons that you guys have -- that I've already
3 outlined I think in our discussion. And so I would submit
4 that maybe we should actually be more targeted and
5 telehealth-specific here than we usually are and not rely
6 on the general CAHPS type surveys, the general other types
7 of quality measurement that we do, lest we not be able to
8 actually detect harms to patients or benefits that we would
9 otherwise miss.
10 Thanks for listening.
11 MS. KELLEY: Jon Perlin?
12 DR. PERLIN: Thanks, Dana. And let me start by
13 thanking my fellow presenters, presenters who are so
14 impassioned and articulate, like Karen and Sue, a vision
15 for the future, and Wayne, really in terms of talking
16 about, you know, how this has been part of the
17 armamentarium of the care of chronic disease. And my view
18 is coming from a 20-year history of working with telehealth
19 in the VA where this was simply part of the fabric of
20 caring for veterans around the country and around the
21 world. So, briefly, six points.
22 First, clearly there's a very different resource

1 use between telehealth and in person, and I think that's
2 one of the inherent controls in terms of overutilization.
3 If you actually look at excessive use and very low
4 utilization, you'll pinpoint fraudulent or inappropriate
5 use of the technology.
6 Two, COVID's with us for a while, but there will
7 be something else after it. There's always infectious
8 disease. There are always impairments to mobility. And,
9 you know, I just reflect on my father being delighted as a
10 Medicare beneficiary not to have to be in a physician's
11 office at this particular time.
12 Three, in terms of access, limitations of access
13 are not just the purview of rural. Urban isolation is well
14 characterized. This is one of the best modalities for
15 connecting with individuals who, for whatever number of
16 structural and systemic reasons, are isolated.
17 Four, I think it's fundamentally incorrect to
18 sign on the use of a technology or its whole based on the
19 payment model. It really needs to be on the basis of
20 clinical appropriateness. Will we limit with an epidemic
21 of diabetes the use of digital glucometers to just one
22 particular payment model? I think there are any number of

1 other controls that can be put into place, and I think
2 that's really what needs to be tested.
3 You know, phone is simply one of the mechanisms
4 for remote care. If the current mechanisms pay for phone
5 care, that's fine. But, you know, I do support that we
6 abide by mechanisms to control security and privacy that
7 are associated with HIPAA, and I'll come back to that
8 because really one of the things that's most interesting
9 now about the use of telehealth is that many of the
10 telehealth mechanisms are simply an extension of the
11 technology of the electronic record. And to disassociate
12 telehealth from the electronic health record is virtually
13 impossible as it's now part of a unified suite of
14 technology.
15 And, finally, if we were to say let's limit this
16 to the purview of A-APMs, we may be exacerbating the
17 digital divide, particularly from rural individuals, if we
18 think about where the geographic and social sort of
19 concentration of those models exist.
20 So, in closing, let me just offer one final
21 comment. You know, right now we're deciding how telehealth
22 will be used. I feel fully confident that our successors

1 will be deciding whether or not Medicare pays for devices,
2 be they physiologic monitoring or communications, for
3 Medicare beneficiaries, because it's hard to envision the
4 world ahead without sort of continuity that really a
5 digital environment not only embraces but requires.
6 Thanks.
7 MS. KELLEY: David?
8 DR. GRABOWSKI: Great. Thanks.
9 Let me start by saying, similar to others, I do
10 support telehealth expansions in the advanced APMs.
11 For other clinicians in fee-for-service Medicare,
12 I do worry about excessive use and low-value care if we
13 continue the expansions under the PHE.
14 As a result, I do believe we need some safeguards
15 in place, and I just wanted to quickly outline three
16 guiding principles here.
17 First, I do think we should cover all forms of
18 telemedicine for high-risk patient populations where access
19 is most likely difficult, and this would be expanding
20 Medicare coverage beyond rural communities to patients, for
21 example, and federally qualified health centers, community
22 mental health centers, nursing homes, and for people with

1 substantial physical and mental disabilities.
2 A second guiding principle for the rest of the
3 Medicare population, I would cover telemedicine only where
4 we see real value or there's a compelling need, and here,
5 we could use conditions as we've been discussing or
6 provider types to determine these coverage decisions.
7 An example of coverage by condition would be
8 similar to Medicare's current coverage of telemedicine for
9 stroke and for opioid use disorder. We've talked a lot
10 about diabetes. There's probably other examples that the
11 clinicians on the Commission could point towards.
12 We could also expand services by provider. An
13 example here would obviously be continuity and financing
14 primary care by covering any form of telemedicine visited
15 for primary care. So there are some options there if we
16 see that there's high value to covering these services.
17 The final guiding principle I would assert is
18 that we do want to pay for telemedicine visits at a rate
19 lower than in-person visits and avoid any sort of
20 telemedicine parity laws. I know that setting up
21 telemedicine requires some significant fixed costs in the
22 short term, but in the longer term, a provider's marginal

1 cost should be lower for these types of visits. And I
2 think our reimbursement model should reflect that.
3 And I do believe that at least for some patients,
4 we should have some cost sharing in place for telemedicine.
5 So I'll stop there and just say thanks.
6 MS. KELLEY: Okay. Thank you.
7 Jaewon, you're next.
8 DR. RYU: Thanks, Dana.
9 A lot of great comments, which I agree with. I
10 think Betty described the spectrum that I would also
11 support, which is the greater that you have financial
12 accountability through an A-APM model, I think you should
13 be afforded greater flexibility, and that if you're on the
14 purely fee-for-service side, I think that's the other end
15 of the spectrum where I think the telemedicine, unless we
16 have firm belts and suspenders in place, I'd be very
17 concerned.
18 The other is I think there's an opportunity if we
19 rolled it out in that way in the A-APM space to do some of
20 that testing and learning around the impact that the
21 vehicle could have on the total cost of care and on the
22 clinical outcomes.

1 The other comment is just around A-APMs, and this
2 gets to the question from Round 1. I think there is
3 complexity, but ideally, I'd love to see if we can limit it
4 and afford the greatest flexibility in areas where the
5 provider participates in an A-APM and is aware of a
6 beneficiary who is also attributed to them within that A-
7 APM.
8 Now, that may not be practical, but I think
9 that's the ideal scenario. These providers will be seeing
10 other beneficiaries who are outside that A-APM. That gives
11 me a little greater pause there.
12 And then the last comment I'd made is A-APMs
13 bring the financial incentives that I think would make me
14 comfortable, but probably, more importantly, I think
15 there's clinical accountability there in a way that in the
16 fee-for-service world, there may not be. I think
17 telemedicine in a Wild West environment has the potential
18 to fragment versus in an A-APM environment where there's an
19 accountable team, accountable provider, I think it could be
20 used for tremendous clinical benefit.
21 DR. CHERNEW: Okay. We are at eleven o'clock.
22 We have two comments left. Just giving a time check. I

1 think Larry is next. Is that right, Dana?
2 MS. KELLEY: That is right.
3 DR. CASALINO: First of all, I agree with Brian
4 and Jonathan about not discriminating against audio. I
5 agree with Brian about expensive DME and I'd say really
6 expensive lab tests. You need an in-person visit. I agree
7 with Paul and a few others about the importance of cost
8 sharing for telehealth, and I agree with Bruce and David
9 that I think there shouldn't be parity, that quite a bit
10 less should be paid for telehealth visits.
11 But that said, I had originally entered the queue
12 because I wanted to make a couple more general comments,
13 which Sue then made extremely eloquently for the second
14 time in two days. I want to reinforce her comments sort of
15 using two trite phrases. One is the genie is out of the
16 bottle. She used "Pandora's box is open."
17 I could tell you at Weill Cornell, physicians
18 thought telehealth was an issue under the devil, very many
19 physicians. There were also some curmudgeons who really
20 thought it was an issue under the devil. That changed
21 within a week of when people started to use it, and now I
22 would say the overwhelming majority of the thousand

1 physicians or so in our organization think it's great.
2 People are using it routinely who I never thought would do
3 it. So that's from the physician's side.
4 From the patient's side, 20 years of practice,
5 for one reason or another, I'd frequently be in the
6 position of talking to a patient about their blood pressure
7 on the phone, for example, and saving a visit by just
8 modifying their therapy for diabetes or hypertension over
9 the phone. And then I would say, "Why don't you increase
10 your lisinopril with the blood level for your hypertension,
11 and then come see me in two or three weeks. And we'll see
12 how you're doing." And the patient's response was
13 invariably, "Okay. But, Doc, how come I have to come see
14 you again in two or three weeks? Why can't we just do this
15 again?"
16 So I think the genie is out of the bottle.
17 There's no substitute for face-to-face visits. You need to
18 have them, patients do like them and physicians like them
19 when there's real value to them. But I think in general,
20 patients who have a good relationship with their doc will
21 be very, very happy to have lots of virtual visits.
22 So the second trite phrase is don't let the tail

1 wag the dog, and I think Sue basically referred to this as
2 well. There are fee-for-service incentives out there all
3 over the place. We don't, for example, try to identify
4 physicians who are having too many follow-up visits for
5 hypertension or diabetes, and I don't see a reason really -
6 - I do see a reason to be cautious and thoughtful about
7 telehealth, but I think we do need to ask ourselves why --
8 we've got to be careful to not discriminate overly against
9 something that could be very valuable tool, while leaving
10 all the other fee-for-services in places they always have
11 been.
12 I think that if there's cost sharing for
13 telehealth, if telehealth is paid at a lower rate, and if
14 there's monitoring for outliers, I think that will reduce
15 the possibility for abuse a lot.
16 And the benefits are so great. I just talked
17 about from the physician-to-patient point of view, but I
18 also did want to say -- I forget who mentioned this now,
19 but increasing primary care access -- I think it was Wayne
20 -- is a big deal.
21 At Cornell, we've had a huge problem with primary
22 care access, huge, and part of it is we just don't have the

1 space to hire more primary care physicians.
2 But now we realize we can do a very large number
3 of primary care visits and specialist visits, for that
4 matter, where we also have an access problem, through
5 telehealth. That means that we have more office space
6 open, more staff time free, and we have physicians working
7 two or three days a week doing telehealth, the other two or
8 three days in the office, and we can hire more primary care
9 physicians and more specialists that way and increase
10 access tremendously. That's a huge benefit.
11 I'm almost done.
12 I think that limiting telehealth to A-APMs would
13 drastically reduce the potential benefits, as Jon Perlin
14 suggested. I can see reasons for doing this, but I think
15 it would be premature at this stage to let this just become
16 the wisdom of the Commission. I think that Jonathan, Sue,
17 and I -- Jonathan Perlin, Sue, and I at least have some
18 reservations about limiting it to A-APM. So I hope we'll
19 have more discussion about this.
20 The last two points, let's not make this too
21 complex for all kinds of reasons, including the more
22 complex it is, the more opportunity for gaming and the more

1 burden on clinicians. And we shouldn't underestimate that.
2 Clinicians really, really, really hate having to think,
3 "Well, am I allowed to do this for that patient, but I
4 can't do it for this patient?" We don't want anything like
5 that.
6 And the last thing, I think there should be more
7 attention to telemedicine by Teladoc companies. This whole
8 discussion that we've had for the last hour has been really
9 framed, I think, with the mental mindset of a patient and
10 their physician or physicians. It's quite a different
11 thing, a patient accessing Teladoc services across state
12 lines with a physician who they've never seen and are never
13 going to see again, and I think we don't want to lose track
14 of that as a kind of a separate area that we might want to
15 pay some attention to.
16 MS. KELLEY: Okay. Pat, you're up.
17 MS. WANG: So, unfortunately, I think -- because
18 following your comment, Larry, and some of the others about
19 the importance of telehealth, which I agree with -- and I
20 think people are circling around some core areas, chronic
21 care, E&M, urgent care. I would add dermatology to the
22 list for video, behavioral health, et cetera.

1 But I think that what we've been discussing for
2 years now in the context of A-APMs is how to restrain some
3 of the worst impulses of the fee-for-service system, and so
4 I am also concerned about adding new -- as important as
5 they are, these services, without some sort of governor or
6 some sort of principle around accountability for how the
7 services are delivered, because more is not necessarily
8 better.
9 Let me just address the Medicare Advantage
10 flexibility that Paul raised, and Brian raised something
11 about Medicare Advantage. So I think these are really
12 important observations, and I would note that within -- but
13 the kind of monitoring that people think is easy in fee-
14 for-service, overutilization and all that, I think it's
15 really hard in fee-for-service. I think that we're always
16 behind the eight-ball in trying to kind of find -- and it's
17 like short of fraud, just kind of like billing patterns,
18 what have you. I don't think the fee-for-service system is
19 really capable of being on top of those and monitoring
20 those things.
21 Plans do that on a regular basis because they're
22 at risk. Primary care physicians who are capitated or who

1 are in fee-for-service risk arrangements, there's a
2 governor there. So it just sort of underscores the
3 importance of the impulse behind wanting to have an A-APM
4 or some other accountability structure around new
5 modalities.
6 Specifically for Medicare Advantage, I think it's
7 important to carry over this discussion into the MA work
8 with respect to risk adjustment because Brian mentions the
9 risk of it, but there's also the clarification of what will
10 count for risk adjustment because depending on the answer
11 to that, MA plans will feel pushed in one direction or
12 another in terms of the flexibility that they have. I
13 think that CMS has recognized the difficulty with risk
14 adjustment during the COVID months because of social
15 distancing and has shown some flexibility. I think it's
16 face-to-face telemedicine.
17 Brian, if it's any comfort to you, at least our
18 early experience with telemedicine claims coming through is
19 that they were barely coded. So the risk is under-capture,
20 not over-capture, but it's all emerging. So I think the MA
21 folks need to kind of be thinking about this in terms of
22 recommendation of what should count, what shouldn't count,

1 and it should sync up with what we are recognizing in fee-
2 for-service.
3 The final thing that I would strongly recommend
4 or request is that we do ask CMS to do the work of
5 understanding what the cost structure is. Right now, it's
6 this kind of, like, one instrument thing. It's facility
7 fee versus the fee schedule fee. I think there's enough
8 here to warrant an actual examination with all the tools
9 and the science that CMS uses when they do the physician
10 fee schedule to understand what we're really talking about
11 in terms of what an appropriate level of reimbursement
12 would be.
13 Thank you.
14 DR. CHERNEW: Great. I know we're a bit over
15 time, so I'm just going to summarize, and then we're going
16 to move on quickly.
17 Karen, you can send your message to the staff or
18 me, and we can deal with that.
19 So here's my view. I think for most of these
20 services, everyone can use -- this is not a question about
21 who is allowed to use this. Everyone is allowed to use
22 this. This is really a question about what they get paid

1 for, and A-APMs effectively get paid, depending on the cost
2 sharing amount, roughly 50 cents on the dollar because it
3 comes out of their bonus or penalty.
4 So in a fully capitated world, of course, no
5 matter what you pay the A-APMs, it would come out of their
6 bonus or capitation. So they would be effectively paid
7 nothing.
8 This is really about what we pay in fee-for-
9 service. My sense is what we will end up doing in most
10 cases is control the utilization concerns with lower
11 payment amounts and some cost sharing. We're going to have
12 to work with the staff about how to sort that out and get
13 back to you.
14 I will say one of the really important questions
15 and comments that really resonates with me, Dana Safran
16 said, which was it's going to be really important going
17 forward to study and adjust is key. I don't think we need
18 to view this as one bite of the apple. This is going to be
19 a process that we're going to put in place, but I do think
20 we're going to have to deal with payment and cost sharing
21 to control potential overuse.
22 I'll stop and we'll move on to vaccines. Thank

1 you all for your enthusiasm, and, Rachel, Kim, and Shinobu,
2 you're up.
3 DR. SCHMIDT: Okay. Good morning. Can everyone
4 hear me okay?
5 MS. KELLEY: Yes.
6 DR. CHERNEW: Yes.
7 DR. SCHMIDT: First, we'd like to thank Nancy Ray
8 for her help on this work, and just a reminder to the
9 audience, a PDF of the slides for this session is available
10 under the handout section of the control panel at the
11 right-hand side of your screen.
12 The COVID-19 pandemic has made us all acutely
13 aware of how important developing and administering
14 vaccines can be for protecting health and the economy.
15 Older adults and people with chronic conditions have higher
16 risk of severe COVID-19 disease. So it's especially
17 important to see that Medicare beneficiaries get vaccinated
18 once a safe and effective vaccine becomes available.
19 Last spring, the Congress decided that Medicare
20 will cover future COVID-19 vaccinations in Part B with no
21 cost sharing. In this session, we'll discuss Medicare
22 policy going forward. We'll review a recommendation the

1 Commission made in 2007 to put all vaccine coverage under
2 Medicare Part B on the basis of this discussion. You may
3 want to just reiterate that recommendation or we could come
4 back in the spring for you to consider supporting an
5 alternative recommendation.
6 Here's a roadmap to the presentation. First,
7 we'll go over some background about vaccines, including how
8 the government is supporting development of COVID-19
9 vaccines. We'll review Medicare's coverage policy and how
10 much the program spends today on vaccines. We'll look at
11 rates of vaccination for some of the most common vaccines.
12 Finally, we'll review the rationale behind the Commission's
13 2007 recommendation and present policy options for you to
14 consider.
15 As background, let's step back for a minute and
16 think about why governments tend to play a large role in
17 vaccine policy. The key reason is that preventive
18 vaccinations have very large social benefits. They are
19 thought to be among the medical interventions with the
20 highest payoff in terms of preserving health and economic
21 activity and reducing stress on the health care delivery
22 system. Vaccines have positive spillovers. When you get

1 vaccinated, it not only protects you but also the people
2 you interact with.
3 So individuals at risk of catching a disease have
4 a stake in seeing that other people get vaccinated too, but
5 there can be a lot of hurdles to getting vaccinated that
6 may affect whether a population reaches herd immunity.
7 Also, prior to COVID, the number of manufacturers
8 developing and producing vaccines had declined. But
9 governments have a continuing interest in making sure
10 vaccines remain available. For these reasons, governments
11 get involved; for example, in the case of state
12 governments, by mandating certain routine childhood
13 vaccinations, but for the federal government, by directly
14 purchasing and stockpiling vaccines, by providing some
15 liability protection to manufacturers, and by investing in
16 research and development to develop new vaccines.
17 In the case of a vaccine for the novel
18 coronavirus, the federal government has gotten involved in
19 a number of ways. Last spring, the Congress allocated
20 about $10 billion towards developing vaccines and
21 treatments in the CARES Act. The administration set up
22 Operation Warp Speed to coordinate federal agencies and the

1 private sector in efforts to develop safe and effective
2 COVID vaccines, with the goal of delivering 300 million
3 doses by early 2021.
4 To do this, the program is supporting several
5 vaccine candidates. Their mailing materials describe three
6 that are in Phase III clinical trials in the United States.
7 Some of the federal contract with manufacturers fund R&D.
8 Other contracts are pre-commitments to purchase hundreds of
9 millions of vaccine doses, even before we know whether
10 they'll succeed in clinical trials.
11 This approach reduces financial risk for vaccine
12 manufacturers and allow them to set up large-scale
13 production capacity much earlier than they would normally.
14 It's possible that the Food and Drug Administration may
15 grant emergency use authorization to some vaccine
16 candidates before they are formally licensed.
17 Medicare's coverage of vaccines spans Part B and
18 Part D. By law, Medicare Part B covers preventive vaccines
19 for seasonal influenza, pneumococcal disease, and hepatitis
20 B for people at high or intermediate risk with no cost-
21 sharing. Part B also covers other vaccines used to treat
22 injury or direct exposure to disease, such as rabies, with

1 Part B's usual 20 percent cost-sharing. The CARES Act
2 explicitly covers new vaccines approved for COVID-19 under
3 Part B with no cost-sharing. Part D covers all other
4 vaccines such as those for shingles and hepatitis A. As
5 with drugs covered under Part D, private plans can charge
6 cost-sharing for vaccines and there is wide variation in
7 what plans charge. Part D plans can also apply utilization
8 management tools to vaccines, but they rarely do.
9 MS. NEUMAN: Medicare spent about $2 billion on
10 vaccines across Parts B and D in 2018. Part B paid for
11 about 21 million doses of vaccines, with spending of about
12 $1.4 billion. Influenza vaccine accounted for roughly 80
13 percent of the doses and half of the spending.
14 Pneumococcal pneumonia vaccine accounted for the most of
15 the rest.
16 Part D paid for about 4 million doses of vaccines
17 in 2018, with spending of about half a billion dollars
18 including beneficiary cost-sharing. Herpes Zoster vaccine
19 for shingles accounted for about three-quarters of the
20 doses and about 90 percent of Part D vaccine spending.
21 In addition to payment for the vaccines
22 themselves, Medicare Parts B and D also pays for

1 administration of the vaccine, which totaled an additional
2 half a billion dollars in 2018.
3 Let's look at how Part B and D compare in terms
4 of vaccine coverage and payment. First, cost-sharing.
5 Under Part B, beneficiaries face no cost-sharing for
6 preventive vaccines. In contrast, most Part D plans
7 require beneficiaries who do not receive the low-income
8 subsidy to pay cost-sharing for vaccines, and the amount
9 varies by plan and benefit phase.
10 Next, payment. Under Part B, fee-for-service
11 pays for vaccines at a rate of 95 percent of the average
12 wholesale price, which is a sticker price that does not
13 necessarily reflect market prices. Under Part D, vaccine
14 payment rates are determined through plans' negotiations
15 with pharmacies. If a particular type of vaccines has
16 several competing products, plan sponsors may be able to
17 use differential cost-sharing to gain more leverage in
18 negotiating rebates with vaccines manufacturers, possibly
19 lowering Medicare's spending.
20 Finally, there are difference is the locations
21 where Part B and D vaccines administered. A wide range of
22 providers can bill Part B for vaccines such mass immunizers

1 like pharmacies, doctors' offices, hospitals, skilled
2 nursing facilities, home health agencies, and others. Part
3 D mostly covers vaccines in pharmacies, but does have
4 provisions for physician offices to bill Part D.
5 Vaccination rates within the Medicare population
6 have generally increased or been stable in recent years,
7 but some established goals for vaccination rates have not
8 yet been reached.
9 In 2010, the Department of Health and Human
10 Services and other stakeholders set national objectives for
11 vaccination rates as part of the Healthy People 2020
12 framework. For flu and pneumococcal vaccines, the goal set
13 was a 90 percent vaccination rate for the age 65 and older
14 population. According to CDC estimates, about 68 percent
15 of elderly individuals received a flu vaccination in the
16 2018-2019 flu season, and about 59 percent of elderly
17 individuals received a pneumococcal vaccine covered by
18 Medicare as of 2017.
19 For shingles vaccines, which is indicated for
20 individuals age 60 and older, the goal set was a 30
21 percent. That goal has been reached, as an estimated one-
22 third of individuals age 60 and older have received a

1 shingles vaccine as of 2018.
2 There are significant disparities in vaccination
3 rates by race and ethnicity in the Medicare population. As
4 shown on this slide, vaccination rates among black and
5 Hispanic beneficiaries are consistently below those of
6 white beneficiaries for vaccines recommended for the
7 Medicare population. These differences occur even when
8 there is no cost sharing, like under Part B for flu and
9 pneumococcal vaccines, and even among Part D for
10 beneficiaries who receive the low-income subsidy and have
11 minimal cost sharing.
12 So in addition to cost-sharing, other factors
13 contribute to disparities in vaccinations rates. For
14 example, according to researchers, individuals may be
15 reluctant to get vaccinated for a variety of reasons such
16 as misconceptions about the benefits of mass immunization,
17 perceived health risk of a particular vaccine, or general
18 mistrust of the health care system.
19 [Pause.]
20 DR. SCHMIDT: We are not hearing you, Shinobu.
21 MS. KELLEY: Rachel, who is supposed to be
22 speaking right now?

1 DR. SCHMIDT: Shinobu is supposed to be up.
2 MS. SUZUKI: Okay. Sorry. As Rachel mentioned,
3 Congress changed the law to cover all COVID vaccines under
4 Part B, but going forward, there still remains the broader
5 issue of what vaccine policy might best serve
6 beneficiaries, taxpayers, and Medicare.
7 In 2007, the Commission recommended that all
8 vaccines be covered under Part B. At the time, there were
9 two major concerns: one, with Part D just getting underway
10 most physicians had no direct way to bill Part D plans, and
11 two, they were concerned that if beneficiaries had to pay
12 for vaccines up front, the cost may deter some from getting
13 the vaccine.
14 Today these concerns no longer apply. Physicians
15 and other immunizers routinely bill Part D plans, so there
16 is very little need for upfront payment by beneficiaries.
17 Nevertheless, there may still be reasons to support the
18 recommendation.
19 In the next few slides, we'll discuss the 2007
20 recommendation and two alternative options. The focus will
21 be on the tradeoffs between social benefits of broader
22 access to vaccines and the effects on manufacturer pricing.

1 Option 1: We could reiterate 2007 recommendation
2 that cover all vaccines in Part B with no cost sharing.
3 Key advantages include wider reach, as more Medicare
4 beneficiaries are enrolled in Part B than Part D, and that
5 there are no cost-sharing under Part B. A wide variety of
6 health care providers are in Part B, so there would be more
7 platforms to reach beneficiaries.
8 In addition, having all vaccines under one
9 program would be less confusing for beneficiaries and
10 providers. However, as we described in your mailing
11 material, the AWP-based payment places little or no
12 constraints on vaccine prices, and the fee-for-service
13 system have limited tools to encourage the use of lower
14 cost vaccines if multiple vaccines with similar health
15 outcomes are available.
16 Option 2: Cover new vaccines to prevent highly
17 contagious diseases in Part B with no cost-sharing, and
18 leave all others in Part D. This is a variation on Option
19 1 that targets Part B coverage to only those that prevent
20 highly contagious diseases. For example, a vaccine to
21 prevent or limit infection of a novel virus that spreads
22 very quickly would be covered under Part B. Viruses that

1 are less easily transmittable would continue to be covered
2 under Part D. Shingles would be an example of vaccines
3 that would be covered under Part D.
4 The main advantage of this option is that it
5 would provide for widest coverage for vaccines with largest
6 social benefits, and by continuing to cover other vaccines
7 under Part D, private plans could negotiate with
8 manufacturers over price for formulary placement and
9 potentially obtain larger rebates if there are competing
10 products.
11 The disadvantages of this option are, as with
12 Option 1, there would be few pricing constraints on new
13 vaccines placed in Part B. Cost-sharing for vaccines in
14 Part D would vary across plans and by benefit phase, which
15 may deter some from getting vaccinated. And it is unclear
16 how well Part D plans could or would constrain prices,
17 particularly if there are no competing products.
18 Option 3 would keep the current approach to
19 vaccine coverage but eliminates vaccine cost-sharing in
20 Part D. Under this option, coverage of new vaccine
21 products would fall under Part D unless already specified
22 in law as a Part B-covered vaccine.

1 This option broadens access to vaccines for Part
2 D enrollees by eliminating a financial hurdle to receiving
3 the vaccine. Relative to Option 2, a larger number of
4 vaccine products would be subject to negotiations with plan
5 sponsors over prices and rebates.
6 However, there are a couple of disadvantages.
7 First, it is not clear how much eliminating cost-sharing
8 would increase vaccine use. Data shows that factors other
9 than cost-sharing play a large role in preventing some
10 beneficiaries from getting vaccinated. In addition, this
11 option would have no effect on access for beneficiaries not
12 enrolled in Part D. Finally, without cost-sharing, plans
13 may have little or no bargaining leverage in their
14 negotiations with manufacturers.
15 In your discussion today, in addition to any
16 feedback, we are also hoping to get your guidance on a
17 potential recommendation in the spring. The material we
18 just presented to you and any revisions will appear in our
19 June 2021 report to the Congress.
20 So we will leave you with the three policy
21 options for you to react to, reiterating the 2007
22 recommendation and two alternative options with different

1 implications for achieving broad immunization versus
2 placing some constraints on pricing. With that, I'll turn
3 things over to Mike.
4 DR. CHERNEW: Great. Thank you, Shinobu and
5 everyone else. I think -- hi, Rachel -- I think we have
6 just a few Round 1 questions. This is great because I want
7 to focus our time on people's opinions of the options.
8 Dana, you're in charge of the Round 1 questions.
9 MS. KELLEY: Mike, you said you had a Round 1
10 question.
11 DR. CHERNEW: No, I don't have a Round 1
12 question.
13 MS. KELLEY: Oh, I'm sorry. I misunderstood.
14 DR. CHERNEW: I think it's Brian and Bruce, but
15 there may be others that haven't shown up to me.
16 MS KELLEY: It is Brian first.
17 DR. DeBUSK: All right. Thank you. Quick Round
18 1 question. In the reading materials, page 32, Table 6.
19 You list out the Part D vaccines, and some of them have
20 their own billing codes, some of them have combined codes.
21 How is that determined? Are those performance-based or are
22 those arbitrary? Who decides when we have a separate code?

1 MS. NEUMAN: So these billing codes are generally
2 established by the AMA. However, CMS does have discretion
3 to modify the billing codes used for vaccines if they find
4 a reason to do so.
5 DR. CHERNEW: That was a perfect Round 1
6 question. Bruce.
7 MR. PYENSON: Thank you. This might have been
8 covered in the reading material and I somehow missed it.
9 My question is, I believe the reading material said that
10 vaccines in Part B are reimbursed on an AWP basis, average
11 wholesale price basis. Did I get that right?
12 MS. KELLEY: Kim, your mic's not on.
13 MS. NEUMAN: Oh, sorry. That's correct. Ninety-
14 five percent of the average wholesale price under Part B
15 for the three preventive vaccines.
16 MR. PYENSON: So my question is if you had looked
17 at converting that to an ASP basis, which other Part B
18 drugs are on, or even a different basis. We had something
19 similar to this in MedPAC for new Part B drugs, I think.
20 MS. NEUMAN: So, Bruce, I think you're recalling
21 from our June 2017 report, where we, the Commission, made a
22 recommendation that payment for new drugs that lacked an

1 ASP for the first couple quarters they were on the market,
2 they had been paid at WAC, which is wholesale acquisition
3 cost, plus 6 percent, and the Commission recommended it be
4 reduced to WAC plus 3 percent.
5 With regard to vaccines and analyzing a
6 conversion to ASP, manufacturers of vaccines are not
7 required to report ASP data so we don't have a sense of
8 where AWP and ASP fall relative to each other for vaccines.
9 MR. PYENSON: So is that something that could be
10 required, since we're putting major issues on the table
11 here, or is that off the table?
12 MS. NEUMAN: I don't know if I can opine on
13 whether it's on the table or off the table, but what I can
14 tell you is I think that would require a statutory change.
15 MR. PYENSON: Okay. Thank you.
16 DR. CHERNEW: So I think we have Marge next in
17 the Round 1 queue. Marge, you're also one of the reactors,
18 so why don't we blend those together and you can just ask
19 your Round 1 question, and then there's no one else in the
20 Round 1 queue, so we will go right into Round 2. Is that
21 right, Dana?
22 MS. KELLEY: Correct.

1 DR. CHERNEW: Great. You're up, Marge, and then
2 we're going to go to you, Jonathan.
3 MS. MARJORIE GINSBURG: Well, except that I
4 actually didn't have a Round 1 question.
5 DR. CHERNEW: Marge, you get to make a Round 2
6 comment.
7 MS. MARJORIE GINSBURG: All right. I'll make a
8 Round 2 comment. So I confess when I first saw that we
9 were doing a discussion on vaccines I thought we were going
10 to get to decide who's going to be the provider of vaccines
11 for the pandemic, you know, how we were going to make a
12 decision about how people get immunized. So then I got
13 down to reality and actually read the chapter, with some
14 degree of relief.
15 This is really a phenomenal report with fabulous
16 background. And what I initially thought was going to be a
17 fairly simply topic is, in fact, not simple at all.
18 The thing that most focused me are the number of
19 people who don't get vaccinated, and it doesn't seem to be
20 a cost-related problem. It isn't about copayments, not if
21 you look at the statistics where you have only 25 percent
22 of people who are on the low-income subsidy who do not have

1 a cost barrier get immunized.

2 So I guess what I would like to say, I know that
3 where we are going are what our options here, but I would
4 also like to throw in -- and maybe the research has been
5 done, and maybe there's nothing more than can be done --
6 but we need to focus more on why people don't get
7 immunized. And I don't know whether this is anything that
8 MedPAC has ever looked at before, in terms of a research
9 topic, but it seems to me this is a really, really
10 important area. And I don't think the immunization rates
11 have improved over time. And perhaps some of you who work
12 more closely with the populations who don't get immunized
13 have some insight as to why, and not only why, because we
14 probably know why, but how do we mitigate that? Is there
15 anything that can be done to convince people it's in their
16 best interest to be immunized?

17 So having said that, the summary of options, I
18 finally landed on Option 2, and I'm going to be very
19 interested, obviously, in hearing what my colleagues have
20 to say as well. But part of this is keep it simple. Let's
21 not make things any more complicated than they already are.
22 And to me, Part 2 really does that. I don't see a

1 compelling reason to move everything into Part B, and it
2 just feels like that Part 2 is a good option, and I'm very
3 interested in hearing other people's comments on it. So
4 thank you.
5 DR. CHERNEW: Jonathan Jaffery?
6 DR. JAFFERY: Thank you. Well, first off thanks
7 for an amazing chapter and a great presentation. I really
8 think this blended three different things for me: the
9 overview of the importance of the government role in
10 vaccines in general, and COVID in particular, a huge
11 background there. You set up an incredibly rich discussion
12 about the concern over disparities that exists in vaccine
13 uptake in the Medicare populations. And then finally, you
14 led us towards a conversation about a discrete policy
15 question that we need to address. So I think it really
16 spanned this big-picture discussion as well as getting into
17 the weeds that, of course, we need to do.
18 So let me just -- I'll just make comments about
19 the second two of those things, the disparities issue, and
20 then I'll get to the summary of options.
21 We're seeing horrible disparities exist and
22 persist in vaccination use, and there is, I think,

1 certainly a lot of concern that that's going to be the same
2 for COVID where we're already seeing huge disparities in
3 the impact of COVID in different populations and in
4 populations of color. This is complex. It goes back many
5 years for a variety of reasons, including lots of very
6 well-earned mistrust about certain things. But I think any
7 policies that we want to enact or that do get enacted going
8 forward really need to try and mitigate these disparities.
9 And so one thing we can think about perhaps is
10 actually reporting on different kinds of inequities going
11 forward, more so than just in our chapters and our
12 discussions. You know, that whole dictum about you can't
13 improve what you don't measure. If there's an opportunity
14 for us to require reporting on some of the different
15 disparities based on race, ethnicity, language, then
16 hopefully we can take some of that both in metrics for MA
17 plans and perhaps quality reporting in fee-for-service.
18 One of the articles in our reading I think spoke
19 to one of the major health plans' pretty significant
20 investments in trying to move their star ratings, and so
21 there's some evidence that providers and plans do react to
22 these things. So I hope that's something that we can

1 consider.

2 And then to the second point, and then I'll

3 conclude. In terms of the options, I'm falling in favor of

4 Option 1. I think actually Marjorie mentioned simplicity,

5 and I think having everything in the same -- in Part B may

6 add some simplicity. I'm not sure how much that matters.

7 But the compelling thing for me was the notion that there's

8 such a significant number of beneficiaries, Medicare

9 beneficiaries, who have Part B but don't have Part D. I

10 think it was 8.5 million individuals in the reading. And

11 so for that reason, I think reiterating 2007

12 recommendations as Option 1 says.

13 That said, I was going to recommend sort of a

14 modified Option 1, which was to use a different -- was

15 thinking about using average sales price, similar to some

16 of the questions that Bruce was raising. It sounds like

17 maybe that is not -- that's an oversimplification of what

18 could be done. So I think maybe a little more thought or

19 discussion about that, but using Option 1 but a different

20 pricing mechanism. And I recognize it's -- as you said,

21 some of that might require a statutory change, but I don't

22 know that that should necessarily be a barrier to us making

1 the recommendation that we think is the best policy
2 decision.
3 Thank you.
4 MS. KELLEY: Okay. Brian, you're next.
5 DR. DeBUSK: Thank you. First of all, great
6 presentation, very thought provoking. I think your answer
7 is Option 1 for the reasons you stated on the slide. I
8 think bringing everything under Part B gives you more
9 options. It covers the most people. Lots of access.
10 You're disadvantaged. I think there's a way to
11 get around that disadvantage, and that is, make -- and not
12 just coronavirus, but make all these vaccines performance-
13 based. I think you could set billing codes based on the
14 performance and characteristics of the vaccine, and what
15 that would allow you to do is stratify the payments,
16 because, you know, you make the point that you don't really
17 have any constraints on pricing if you push this all under
18 B. Well, if you provide distinct performance categories
19 for viruses -- I'm sorry, for vaccines, then it will give
20 us the ability to group the vaccines with similar health
21 effects and pay accordingly. And if you notice, again,
22 back on page 32 of the reading material, we've had average

1 annual price growth of anywhere from minus 0.3 percent up
2 to what looks like 1.1 percent for over, what, a three- to
3 five-year period for some of these vaccines that have the
4 combined billing code. So I think the answer is Option 1
5 with combined billing codes based on vaccine performance.
6 Thank you.
7 MS. KELLEY: Bruce?
8 MR. PYENSON: Thank you. I would like to amplify
9 Jonathan and Brian's point. Since we're talking about a
10 statutory change for Option 1, anyway, which I support, I
11 would like to suggest an ASP basis. But there's a feature
12 of Medicaid best price that I think we should suggest here,
13 which is that, as you know, Medicaid best price has two
14 components. One is a statutory reduction, and the other is
15 what you might call an inflation penalty.
16 I would suggest adding an inflation penalty to
17 the ASP for vaccines, move it all into Option 1. I
18 disagree that there is better price control in Part D. I
19 think there's weak evidence supporting that claim. But the
20 Option 1 is my favorite, and I think we can deal with the
21 prices through an ASP or modified ASP basis along with the
22 grouped HCPCS codes that Brian was referring to.

1 MS. KELLEY: Larry -- I'm sorry. Paul, I think
2 you're next.
3 DR. PAUL GINSBURG: Sure. This is very well-done
4 work, and, you know, my reaction to it was I didn't think
5 it was really -- I think the important thing is to have
6 vaccines for highly contagious diseases in Part B because
7 it covers more people and with no cost sharing. But the
8 difference between the options -- that's included in all
9 the options. The difference between the other options to
10 me is so small compared to the challenge of getting -- of
11 purchasing more effectively in Part B. And I think that as
12 we go forward, that's what most of the work should be on,
13 is, you know, whether to use Brian's approach, whether to
14 use an ASP approach, and there may be other approaches.
15 This seems to be something ignored for a long time in
16 Medicare when the markets have changed. And, you know, of
17 course, there are many other examples of that. That's our
18 challenge.
19 But I would just put all of our energy into
20 finding more effective ways to purchase vaccines in Part B.
21 MS. KELLEY: Larry.
22 DR. CASALINO: Yeah, so I think Jonathan, Brian,

1 Paul, and Bruce have already said what I had planned to
2 say. I'll just reiterate I think Option 1 from what I
3 understand is preferable. It's much simpler, which is
4 important, I think. There's no cost sharing, which I think
5 is great. We are not worried about overuse of vaccines.
6 Quite the opposite.
7 I think an overwhelming reason is the fact that
8 everyone would be covered. We don't want to make
9 disparities worse than they already are, and, of course, we
10 want everyone covered for vaccines. So a plan that depends
11 on Part D which not everyone has seems to me undesirable.
12 And then the last point is we've had a lot of
13 work that the staff has presented in the last six months or
14 so suggesting that Part D has not been very good about
15 controlling pharmaceutical prices. I think Medicare could
16 control vaccine prices any way it wants to. It would
17 require a statutory change, but there have been a couple of
18 suggestions about how it could be done. But Part B could
19 pay what it wants to pay, essentially. Obviously, you
20 can't pay two low or we wouldn't have vaccines. But I
21 don't see that Part D would control prices better than Part
22 B.

1 So, to me, who was very ignorant of this topic
2 before I read the staff's excellent materials, Option 1
3 does seem superior.
4 MS. KELLEY: Dana?
5 DR. SAFRAN: Thanks. Just very brief.
6 Everyone's already made all the important points. I think
7 Option 1 for me is by far the favorite, just for all the
8 reasons described, but in particular creating universal
9 access, as close as we can to universal access, which Part
10 D wouldn't help us do; and avoiding cost sharing as a
11 barrier. And in particular to address the disparities that
12 we know exist, I think we should be lowering every
13 threshold we can, and Option 1 seems to do that best.
14 Thanks.
15 MS. KELLEY: Betty.
16 DR. RAMBUR: Thank you. This was actually very
17 fascinating to me, and I just wanted to make a couple of
18 comments.
19 One, I agree the disparities are clearly a
20 concern, but I'm also pondering this anti-vaxxer movement
21 that's happened in the United States and other wealthy
22 countries, and it's really unclear which direction,

1 whatever happens with COVID, is going to take that. It may
2 depend on its effectiveness and safety. But I'm not sure
3 we can take on all of that within this policy space.
4 So when I was looking at these options, my
5 initial ranking was Option 2, Option 1, and then Option 3.
6 And so I've appreciated the other nuances that you have
7 added, and I'll be looking forward to understanding more
8 about the details of some of those as we move towards a
9 final recommendation.
10 Thank you.
11 MS. KELLEY: Jon Perlin?
12 DR. PERLIN: Thanks. I strongly support Option
13 1. I think it's unconscionable to exacerbate potential
14 barriers, financial barriers in the face of no disparities
15 in terms of the access to and equity of use of vaccines.
16 Second, I have a philosophical issue with the
17 other options, which is it's a slippery slope when we
18 decide which vaccines are in and which are out. So, for
19 example, if indications for the human papilloma virus
20 vaccine, which is now administered to teens and young
21 adults to prevent cervical cancer, were expanded to other
22 individuals, would we say, well, that's not in? And it

1 gets to all sorts of issues I don't think we should get to.
2 Third, you know, the characteristics of a good
3 vaccine is that they have a positive return on investment
4 in terms of forgone need for additional care and services,
5 and toward that end private insurers and even other
6 programs have offered incentives, additional incentives
7 beyond no cost, to encourage the uptake of vaccine,
8 particularly in the face of, as Betty just offered, as is
9 clinically correctly known, vaccine hesitancy.
10 DR. RAMBUR: Thank you for that.
11 DR. PERLIN: Beyond the notion that we should
12 encourage the uptake of vaccines amongst the beneficiaries
13 themselves, I am actually frankly surprised we haven't
14 discussed Medicare provider accountability for vaccinating
15 patients. But toward that end, I would endorse that we do
16 everything we can to make it easy to get vaccinations out,
17 and particularly as we look toward the promise, we hope, of
18 one or more effective COVID vaccines and that we even
19 contemplate mechanisms such as roster billing where there's
20 a one-to-one beneficiary accountability but a mechanism to
21 simplify the administrative burden to make sure vaccination
22 occurs.

1 Thanks.
2 MS. KELLEY: Karen?
3 DR. DeSALVO: Thank you. I support Option 1 for
4 the reasons that have been mentioned. My other comments
5 are more related to public health and COVID considerations.
6 I think we should spend a little time on the language
7 "highly infectious" or "highly contagious" because there
8 are a lot of diseases that are highly contagious but don't
9 have the morbidity and mortality associated with them, and
10 that's really what we're trying to protect for those who we
11 vaccinate. So maybe I can work with the staff on some
12 language that speaks more to what we're really trying to do
13 for protection because it's not -- "contagious" isn't
14 exactly -- I think what you're trying to get to is things
15 that are common and communicable.
16 The other categories about COVID are the COVID
17 vaccine or vaccines, plural, are likely to be annual and
18 paired with influenza. So as you're thinking about this
19 going forward, wherever it is, it should be married to
20 going to the office and getting or going to the church or
21 wherever you're going to go and getting both concurrently,
22 which also sort of pushes it towards a Part B payment.

1 I think the other issue is something that Bruce
2 has raised in the last couple of days about deflation and
3 also that Brian talked about with value. And I don't have
4 an answer here, but just for consideration, the first-gen
5 COVID vaccine is more -- is potentially going to be less
6 expensive but maybe not as effective as some of the second-
7 gen and other iterations of the vaccines may be, and they
8 may be more expensive to manufacture since it's new, but
9 they also might have more value because they'll be more
10 likely to prevent not only disease but potentially
11 transmission, the two characteristics.
12 So this one will be interesting, but probably
13 it'll be more like influenza where it will prevent disease
14 and not transmission. But I just want us to be monitoring
15 the fact that what comes out in the next few months
16 probably won't be what we have longitudinally. And, in
17 fact, certain populations may have certain specific
18 vaccines, so mRNA make more sense for some populations than
19 an attenuated adenovirus.
20 The last thing I just want to say is I don't know
21 what Medicare policy is about paying for therapeutics that
22 have been approved via emergency use authorization, but if

1 that seems like a likely pathway for COVID vaccine, it's
2 that it would be approved by EUA, which may either preclude
3 additional science on other vaccines or stop the interest
4 in manufacturing, and that may be the bar that it's held
5 to. And that may be a Round 1 question, Mike, but I think
6 it's something we should make sure that Medicare policy
7 allows us to longitudinally pay for something that hasn't
8 been through full FDA review.
9 MS. KELLEY: Pat?
10 MS. WANG: Thank you. I would echo some of the
11 earlier comments. I think Paul summarized it really well.
12 I think, you know, Option 1, Part B, is the superior
13 distribution mechanism, but the cost has got to be -- we've
14 just really got to grapple with that, whether it's Bruce's
15 suggestion or Brian's or what have you. I think it's
16 really, really important. Part B for distribution channel,
17 but price has to be addressed.
18 I do want to pick up on something that Jon Perlin
19 mentioned, though, about provider accountability, and Jon
20 Jaffery referred to this. Organizations that are
21 incentivized because it's part of a quality bonus, as it is
22 in Stars, to achieve certain flu vaccination rates, for

1 example, they go in the direction of that signal. And I
2 wonder whether given the importance -- I mean, like we are
3 focused on flu vaccine right now. In advance of COVID, the
4 flu vaccine is critically important for the population.
5 But I wonder whether we can contemplate adding, for
6 example, to ACO metrics flu vaccination rates, ultimately
7 other important vaccine vaccination rates. I don't know
8 how to achieve what Jon Perlin described, but I think we
9 should be thinking about it, because it's a very complex
10 issue why people don't get vaccinated. It's baffling to
11 those of us who routinely get our flu shot every fall that
12 many people misunderstand that they need one, they think
13 they never had flu so they don't need to get a flu shot;
14 they don't have time; they can't be bothered; they're
15 suspicious. It's really multifactorial, and it takes the
16 entire system, I think, to move the needle on achievement
17 of desirable vaccination rates. So I think we should add
18 that into our thinking, how to incentivize that.
19 Thank you.
20 MS. KELLEY: Marge?
21 MS. MARJORIE GINSBURG: Yes, I wanted to mention
22 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,

1 Bruce, Pat, and others have raised around needing some
2 price controls here. And so I think Option 1 has a lot of
3 advantages, but are there ways of controlling the potential
4 prices. And so, as I said, I'll be brief, but I really
5 like the way this is shaping up. Thanks.
6 MS. KELLEY: Amol?
7 DR. NAVATHE: Hi. So I agree generally with much
8 of what's been said. I'll just try to add a couple of
9 pieces here. So just like David said, I think generally
10 speaking I'm supporting Option 1 with some change in the
11 pricing here, to ensure some price constraints, pressure on
12 accountability in the prices.
13 That being said, a couple of things to consider.
14 So one, if we really wanted to prioritize access, then
15 maybe potentially proposing Part A, since Part A is much
16 more widely adopted as basically an entitlement, relative
17 to Part B, which does require a premium and opt-in, if you
18 will. So potentially Part A as a financing mechanism.
19 The second thing is I think we all value, likely,
20 innovation, continued innovation in this space. I think
21 the paper did a nice job of actually describing how some
22 diseases, some highly communicable diseases have greater

1 social impact and there's greater social welfare with broad
2 vaccination. So if we did put everything in Option 1, Part
3 B, and there's no variation, if you will, between the
4 pricing pressure, then you could get in a situation where
5 we actually don't have equivalent, if you will, or even
6 better incentives and rewards for manufacturers to pursue
7 vaccines for these highly communicable diseases. That is
8 one thing that's sort of nice, if you will, about the
9 legacy option or the prior option. So I just wanted to
10 bring that up. If we do put forth an Option 1, do we also
11 want to put something out there about pairing it with a
12 policy to try to promote rewards in the highly communicable
13 disease category.
14 MS. KELLEY: Paul, I think you said you had
15 something else to say?
16 DR. PAUL GINSBURG: Sure. Yeah. I also support
17 Option 1. I just wanted to mention that. And I don't know
18 if it's part of this project or something else. I think
19 that increasing vaccine compliance is likely something we
20 should get into, because it's so important, especially in
21 the COVID environment.
22 And in answer to Amol, I don't think Part A is

1 the right way to go, because I don't think Part A has any
2 experience in paying providers and paying clinicians. And
3 also, I believe that pretty much everyone in Medicare is
4 enrolled in Part B, unless they already have strong
5 insurance coverage, and thus Part B would be redundant for
6 them. So I don't think that necessarily would be a big
7 difference in coverage.
8 DR. CHERNEW: Okay. I'm going to jump in.
9 First, it is amazing how when you all have planes to catch
10 things go really quickly.
11 Anyway, I do want to make sure we hear from, I
12 think, Wayne and Jaewon and Sue, just to get your sense of
13 the options. But I will say a few things.
14 First, with regards to the Part A issue, there's
15 another concern that Part A is paid in the trust fund,
16 which is going to create a whole other set of problems, but
17 I don't want to focus on that. I actually -- and this has
18 been a great discussion. There seems to be a fair bit of
19 consensus around the principles, and even on some of the
20 actual strategies of what we will do. And I agree with the
21 comment that Paul said, and I think a lot of you echoed,
22 that getting the pricing right is important.

1 It is challenging because we have to balance the
2 incentive for a program with fiscal integrity, which I care
3 a ton about, with the incentives to actually have the
4 vaccines developed, which I care a ton about. And so
5 there's always this tension in new products between what
6 you want to pay once you have them and what you want to pay
7 before you do, and that's going to make this a particularly
8 challenging thing for us to get into. That doesn't mean we
9 should shy away from it. It comes up in a lot of other
10 parts of our work, so we will do that.
11 But at least on the narrow question at hand, I
12 think we agree that we want to have the widest access
13 possible, and that seems to be promoted by Part B coverage
14 without cost-sharing, and we will worry or think about or
15 ponder the pricing concerns, as some of you have remarked
16 on.
17 So that's where I am. I think we're through the
18 queue, so I'm adding to the queue people, mandatorily in
19 this case, so Wayne, do you want to comment quickly or
20 briefly?
21 DR. RILEY: Yeah. Terrific work by the staff
22 again. I have heard all the comments. I firmly favor

1 Option 1. And again, you know, the thing that gives me a
2 little queasiness about all this is the low penetrance
3 among black Medicare beneficiaries for, you know, flu,
4 shingles, and pneumococcal pneumonia, which, to me, is a
5 harbinger of how difficult it's going to be to get them to
6 embrace a likely COVID vaccine. And, you know, I think we
7 all know part of the vaccine headwind we're facing is the
8 anti-vaccine sophistry bits in the public domain.
9 So to the extent that MedPAC feels that it can
10 wade into that space, I think it would -- I agree with
11 Paul. This is something that affects the health of
12 beneficiaries, and it's something that MedPAC should find a
13 way to articulate a strong recommendation to Medicare
14 beneficiaries and to Congress that vaccines should be
15 embraced more fully than we've ever embraced vaccines.
16 DR. CHERNEW: Thank you, Wayne. I agree. I
17 think there's a lot of positive sentiment towards that
18 view. Jaewon?
19 DR. RYU: Yeah, I agree with Option 1 as well,
20 but also share people's concern around the pricing.
21 Thanks.
22 DR. CHERNEW: And that brings us, I think, to

1 you, Sue.

2 MS. THOMPSON: Thank you. And I too agree with

3 Option 1. Again, thank you to the staff for your work on

4 this topic. I also am intrigued with some attachment of

5 adherence, in compliance to the measurements of

6 participating in Medicare by our providers, although I just

7 think that's worthy of more discussion. But I appreciate

8 and want to call our Marge's passion in the opening of this

9 discussion around the importance of us focusing on how do

10 we improve the overall compliance to vaccination for this

11 population.

12 So those would conclude my comments. Thank you.

13 DR. CHERNEW: Thanks, Sue. And if I followed

14 correctly, Dana, you had something else that you wanted to

15 say. Am I reading that right?

16 DR. SAFRAN: No. I did not.

17 MS. KELLEY: I think Bruce might have something

18 else.

19 DR. CHERNEW: Okay. Bruce might have something

20 else.

21 MR. PYENSON: Thanks. This is in response to the

22 enthusiasm of this group, which I share, for promoting

1 vaccination. And for childhood vaccinations there is a
2 liability program that exists that encourages manufacturers
3 to produce vaccines. That does not apply, I believe, to
4 adult vaccines. And as that is something, if we can figure
5 out a way to make that part of MedPAC's response domain
6 relevance, I think would be useful to have staff look into
7 that.

8 DR. CHERNEW: Great. Thank you, Bruce. I
9 believe now we have not only made up for the deficit in
10 time from our wonderful telehealth discussion, but we are
11 now ahead of schedule. So I think that's great. It's been
12 a wonderful morning and wonderful meeting for me, so I want
13 to again thank all of you for your comments. I want to
14 really thank the public for tuning in, and I emphasize that
15 there's ways to reach out to us through the MedPAC staff,
16 and I think, Jim, you can talk about maybe on the website
17 to get their comments in. We do miss hearing them in
18 person.

19 And a double shout-out to the staff and all of
20 their work for both preparing this material, their terrific
21 presentations, and their willingness and skill at answering
22 all of our questions.

1 So that's really where I am. I'm going to turn
2 it to Jim and Dana for their final thank-yous and goodbyes.
3 Jim?
4 DR. MATHEWS: Oh, likewise. I appreciate
5 everyone's engagement in the discussion. You have proven
6 the fact that MedPAC is also able to relatively adapt to
7 new circumstances and new technologies, and I thought this
8 went very well, and you've given the staff a lot to work
9 with as we head back next week.
10 And lastly, I would like to commend our new
11 Commissioners and welcome you to, you know, what is going
12 to be a six-year interesting, hopefully, experience for
13 you. And in particular, Mike, you did a nice job in your
14 first outing as chair. So thank you, everyone.
15 DR. CHERNEW: Thanks, Jim. Dana, anything to
16 add?
17 MS. KELLEY: No. Thanks, everyone, and just let
18 us know if you have any questions. The public can submit
19 comments online, and we, of course, will review them as we
20 receive them.
21 DR. CHERNEW: Okay. So thank you all. Enjoy the
22 rest of your Friday, and if anything else, to the

1 Commissioners, comes to mind, don't hesitate to reach out
2 to me. Thanks again and we'll be in touch.
3 MS. KELLEY: Great job.
4 [Whereupon, at 12:06 p.m., the meeting was
5 adjourned.]
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